

Perirenal hemorrhage after successful stent placement

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Atherosclerotic renal artery stenosis (ARAS) is an important but often underestimated cause of hypertension. Most patients diagnosed with ARAS are effectively managed with antihypertensive medication alone. percutaneous renal angioplasty can be a better therapeutic option in some cases. We report a case of perirenal hemorrhage after successful renal artery stent placement in a patient diagnosed with unilateral ARAS. A 50-year-old man was admitted for assessment and management of intermittent headache of 2 months' duration. his blood pressure was 220/120 mmHg on admission. initial physical exam, laboratory tests were normal. Continuous infusion of nicardipine was initiated after admission. CT of the abdomen was performed to assess for secondary causes of hypertension, which revealed severe atherosclerotic stenosis of the ostium of his right renal artery with delayed perfusion to the ipsilateral kidney consistent with unilateral ARAS. Percutaneous renal angiography was performed on hospital day 3. Successful placement of a renal artery stent was followed, which was confirmed by serial angiography. We also checked that there was no bleeding after the procedure. Aspirin therapy was initiated to prevent stent thrombosis. His blood pressure started to return to normal without use of antihypertensives. However, a day later, he complained of sudden onset of right flank pain. A follow-up CT scan showed right-sided perirenal hemorrhage without any evidence of active bleeding during the arterial phase. We opted for conservative management instead of performing embolization. Aspirin was withheld, and the patient remained stable with improving flank pain. Perirenal hemorrhage is among the least frequently reported complications. however, rapid and massive bleeding into the perirenal space can often lead to circulatory collapse and death. The exact mechanism of perirenal hemorrhage following renal angioplasty remains controversial. Ischemia-reperfusion injury might be a possible mechanism of this case. Based on previous studies, impaired autoregulation is considered the primary pathophysiology to account for hemorrhage after revascularization of culprit lesions.

Primary hyperparathyroidism caused by parathyroid carcinoma resulting in renal insufficiency

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Background: Parathyroid carcinoma is a rare cancer and it is frequently associated with hyperparathyroidism that resulting in high serum calcium levels and PTH, bone diseases, renal insufficiency. We report a case of 68-year-old man who had symptoms of nausea and anorexia and decreased urine output. **Method:** Neck CT and parathyroid scan (Tc-99m MIBI), Lab data, surgical biopsy were used. **Result:** 65- year-old man who was primarily diagnosed hyperparathyroidism was admitted to the hospital. He received Lt. thyroidectomy and central neck dissection 6yrs ago. After he discharged from the hospital, loss to follow-up. After 6 year, the man had symptoms of anorexia, nausea and epigastric pain. Initial laboratory data also showed hypercalcemia and azotemia. [Tca: 17.4, P: 6.5, BUN:96.0, Cr:4.53] The serum PTH level was elevated to 473.26 ng/mL and Total amylase, lipase level also elevated, 1627, 2091 respectively. the laboratory findings showing hyperparathyroidism, combined with renal insufficiency and acute pancreatitis. Admission to the ICU received CRRT, even hemodialysis consequently. The parathyroid MIBI scan showed hyperfunctioning parathyroid gland in left anterior neck. Clinically assumed primary hyperthyroidism and Lt. parathyroidectomy was proceeded to this patient. pathologic study with the result of parathyroid carcinoma. Furthermore, abdominal CT showed the fluid collection in pancreas. Resting GI track by diet restriction was done until serum amylase and lipase had been stabilized to the normal range.

