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SCRIPTA MANENT EDIZIONI

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CASE REPORT

Wunderlich's syndrome: Three cases of acute spontaneous renal bleeding, conservately treated

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Summary

Wunderlich's syndrome is a clinical condition defined as a spontaneous renal bleeding of non traumatic origin, contained within the Gerota's fascia.
Wunderlich's syndrome is rare. Spontaneous bleeding of kidney tumors, either benign or malignant, represents the more common causes.
Classically it presents with acute flank pain, tender palpable mass and clinical hemodynamic deterioration. These symptoms are defined as the Lenk's classic triad.
We present three cases of spontaneous renal bleeding.

KEY WORDS: *Kidney; Spontaneous bleeding; Angiography; Kidney tumours.*

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No conflict of interest declared

INTRODUCTION

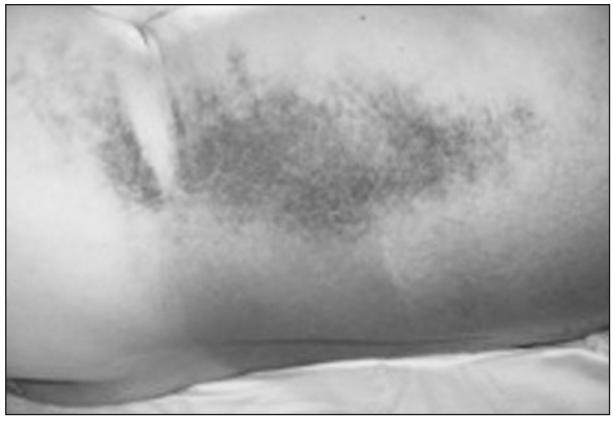
Wunderlich's syndrome is a clinical condition defined as a spontaneous renal bleeding of non traumatic origin, contained within the Gerota's fascia.
In 1700, Bonet was the first one who described this condition, while C.R.A. Wunderlich was the first to make a clinical description in 1856 (1). Coenen used the term Wunderlich's syndrome for the first time in 1910 (2).
Various authors find as underlying causes: nephritis, tumours, vascular diseases, cysts rupture (3-7).
Classically it presents with acute flank pain, tender palpable mass and clinical hemodynamic deterioration. These symptoms are defined as the Lenk's classic triad (8).
We present three cases of spontaneous renal bleeding.

CASE 1

A 72 years old man presented to the emergency department with severe generalized abdominal pain. He described a 3-hour history of acutely worsening abdominal and left lumbar pain and vomiting. Neither urinary symptoms nor history of trauma. He had a previous medical history positive for hypertension, dyslipidaemia and hyperuricemia. Clinically he had hypertension (160/100 mmHg), tachycardia, a voluminous lumbar tumefaction and haematoma (Figure 1). Haemoglobin was 7.1 g/dL.
A computed tomography (CT) was performed, showing a

Figure 1.

Case 1: voluminous lumbar tumefaction and haematoma.



large (16 cm) left perinephric haematoma with an active bleeding in the sub capsular and perirenal space. Normal controlateral kidney (Figure 2).
The patient's haemoglobin levels continued to decrease, and he was transfused with 4 units of blood.
The patient underwent emergency embolization (Figure 3) of a 3-cm avascular area in the left kidney at the middle third (possible sub capsular lesion) with an active bleeding from a thin arterial capsular branch of the lower renal pole.
Then, he was admitted to the *Intensive Care Unit* (ICU) for close observation and strict bed-rest.
His haemoglobin level stabilized, and he was treated conservatively. He was discharged from the Urology Department after 30 days.
CT scans before leaving the hospital and the one made after 90 days showed significant reduction of the perirenal haematoma (Figures 4, 5).
One year after the patient is fine. The haematoma is completely disappeared (Figures 6, 7).
He still has problems of blood pressure that he is controlling with different drugs.

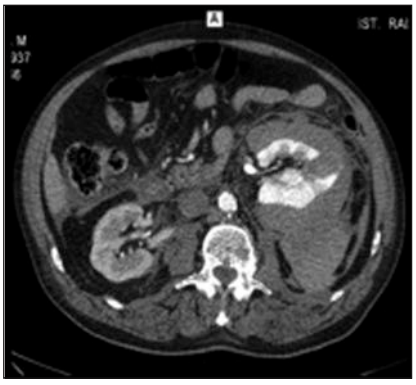


Figure 2.

