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## **A Case Of Cervical Carcinoma With Bilateral Perinephric Hematoma: A Diagnostic Dilemma**

Dr.Shivani R Kundur, Dr.Manjunath V, Dr.Abhilash Gautham

### **CLINICAL HISTORY:**

#### *History of Presenting Illness:*

A 40-year-old female patient presented with complaints of pain abdomen since 3 days and bleeding per vagina since 3 days.

The patient complained of pain abdomen since 1 year, acute onset, and dull aching type, gradually progressive and of intermittent nature. The pain gradually increased in intensity for the next 6 months. The pain was aggravated during menstruation and relieved temporarily on medication. History of menorrhagia present.

The patient now complains of pain abdomen, right-sided, acute onset, dull aching type, and of continuous nature since 3 days. The patient also complained of bleeding per vagina since 3 days, no clots, using 4-5 pads per day.

No history of vomiting/ loose stools/ hard stools/ decreased appetite.

#### *Past history:*

The patient was admitted for the same complaints 3 months back and diagnosed to have left ureteric stenosis with huge subcapsular renal hematoma. She underwent left Ureteroscopy plus Double J stenting and Percutaneous Nephrostomy drainage (around 350-400 ml of thick, dark blood drained out) on 21/05/2020. She now presents with similar complaints on the right side.

#### *Obstetric and Menstrual history:*

Her obstetric history is Para 2 Living 2 with all full-term normal delivery and underwent tubal sterilization after her last childbirth 21 years back.

Her cycles are regular lasting 3/28 days, regular and moderate flow, no pain, and no clots.

Her last menstrual period was on 21/08/2020.

### **EXAMINATION AND INVESTIGATIONS:**

Pallor present + +

Bilateral Pedal Edema +

No icterus/ cyanosis/ clubbing/ lymphadenopathy

#### Vitals:

Pulse Rate- 80 beats per minute

Blood Pressure- 140/90 mm Hg

Respiratory Rate- 18 cycles per minutes

SpO<sub>2</sub>- 98% at room air

Temperature- Afebrile

#### Systemic Examination:

1. Per Abdomen:

#### Inspection:

The shape of the abdomen appears normal.

Corresponding quadrants move equally with respiration.

Previous surgical scar present.

No sinuses.

Palpation:

No local rise of temperature.

The shape of the abdomen appears normal.

The abdomen is soft.

Corresponding quadrants move equally with respiration.

Tenderness present in the right iliac fossa, left iliac fossa, suprapubic region.

Previous surgical scar present.

No sinuses.

Percussion:

No evidence of free fluid.

Auscultation:

Bowel sounds heard.

2. Per Vaginal Examination:

Normal.

Per vagina is roomy.

Cervix flushed with vault, no growth.

Not bleeding on touch.

No mass or induration present.

3. Cardiovascular System- S1, S2 heard, No murmurs.
4. Respiratory System- Bilateral normal vesicular breath sounds heard, No added sounds.
5. Central Nervous System- No focal neurological deficits.

Hb- 6.6 gms/ dl

RBC- 3.30 million/ cu mm

TLC- 8100 cells/ cu mm

N/L/E/B- 68.8/23.1/3.8/4.3 %

Platelet- 4.62 lakhs/ cu mm

Serum Urea- 18 mg/ dl

Serum Creatinine- 1.40 mg/ dl

Uric acid-5.2 mg/ dl

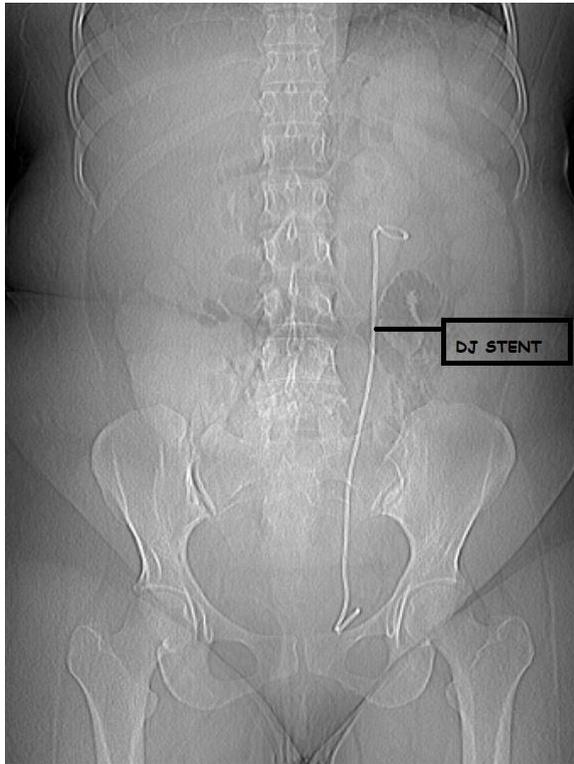
Na<sup>+</sup>/K<sup>+</sup>/Cl<sup>-</sup> – 143/4.0/109 mmol/ L

USG abdomen and pelvis:

