Left ureteral appendiceal interposition: Exercise caution and do not be mislead By postoperative radiological obstruction

Aderivaldo Cabral Dias Filho 1, Carlos Alberto Toledo Martinez 1, Maria Bianca Côrte 2, Marcus Vinicius Osorio Maroccolo 1

1 Unidade de Urologia, Hospital de Base do Distrito Federal, Brasília, DF, Brasil; 2 Unidade de Proctologia, Hospital de Base do Distrito Federal, Brasília, DF, Brasil

ABSTRACT

Postoperative imaging after appendiceal ureteral interposition may be difficult to interpret, misguiding the urologist towards intervention. We present a case in which radiological obstruction was not endorsed by a 99TcDTPA nephrogram, with favorable outcome after conservative treatment.

CASE PRESENTATION

Intraoperative consultation was requested by proctology. During left colectomy for adenocarcinoma, the left upper-mid ureter of a 69-year-old man was resected, leaving a 12cm gap. To spare the patient of another enterenterostomy, antiperistaltic ureteroappendiceoureterostomy was performed over a double-J stent (Figure-1, upper left). The patient was discharged from the hospital at the 17th postoperative day (POD). We removed the double-J stent at the 53th POD, and left pyeloureterectasis with obstruction at the proximal ureteroappendiceal anastomosis was seen on an intravenous pyelogram performed at the 82th POD (Figure-1, right). A 99TcDTPA nephrogram immediately followed, which showed adequate emptying (Figure-1, lower left). After 2 years the patient remains asymptomatic, with symmetric renal function (glomerular filtration rate: left=36.52, right=37.16mL/min/1.73m²). Computed tomography revealed mild-moderate left pyeloureterectasis, with good cortical uptake (Figure-2). Figure-3 displays both left and right urinary tracts as well as proximal and distal ureteroappendiceal anatomoses.

DISCUSSION

The appendix can replace the left ureter via mobilization of the cecum and right colon (1-4).
Due to the rarity of the procedure, and as previous case reports diverge regarding post-operative imaging routines, we opted for radiological surveillance according to our previous experience with ileal substitution of the ureter. Still, postoperative radiological abnormalities are not unexpected: There is a mismatch between the thin-walled ureter and thick-walled appendix, and ureteral peristalsis ceases at the ureteroappendiceal juncture.

Another possible explanation for the radiological aspect of obstruction we observed could be the choice of interposing the appendix in an antiperistaltic fashion. However, evidence has shown that antiperistaltic interposition does not hinder urine flow (5, 6). Since appendiceal peristalsis is not propulsive (7, 8), the interposed appendix behaves as a passive conduit, hence urine flows through the segment regardless of whether interposition is performed in an antiperistaltic or peristaltic fashion. Matter-of-fact, one could argue against peristaltic interposition, as it twists the mesoappendix, reducing its distal blood supply, which may cause leakage at the proximal anastomosis (5).

The astute urologist should be suspicious when challenged with incongruent clinical-radiological evidence of obstruction after appendiceal ureteral interposition, and proceed first with functional investigation.

**CONFLICT OF INTEREST**

None declared.

**REFERENCES**


Correspondence address:
Aderivaldo Cabral Dias Filho, MD
Unidade de Urologia Hospital de Base do Distrito Federal
SHS Quadra 101, Area Especial s/n, 8º andar, Asa Sul
Brasília, Distrito Federal, 70335-900, Brasil
Telephone: + 55 61 3315-1479
E-mail: urohbdf@gmail.com

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