Case 1: computed tomography (CT) showing a large (16 cm) left perinephric haematoma with an active bleeding in the sub capsular and perirenal space.

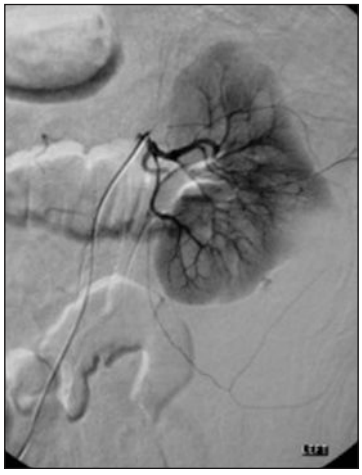
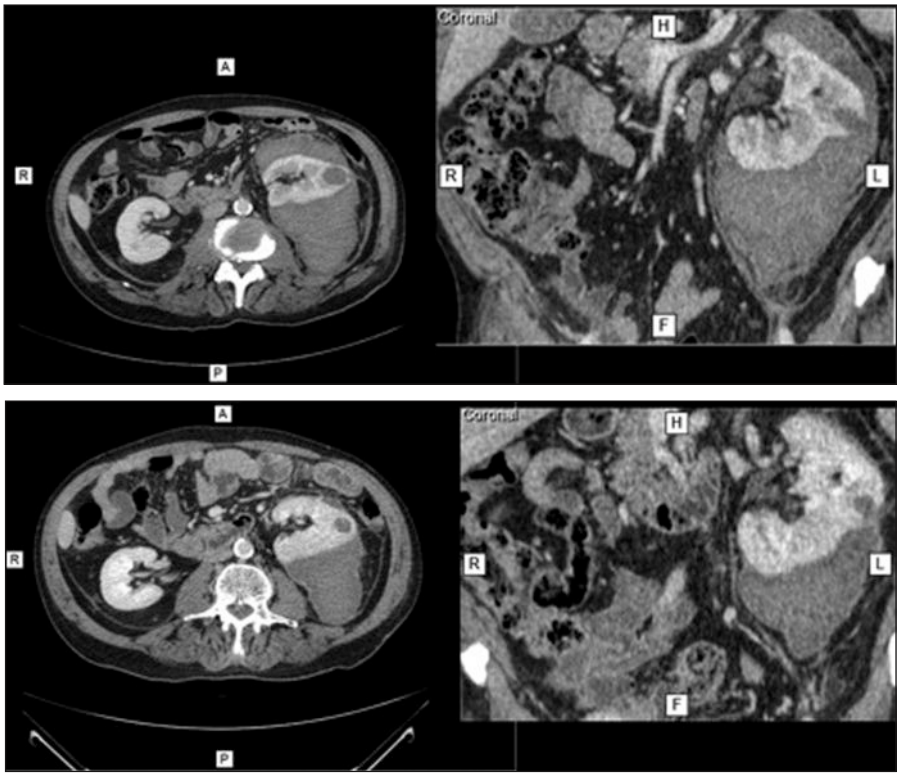


Figure 3.

Case 1: emergency embolization of a 3-cm avascular area in the left kidney at the middle third (possible sub capsular lesion) with an active bleeding from a thin arterial capsular branch of the lower renal pole.

Figures 4-5.

Case 1: CT scans at dismissal and after 90 days showed significant reduction of the perirenal haematoma.



Case 2

A 75 years old woman presented to the emergency department with severe left lumbar pain.
Neither urinary symptoms nor history of trauma. She had a previous medical history positive for ischemic heart disease, atrial fibrillation in therapy with anticoagulants, hypertension, cronic kidney failure with an atrophic right kidney.
Clinically he had hypotension (110/70 mmHg), tachycardia, haemoglobin 7 g/dL, serum creatinine 300 mmol/L.
The patient's haemoglobin levels continued to decrease, and she was transfused with 5 units of blood.
The patient underwent a CT scan that showed an important lumbar haematoma (Figure 8).
The patient underwent emergency renal arteriography that described: stenosis of the left renal artery, with no parenchymal vascularisation. The left artery was embolized with kidney exclusion. Then, she was admitted to the ICU for close observation and strict bed-rest.
The haemoglobin levels during the staying in the ICU

Figures 6-7.

