

When is an Ectopically Placed Ureteral Stent Acceptable?



We report a rare case of an ectopically placed ureteral stent, which was acceptable and functional. A 42-year-old man with spina bifida, ileal conduit, and recurrent urosepsis presented with an obstructing 8×15 -mm proximal right-sided ureteral calculus. There were also multiple non-obstructing renal calculi on the left side. An antegrade ureteral stent was placed to relieve his infected and obstructed right kidney.

During stent placement, the interventional radiologist was unable to keep the distal end of the ureteral stent coiled in the ileal conduit. Unintentionally, the distal end of the guidewire was fed into the contralateral ureter. This resulted in the ureteral stent being placed across both renal collecting systems via the ileal conduit. The inadvertent placement of the ureteral stent into both ureters is rare; that the patient had a Bricker anastomosis, which makes it even less likely. Subsequent nephrostogram demonstrated bilateral patent ureters. Once the sepsis resolved, the patient underwent a right percutaneous nephrolithotomy. During this procedure, the ectopic ureteral stent was also removed. An elective left percutaneous nephrolithotomy was performed to clear his left renal calculi.

Urinary tract infection and lower urinary tract reconstruction are associated with a higher incidence and recurrence rates of urolithiasis.^(1,2) Surgical options for the ureteral calculi include ureteroscopic lithotripsy, pyeloscopic lithotripsy, percutaneous nephrolithotomy, and extracorporeal shockwave lithotripsy.⁽³⁾ It is important for the urologist to acknowledge the difficulty in managing the stone disease in patients with spina bifida. An infected, obstructed kidney is a urological emergency. Due to the difficulty in retrogradely disobstructing the urinary system via an ileal conduit, a nephrostomy and antegrade ureteral stent should be placed without delay. This provides control of the urinary tract and an opportunity to plan the most appropriate definitive management once the patient is clinically stable.

Yeng Kwang Tay,* Dan Spernat, John Stuckey, Sree Appu

Department of Urology, Monash
Medical Center, Victoria, Australia

*E-mail: yktay2@gmail.com

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