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# A Case of Unexplained Abdominal Pain with Unilateral Pelvic Kidney

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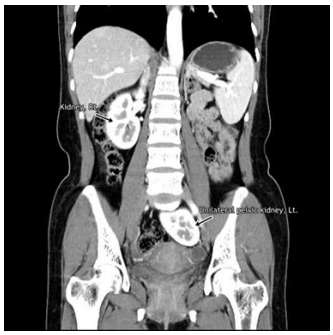
**서론/목적:** Anomalies in the kidney may occur in the number, position, shape, size and rotation. Incidence of ectopic kidney is 1 in 100 and 1 in 500, and pelvic kidney has been approximated at between 1 in 2,200 and 1 in 3,000. Anomalies of the kidney are mostly asymptomatic, and often found only during physical or radiological studies, incidentally. We present a case of unilateral pelvic kidney on the left side with unexplained relapsing abdominal pain. **증례:** A paient, 43-year-old woman, frequently had discomfort of Lt. abdomen. We studied blood, urine analysis and radiologic exam to evaluate abdominal pain and available comorbidities. In the microscopic urine analysis test, the results were that WBC 5-9/HPF, RBC 0-1/HPF, Squamous epithelial cell 10-19 /HPF and morderate bacteria. Serum BUN and creatinine level were within normal range. Lt. kidney was coffee-bean like shape, located below of the pelvic inlet and the height was 9.5 cm, in the abdomen computed tomography (CT). The Lt. kidney's upper pole was seen at the body of L5 vertebra. On the other hand, Rt. kidney was located in the normal T-spine level, and no other accompanying anomalies (i.e aorta, internal- or external-iliac artery, bladder, ureter). Gastroduodoscopy and colonoscopy were done and non-specific finding. **결론:** In the pelvic kidney patient, the risk of stone formation and infection disease were high, cause by the altered geometry of urinary drainage. We follow up that patient for obstructive disorder or infection related by abdominal pain.

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# BNP predics an ischemic etiology of acute heart failure in patients with stage 4-5 CKD

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**Aims:** The non-invasive differentiation of ischemic and non-ischemic acute heart failure (AHF) not resulting from acute myocardial infarction is difficult and has therapeutic and prognostic implications. The aim of this study was to assess whether serum B-type natriuretic peptide (BNP) can identify ischemic etiology in patients with chronic kidney disease presenting with AHF. **Methods and results:** We prospectively analyzed 56 patients. The diagnosis of ischemic AHF was confirmed by coronary angiography or stress myocardial perfusion imaging. Serum levels of BNP were measured at admission (BNP1) and 48 h after admission (BNP2). Patients with ischemic etiology had higher levels of BNP1 and BNP2 than those without ischemia. The area under the receiver operating characteristic curve was 0.720 ($p$=0.002) for left ventricular ejection fraction, 0.640 ($p$=0.022) for regional wall motion abnormality, 0.755 ($p$=0.001) for BNP1 and 0.854 ($p$<0.001) for BNP2 to detect ischemic etiology of AHF. BNP2 showed the best diagnostic capabilities and serum BNP1 >2,907 pg/mL (odds ratio [OR], 10.6; 95% confidence interval [CI] 2.6-44.0; $p$=0.001) and BNP2 > 2,202 pg/mL (OR 35.0, 95% CI 5.4-226.5; $p$<0.001) were independently associated with an ischemic etiology of AHF. **Conclusions:** Serum BNP 48 h after admission exhibited the best diagnostic accuracy in detecting ischemic etiology of AHF and serum BNP may represent a clinically useful non-invasive tool for identification of ischemic etiology of AHF not resulting from acute myocardial infarction in patients with stage 4-5 chronic kidney disease.