Case 1: CT scan after 1 year showing that haematomais completely disappeared.

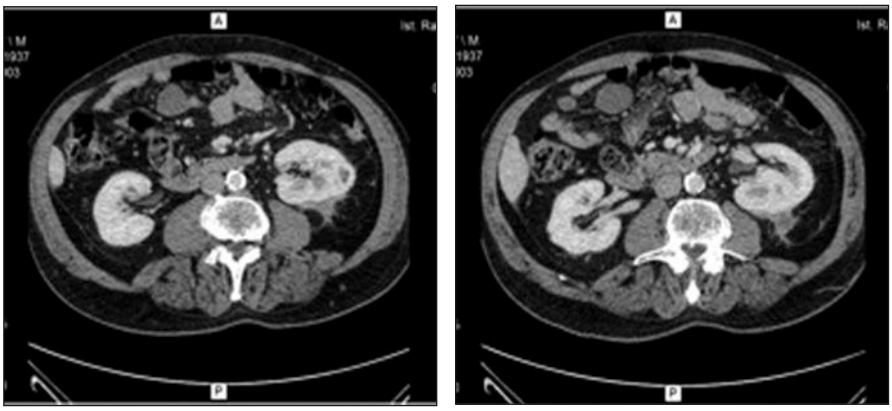
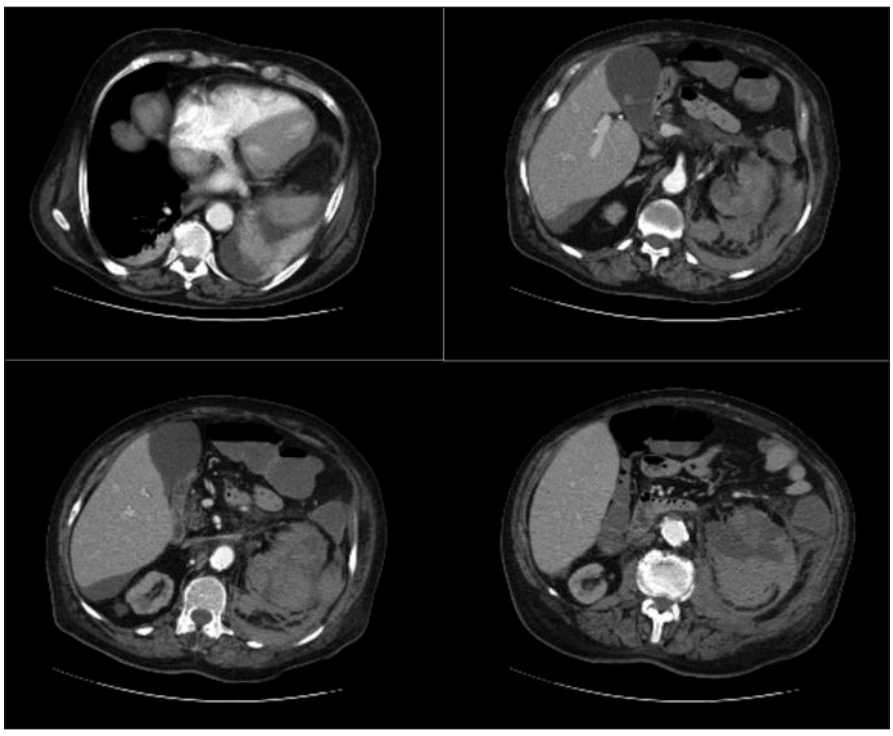


Figure 8.

Case 2: CT scan showing an important lumbar haematoma.



started to rise up. She was discharged from the Urology Department after 12 days with haemoglobin value of 10.3 mg/dl.
The patient was lost at follow-up.

Case 3

A 57 years old man presented to the emergency department with acute right lumbar pain.
Neither urinary symptoms nor history of trauma. He had a previous medical history positive for hypertension. Clinically he had normal blood pressure (140/80 mmHg). Haemoglobin was 12.1 g/dL. A CT was performed, showing a large (10 cm) right perinephric haematoma with no evidence of active bleeding and a 6 cm sub capsular mass. Normal contralateral kidney.
We decided to treat him conservatively and to treat the mass surgically after the acute problem was resolved. He was discharged from the Urology Department after 12 days. CT scan before leaving the hospital showed significant reduction of the perirenal haematoma and confirmed the presence of a solid area.
One month after, the patient underwent open right partial nephrectomy. The pathological report showed a type 2 papillary RC, Fuhrman grade 3, pT1aNx.