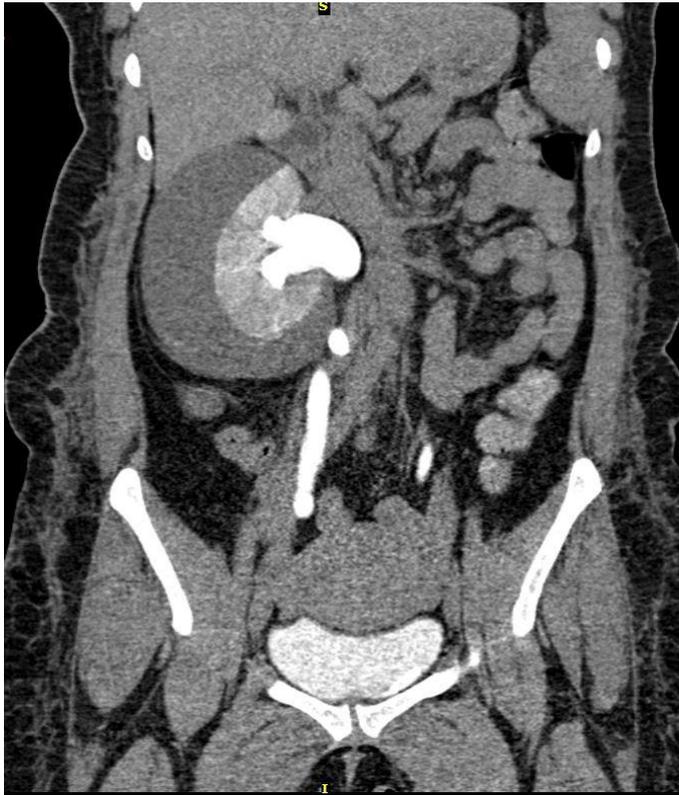
1. Anechoic collection was noted in relation to all the poles of the right kidney.

2. A thin rim of anechoic collection was noted in the mid pole of the left kidney. DJ stent noted in situ.
3. Uterus looks bulky in size.

CECT Whole abdomen and pelvis:



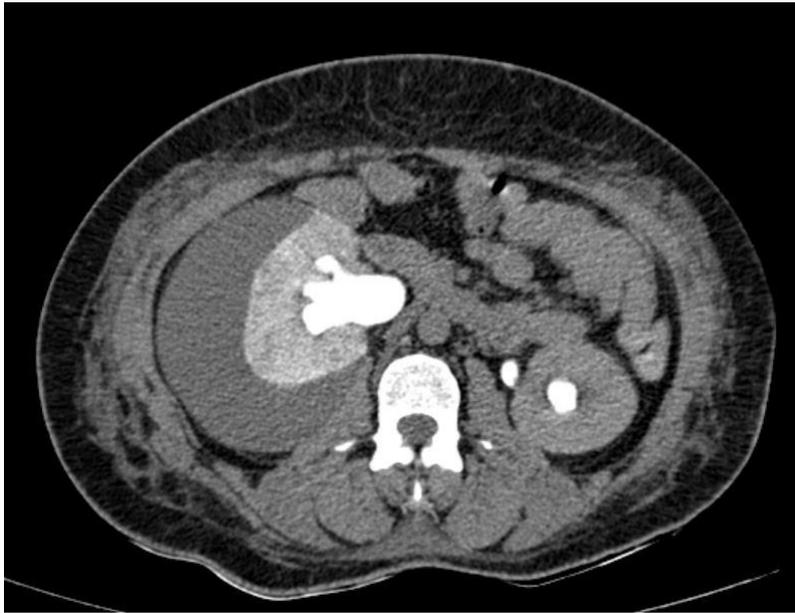
CT scan showing left kidney DJ stent in situ.



CT scan showing right sided moderate hydroureteronephrosis, stricturous narrowing of the distal ureter with large well defined subcapsular collection occupying all poles of right kidney.

Left sided mild hydroureteronephrosis, stricturous narrowing of distal ureter with minimal

