An unusual cause of constipation in a 72-year-old man with a rising creatinine

Dominic Pimenta, Dilsan Yilmaz, Rebecca Grossman, Bob Soin

Wexham Park Hospital, Slough, UK

Correspondence to
Dr Dominic Pimenta,
dpimenta@doctors.org.uk

DESCRIPTION

A 72-year-old man with a history of hypertension and chronic back pain presented to accident and emergency department (A&E) with right flank pain and nausea. He had not opened his bowels for 4 days. Observations were within the normal range. The blood profile showed a white cell count (WCC) of 15.4×10^9/L with a neutrophilia, C reactive protein (CRP) of 132 mg/L, and creatinine of 150 µmol/L. An abdominal radiograph showed gas-filled large bowel without evidence of obstruction. A dipstick showed 2+ blood but no other abnormality. A diagnosis of constipation or diverticulitis was made without further imaging and he was discharged with an outpatient flexible sigmoidoscopy.

He returned 3 days later with persistent right upper quadrant (RUQ) pain and new right lower quadrant pain, nausea and similar constipation. A mass was felt in the RUQ. The differential diagnosis included appendicitis and suspected locally perforated right colon cancer. His creatinine level had risen to 190 µmol/L with persistently elevated inflammatory markers. After 1 day his pain had not resolved and an urgent CT scan was requested (figure 1). A diagnosis of pyonephrosis secondary to urothelial tumour was made and the patient was transferred to a tertiary centre for urgent nephrostomy. Pyonephrosis is relatively rare, but common in cases of urinary tract obstruction. In retrospect, the classic features of fever, flank pain, leucocytosis and a rising creatinine[1] were all present in this case.

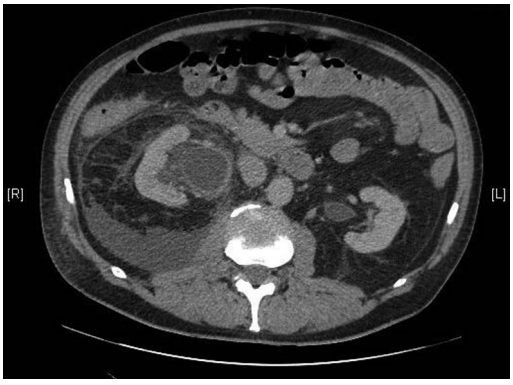

Figure 1 CT abdomen/pelvis with contrast: there is evidence of right hydronephrosis with stranding of the perinephric fat and obstruction at the right upper ureter by a 3 cm solid right pelviureteric junction lesion, presumably a urothelial tumour. This was later confirmed to be a G3 pT3 N1 Mx transitional cell carcinoma and the patient underwent radical nephroureterectomy after an initial emergency nephrostomy.

Learning points

- Diagnostic overshadowing can be handed from team to team without anyone reconsidering the most likely diagnosis.
- Although constipation can be a primary diagnosis, it is often a non-specific symptom of any intra-abdominal pathology and this should always be ruled out.
- Right upper quadrant pain can be caused by pathology in the liver, kidney, bowel or gallbladder and from referred spinal pain. These should all be considered at initial clerking.

Contributors All authors were involved with the patient and collecting the data, reviewing and revising the article and approving the final draft.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCE

1 St Lezin M, Hofmann R, Stoller ML. Pyonephrosis: diagnosis and treatment. *Br J Urol* 1992;70:360–3.

To cite: Pimenta D, Yilmaz D, Grossman R, *et al*. *BMJ Case Rep* Published online: [*please include* Day Month Year] doi:10.1136/bcr-2013-010219