Discussion

Wunderlich's syndrome is a rare syndrome, with about 300 cases described in the literature. The most common causes of these spontaneous haemorrhages are represented by neoplasm (61%) (9). As benign lesion, angiomyolipoma (31.5%) is the most common, while renal cell carcinoma is the most common malignant one (10, 11). Some authors have also described some other different causes as vasculitis, arteriovenous fistulas, rupture of renal artery aneurism rupture and nephritis (12).
The imaging studies, for patient with suspicious of a spontaneous renal bleeding, are CT scan or angiography (9, 10). CT scan can give the opportunity to know the entity of the haematoma and the presence of an active bleeding. Selective angiography with embolization is often useful in the acute phase of the haemorrhage in order to control bleeding, contribute to diagnosis and reduce the need for surgery. The management is dictated by the clinical condition of the patient and by the underlying aetiology. Sometimes subjects with unstable haemodynamic condition can require an emergency nephrectomy especially if the cause of the bleeding is clear (i.e. renal cancer). In other cases, as the one described above, a conservative treatment to preserve renal function can be the best choice. Also in kidney bleeding following a trauma, many Authors recommend a conservative treatment if major complications, as other abdominal injuries, are not present (13, 14).
Eventually, if the imaging done during the follow-up shows a clear diagnosis a nephrectomy must be per-

formed. The follow-up, after patient discharge, should be done with CT scans to monitor the haematoma reduction and with measurements of blood pressure to exclude Page syndrome (15, 16).

Conclusion

Wunderlich's syndrome is rare. Spontaneous bleeding of kidney tumours, either benign or malignant, represents the more common cause.
CT scan and angiography are the preferred diagnostic tools. The treatment must be tailored for single cases. Conservative treatment with a periodic follow-up is often a feasible approach.

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Abano Terme (PD) - 22-24 Maggio 2014

Giovedì 22 Maggio 2014 - Ore 13.00

Videochirurgia "in house" certificata UrOP – Neoplasie del Rene
- Nefrectomia radicale laparoscopica 3D
- Enucleoresezione retroperitoneoscopica
- Enucleoresezione robotica transperitoneale

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- Retrograde intra-renal surgery (RIRS) per calcolosi renale
- Retrograde intre-renal surgery (RIRS) per neoplasia
- Endoscopic combined intra-renal surgery (ECIRS)

News & Hot topics: Litiasi Urinaria e Neoplasie del Rene
Litiasi urinaria
Introduzione: La letteratura dell'ultimo anno in 7 minuti
- La terapia medica delle litiasi: quale farmaco a quale paziente
- Devices e procedure nella terapia endoscopica della litiasi: up to date

Lettura ad invito: La terapia idropinica
Neoplasie del rene
Introduzione: La letteratura dell'ultimo anno in 7 minuti
- La terapia medica delle neoplasie renali: cosa l'urologo deve sapere

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Videochirugia "in house" certificata Urop - Carcinoma prostatico
- Prostatectomia radicale robotica extraponeurotica
- Linfectomia pelvica estesa robotica per Ca prostatico
- Prostatectomia radicale robotica nerve sparing

Videochirurgia "in house" certificata Urop - Basse vie urinarie
- Enucleazione prostatica con Holmio (Holep)
- Vapoenucleazione con Thullio (Tulep)
- B-TUEP (enucleo vaporizzazione al plasma)
- Vaporizzazione con Green laser
- Ejaculatory sparing UROLIFT
- TURBT PDD
- **Lettura ad invito:** FISH a chi e quando

News & Hot topics: Carcinoma prostatico
Introduzione: La letteratura dell'ultimo anno in 7 minuti
Diagnostica e Stadiazione:
- La risonanza magnetica e la biopsia, due mondi che si incontrano
- Test molecolari a chi e quando

