



Splenic infarction revealing a double "j" stent in the abdominal aorta

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Splenic infarction revealing a double "j" stent in the abdominal aorta

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Abstract

We report a 52-year old patient with a double J ureteral catheter displaced out of the ureter in the initial part of the abdominal aorta. The catheter was removed successfully by endoscopic usual technic after introduction of a safety intra-aortic balloon and without vascular complications.

Introduction

Double J catheters are used for maintaining the urine flow from kidneys to bladder due to ureteral stenosis caused by intrinsic or extrinsic pathologies [1]. They are usually implanted temporarily for 3–6 months. The procedure is routinely performed under cystoscopic or scopic guidance. Rarely may these catheters be displaced through the large vascular trunks [2–4]. In this case report, we present the successful treatment of displacement of a double J catheter into the abdominal aorta after introduction of a safety balloon in its descending thoracic portion through the femoral artery.

Case Report(s)

A 52-year old male patient was treated with a ureteral stent due to an infected hydronephrosis secondary to a probable syndrome uretero-pelvic junction 9 months ago. It was understood that no cystoscopy was used as a guidance, and that massive hematuria occurred during implantation. Moreover, the patient was not in compliance with the routine follow-up protocols. The patient had consulted for severe pain of the left hypochondrium which prompted us to perform abdominal CT.

This exam revealed the displacement of the top of the catheter through the retroperitoneum within a distance of 5 cm, then through left edge of the infrarenal aorta. The tip of the catheter extended to 2 cm above the celiac trunk and does not contain calcifications or blood clot. The spleen was infarcted.(Fig. 1-2).

The removal of the double 'j' was done in two stages under cardiopulmonary monitoring. At the beginning, a

safety balloon was set up in the thoracic aorta via the femoral artery puncture, then comes the cystoscopic time that allowed the progressive and careful catheter ablation controlled by aortic opacification and fluoroscopy. The intra-aortic balloon inflation was not required since the removal of the double j stent was done successfully and without leakage of contrast.

Conclusion

We conclude that the catheter was improperly implanted at the first procedure and the stent migrated to abdominal aorta. Inappropriate procedural protocol without using cystoscopy guidance might have contributed to this complication. Imprecise placement of ureteral catheter may result in malposition or displacement leading to undesirable vascular or cardiac extensions.

The removal of the ureteral stent after introduction of the safety intra-aortic balloon may provide a safe option for the treatment and avoid the risk of bleeding due to vascular breach.

Authors contribution(s)

All authors of the manuscript have read and agreed to its content.

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