DUODENAL STENOSIS DUE TO PYONEPHROSIS

A CASE REPORT

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In the September volume of the *British Journal of Urology* a case is reported in which a fistula developed between the kidney and the duodenum as the result of a stag-horn calculus and perirenal sepsis. The author points out that only 8 other such cases have been reported in the literature, but the following type of complication is even rarer and therefore probably deserves recording.

A married European female of 67 complained of abdominal pain, flatulence and pain through to her back on the right side, typical of gall-stone dyspepsia. Cholecystograms confirmed the diagnosis of cholelithiasis and cholecystectomy was performed. Her gastric symptoms improved markedly, but she was left with a pain in her right loin and right lower chest region, and attacks of nausea whenever there was exacerbation of symptoms.

It was only at this stage that I started searching for a further cause, and on further detailed questioning she disclosed the fact that she also had dysuria and frequency during attacks, and rigors on a few occasions.

The urine contained numerous pus cells, red blood-cells and many motile bacilli.

An I.V.P. showed no concentration of dye on the right side, but a normal left kidney, and a retrograde pyelogram on the right side showed gross destruction of renal substance.

Nephrectomy was exceedingly difficult in a very short and fat elderly lady, even after removal of the 12th rib. The kidney was about two thirds the normal size and grossly adherent to the peritoneum, inferior vena cava and duodenum, and in fact I considered myself extremely lucky in getting away without a duodenal fistula developing.

On the day after the operation I showed the specimen at a medical meeting and no one could recognize it as kidney. The pathology report was pyonephrosis with areas of spread of the infection into the renal tissues right through to the surface of the kidney.

Convalescence was smooth, and the patient was very well for 6 months, when she started getting pain of a colicky nature after food, sometimes followed by vomiting. This became worse and eventually Dr. J. A. Louw of Libode referred her back to me with a clinical diagnosis of pyloric obstruction, probably due to carcinoma. A barium meal showed a dilated stomach, no sign of carcinoma, and incomplete obstruction in the second part of the duodenum.

After dieting and stomach washes, she improved so much that she refused operation, but was back a week later again with obstruction.

At operation I found scarring round the second part of the duodenum, and no sign of a tumour.

I performed a simple posterior gastro-enterostomy and now, almost 6 years later, she is still quite fit and enjoys her meals.

SUMMARY

A case is related in which gall-bladder pathology masked the presence of a kidney severely damaged by pyonephrosis.

Six months after nephrectomy the duodenum stenosed up as a result of extensive perirenal infection, requiring gastro-enterostomy.