Trattamento
Terapia chirurgica: La chirurgia robotica nella malattia ad alto rischio
Focal Therapy: A che punto siamo
Terapia medica: La gestione moderna degli analoghi

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Introduzione: La letteratura dell'ultimo anno in 7 minuti
Terapia medica:
- IPB e PSA moderna gestione del paziente e della sua terapia
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Anemia, Sanguinamento, Antiaggreganti e Anticoagulanti: Cosa l'urologo deve sapere
Gestione pre-operatoria:
- Inquadramento e preparazione all'intervento del paziente Anemico
- La terapia antiaggregante e anticoagulante nel paziente candidato a intervento urologico

Gestione intra-operatoria
- Il contributo anestesiologico ad un emostasi ottimale
- Emostatici: news and hot topics
- Surgical Devices: news and hot topics

Gestione post-operatoria
- Eparine: quando, a chi e per quanto tempo
- Appropriatezza trasfusionale: un flash dell'esperto

Seduta Amministrativa Urop

Sabato 24 Maggio 2014 - Ore 9.00

News & Hot topics: Disfunzioni Sessuali Maschili
Introduzione: La letteratura dell'ultimo anno in 7 minuti
Terapia medica del DE: Ad ogni paziente la propria terapia
L'eiaculazione precoce: Up to date 2014

IPP e Terapia chirurgica:
- quale tecnica
- quale patch
- quale protesi

News & Hot topics: Urologia femminile
Introduzione: La letteratura dell'ultimo anno in 7 minuti
Incontinenza urinaria:
Terapia medica: Ad ogni paziente la sua terapia
Terapia chirurgica: Quale protesi e quale tecnica
Prolasso urogenitale:
- Correzione vaginale o laparoscopica?
- Ricostruzione fasciale o protesi?

Sabato 24 Maggio 2014 - Ore 9.00
DALLO STUDIO SPECIALISTICO ALLO STUDIO MEDICO
Corso in collaborazione con i Medici di Medicina Generale e Specialisti Urologi Territoriali

9.30-10.30 **Modulo 1 - IPB up to date**
- Linee guida: novità e hot points
- Terapia medica
- Terapia chirurgica
- Presentazione caso clinico
- Discussione interattiva

10.30-12.00 **Modulo 2 - Disfunzioni sessuali up to date**
- Linee guida DE ed EP: novità e hot points
- Terapia medica DE
- Terapia medica EP
- Presentazione caso clinico
- Discussione interattiva

12.00-13.30 **Carcinoma prostatico up to date 2014**
- Linee guida: novità e hot points
- Terapia chirurgica
- Terapia radiante
- Terapia medica
- Presentazione casi clinici
- Discussione interattiva

13.30-15.00 **Incontinenza urinaria up to date 2014**
- Linee guida: novità e hot points
- Terapia medica
- Terapia chirurgica
- Presentazione casi clinici
- Discussione interattiva

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9° Congresso Nazionale 2014

22-24 Maggio 2014

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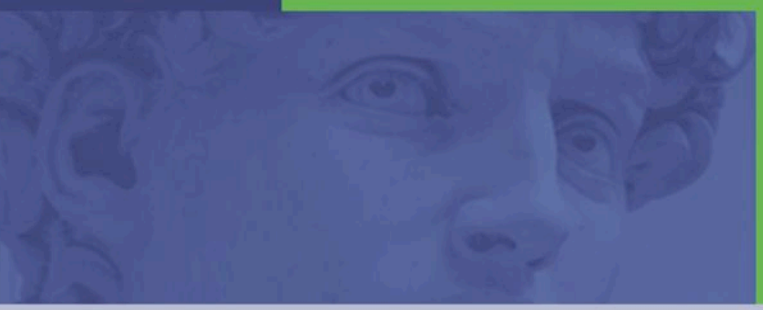

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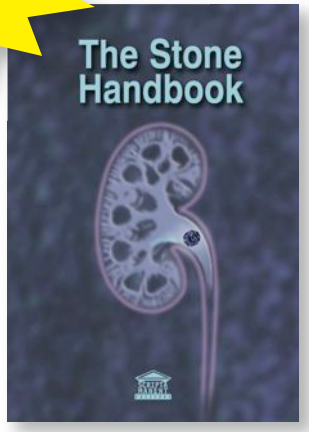

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