CASE REPORT

CECT FEATURES OF RETROPERITONEAL FIBROSIS WITH BILATERAL OBSTRUCTIVE UROPATHY SECONDARY TO ANEURYSM AND DISSECTION OF ABDOMINAL AORTA
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ABSTRACT: Retroperitoneal fibrosis is one of uncommon cause of obstructive uropathy. Aortic dissection without rupture is still uncommon cause of retroperitoneal fibrosis. We present unusual case of aortic aneurysm with dissection without its acute rupture causing retroperitoneal fibrosis with its contrast computed tomography features. We report imaging features of computed tomography of abdominal aortic dissection complicated by retroperitoneal fibrosis with bilateral ureteral obstruction. The patient underwent successful bilateral transurethral ureteral stenting to relieve acute obstruction and started on corticosteroid treatment.

KEYWORDS: Retroperitoneal fibrosis, obstructive uropathy, abdominal aortic dissection, computed tomography.

CASE: A 40-year-old female complains of anuria and vague abdominal pain came to surgery department. USG features were suggestive of bilateral hydronephrosis and proximal hydroureter with dilatation of aorta. Her serum BUN and creatinine levels were slightly raised.

She underwent non contrast CT to look for cause of renal obstruction. Non contrast CT shows dilatation of bilateral pelvicalyceal systems with proximal hydroureters upto L3 –L4 vertebral level. Abdominal aorta seen dilated at this level with atheromatous changes in the form of vessel wall calcification. Minimal hypodensity seen at periaortic region adjacent to mid ureter. IV contrast study was done to delineate aortic pathology better. CECT study shows an abdominal aortic aneurysm (3 cm in diameter) distal to the origin of the renal arteries and was encircled by a very small amount of nonenhancing hypodense soft tissue density i.e., fibrotic tissue .There was short segment dissection in abdominal aorta. Bilateral hydronephrosis with hydroureter are seen up to this level. The interpretation of these findings is minimal RPF with aortic aneurysm and dissection. Patient was referred to urology department for further management.

INTRODUCTION: Although extrinsic ureteral stenosis is reported in up to 71% of patients referred for abdominal aneurysms1 ureteral obstruction secondary to perianeurysmal fibrosis is uncommon.2 The cause of such fibrosis is still unknown. Periureteral extension of the inflammatory disease that has affected the aorta and mere coincidence (the coexistence of idiopathic retroperitoneal fibrosis and an abdominal aneurysm) are the 2 main pathophysiologic mechanisms that have been proposed.3,4

Retroperitoneal fibrosis (RPF) is defined as an inflammatory and fibrotic mass that develops in the retroperitoneum. Albarran5 first described the disease in 1905, but it was not until Ormond6 reported cases of RPF in 1948 that it became a recognized clinical entity. The disease became
acknowledged as RPF in the 1960s, and this remains the current preferred term. A variety of terms have been used to describe the disorder, including Ormond’s disease, periureteritis fibrosa, periureteritis plastica, chronic periureteritis, sclerosing retroperitoneal granuloma, and fibrous retroperitonitis. In most patients (approximately 68%), no etiologic factor is found. Therefore, the term idiopathic RPF is used. Evidence suggests that RPF is an autoimmune response to an insoluble lipid called ceroid that has leaked through a thinned arterial wall from atheromatous plaques.\(^7,8\)

Other implicated causes include drugs, abdominal aortic aneurysm, ureteric renal injury, infection, retroperitoneal malignancy, post irradiation therapy, chemotherapy and hemilaminectomy, hypothyroidism and carcinoid tumor.

More than 90% patients presents gradually as acute renal colic. Constitutional symptoms like malaise, anorexia, fever, weight loss, neurovascular compromise can be present. Venous complications are may be due to IVC involvement like lower extremity edema, phlebitis, DVT. Arterial complications are may be due major arterial involvement like Claudication, mesenteric ischemia. Symptoms of renal insufficiency or failure from obstructive uropathy at the ureteral level.

Previously plain radiograph, intravenous urography and retroperitoneal pyelography have been used as imaging modalities. Computed tomography scanning and magnetic resonance imaging provide superior delineation of the extent of the masses of RPF.\(^9-12\)

Isotope renography is useful in the serial assessment of renal function. Gallium scintigraphy may demonstrate increased uptake, depending on the activity of inflammation. The use of fluorodeoxy glucose positron emission tomography (FDG-PET) in differentiating benign from malignant RPF is promising.\(^13-15\)

With CT and MRI, the anatomical extent and involvement of other structures can be shown in more detail. The symmetrical distribution and geometric shape are highly suggestive of RPF.

RPF can be seen in detail on CT scans. The exact etiology cannot be identified, but it can be suggested by excluding other identifiable causes.

On CT scans, RPF may appear as a rind of soft tissue around the aorta and inferior vena cava extending between the renal hilum and sacral promontory. Laterally, RPF spreads to involve the ureters, causing varying degrees of obstruction.

The fat plane between the mass and the psoas muscle may be obliterated. The mass tends not to displace the aorta anteriorly. The attenuation value of the mass is similar to that of muscle and shows variable degrees of enhancement depending on the stage of the disease.

Certain CT features can help in differentiating benign masses from malignant masses. The mass in RPF may be bulky but not as massive as neoplastic lesions; however, some exceptions exist. The presence of enlarged mesenteric nodes and displacement of the aorta from the spine by the periaortic mass favors malignancy, although some displacement can occur in RPF. Unlike RPF, most retroperitoneal neoplasms displace the ureters laterally. RPF does not produce local bone destruction. The CT value and contrast enhancement have no role in distinguishing benign masses from malignant masses.

In conclusion, abdominal aortic dissection with aneurysm should be considered as a possible cause of ureteric obstruction. CT is the imaging modality used to diagnose RPF and to perform follow-up studies. CT scans help in assessing the extent of disease and in studying the effects on other organs.
CASE REPORT

REFERENCES:


Fig. 1: Non-contrast CT axial image shows bilateral mild hydronephrosis with proximal hydroureter
Fig. 2: Non-contrast CT axial image shows dilated aorta with atheromatous calcified plaque
Fig. 3: Contrast CT axial image shows dilated aorta with aortic dissection
Fig. 4: Contrast CT axial image shows aortic dissection with minimal periaortic soft tissue