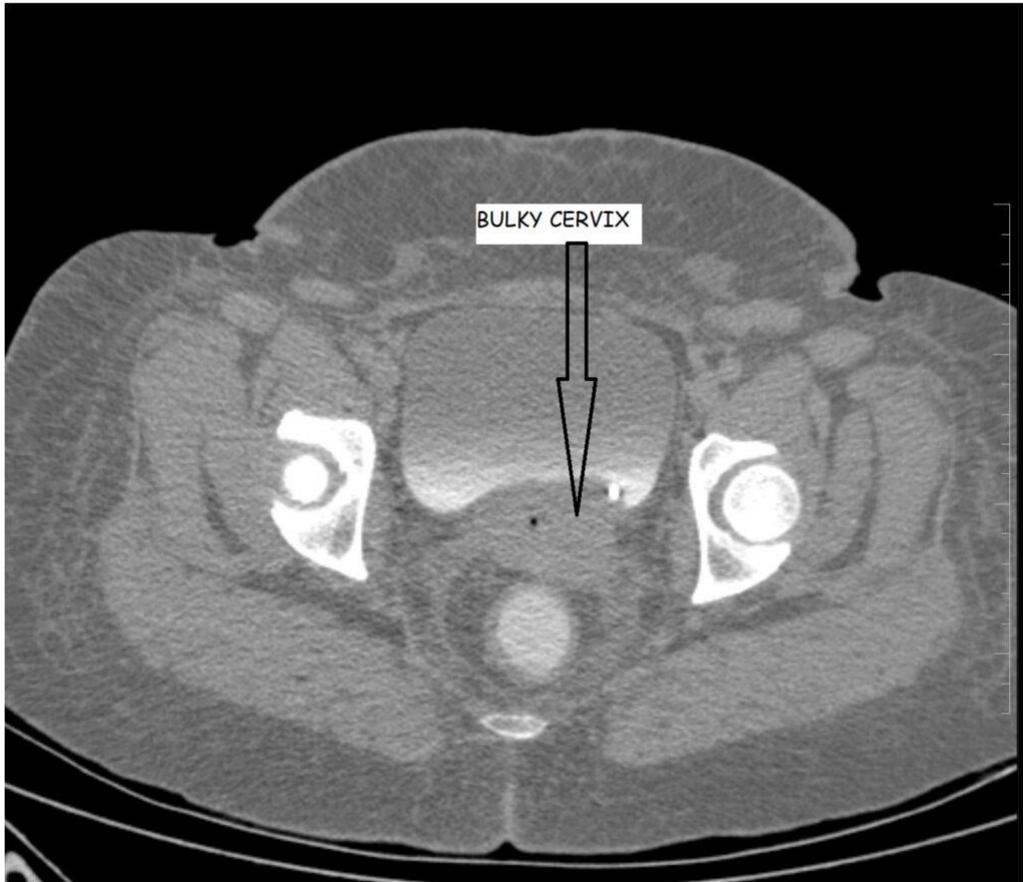
subcapsular collection along the inter polar region of left kidney.



CT scan showing right sided moderate hydroureteronephrosis, stricturous narrowing of the distal ureter with large well defined subcapsular collection occupying all poles of right kidney.

Left sided mild hydroureteronephrosis, stricturous narrowing of distal ureter with minimal

subcapsular collection along the inter polar region of left kidney.



CT scan showing bulky cervix.

**FINAL DIAGNOSIS:**

- Fibroid uterus
- Right Sided Perinephric hematoma
- Anemia

**DISCUSSION:**

Perirenal or perinephric hematoma is the collection of blood around the kidney. Spontaneous perinephric hematoma is a rare condition that is usually caused by benign and malignant renal tumors, vascular abnormalities, and inflammatory disorders. However, a few patients in whom there is no apparent underlying disease are described as having idiopathic spontaneous perinephric hematoma.[1]

On the other hand, over 70% of patients with cancer cervix present in advanced stages of the disease with coexisting urological complications. Patients can present clinically with incontinence of urine, dribbling of urine due to vesicovaginal, ureterovaginal or rectovaginal fistula leading on to uremia, lower urinary tract obstruction progressing to bilateral hydronephrosis, bilateral limb edema, recurrent urinary tract infections, bladder calculus, haematuria, pyuria, atonic bladder function and so on. The most common presenting symptoms are anuria or oliguria, flank pain, dyspnea, leg edema, and body malaise.

Anatomically, the terminal segment of the ureter is close to the cervix. So cervical cancer could lead to initial hyperemia, later on, compression or angulation of the ureter due to parametrial involvement. The involvement of the urethra, abdominal portions of the ureters, and the kidneys is usually a secondary phenomenon, either due to infiltrating malignancy or back pressure changes. Hence, due to posterior cervical wall thickening, incidences of the same causing ureteral narrowing resulting in hydroureteronephrosis have been noted. The resultant hydroureteronephrosis can cause perinephric collection and can present as either perinephric hematoma or an abscess.

So, carcinoma cervix with symptoms of menorrhagia/ oligomenorrhea/ polymenorrhea/ abnormal uterine bleeding should be suspected in any case of bilateral perinephric hematoma or abscess. Also, a case of Adenomyosis can present with similar complaints, hence the patient needs to be distinguished and diagnosed correctly.[2]

CT scan remains the investigation of choice for diagnosing perinephric/subcapsular hematomas and may be able to delineate the potential underlying etiology.

Nonoperative interventions with selective angiography and embolization of the offending arterial bleeder are often the treatment of choice if another surgery is not indicated.

Percutaneous management to control the bleeding and to drain the kidney can be done as this would potentially salvage the kidney. Alternatively, a ureteral stent combined with angioembolization would also be an option.

Given the location of the perinephric hematoma and the minimal degree of hydronephrosis, the outcome of renal embolization in the presence of an active infection is unknown and concerns for being able to clear the infection with devitalized tissue exist. A minimally invasive nephron-sparing option is a ureteral stent with or without embolization.[3]

A Double J stent is a ureteral stent with curving ends that prevent the stent from slipping into the bladder or the kidney. They are placed to reduce sharp pain due to colic or to allow drainage when an infection is present. They allow healing after a surgical procedure and ensure any swelling does not block the drainage of the urine after the procedure.[4]

**ACKNOWLEDGEMENTS:** None

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