

Urosepsis secondary to ureterosciatic hernia corrected with ureteral stent placement: A case report and literature review

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Case report

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Abstract

Background

Ureterosciatic hernia is a rare type of pelvic floor herniation that occurs through the sciatic foramen. The resulting ureteral obstruction may lead to hydronephrosis and to further complications including urinary tract infection and urosepsis. There have been 30 reported cases of ureterosciatic hernia. Ureteral stenting and surgical repair have been used as treatment options.

Case Presentation

We report the case of an 86-year-old woman who was transferred to our hospital with symptoms of fever and septic shock. Her computed tomography scan revealed left hydronephrosis and deviation of the left ureter into the sciatic foramen; she was therefore diagnosed with a left ureteral sciatic hernia, and admitted in our intensive care unit for further treatment with resuscitative fluids, vasopressors, and antibiotics. Following a retrograde insertion ureteral catheter insertion, ureteral incarceration was relieved, and a double-J ureteral stent was placed in situ. Antibiotic treatment was initiated, and the patient's hemodynamic status gradually improved.

Conclusions

Although ureterosciatic hernia is a rare disorder, it is associated with serious complications including urinary tract infection with sepsis, which may warrant urgent corrective procedure to relieve the structural obstruction. Treatment may be conservative or surgical, though treatment with ureteral stent placement may be a favorable approach in elderly patients with multiple comorbidities presenting with urosepsis.

Background

Ureterosciatic hernia is a relatively rare disorder that commonly occurs in elderly women, wherein the ureter herniates through the sciatic foramen.¹ This condition may lead to ureteral occlusion, and subsequent complications including hydronephrosis and urinary tract infection, which warrant urgent treatment to relieve the structural ureteral obstruction.² Although reports of conservative treatment by ureteral stent placement have increased in recent years, there are no fixed guidelines on determining a particular treatment approach such as surgery or stent placement. We report the case of a patient who developed urosepsis secondary to ureterosciatic hernia, and who improved following ureteral stent placement. We also review existing literature on the treatment of ureterosciatic hernia that will help determine a treatment strategy in affected, comorbid patients who may be hemodynamically unstable at presentation.

Case Presentation

An 86-year-old woman was transferred to our emergency and critical care center from a nearby general hospital with vital signs indicative of shock. She had been diagnosed with urinary tract infection. She had a medical history of chronic heart failure with pulmonary hypertension and was on home oxygen therapy for chronic respiratory failure.

On initial physical examination at arrival to our facility, she was conscious and oriented with a Glasgow Coma Scale score of 15, and a body temperature of 36.0°C. On receiving 0.3µ dose of noradrenaline, her blood pressure, pulse rate, and respiratory rate were maintained at 91/63 mmHg, 90 beats/min, and 24 breaths/min, respectively. Her oxygen saturation was 100% while receiving 10 L/min oxygen through a face mask. On physical examination, her

left abdominal and left lumbar areas were tender. Her initial arterial blood gas analysis while on 10 L/min oxygen, revealed a pH of 7.441, PaCO₂ of 44.6 mmHg, PaO₂ of 275.5 mmHg, HCO₃⁻ 29.9 mmol/L, SaO₂ of 93.1%, and lactate of 1.3 mmol/L.

The patient's urine was negative for nitrite, white blood cells, and bacteria. Serum white blood cell count was 11,900 /mm³, platelet count was 17.8 mm³, total bilirubin was 0.46 mg/dl, creatinine was 1.94 mg/dl, and C-reactive Protein was 6.92 mg/dL. An unenhanced abdominal computed tomography scan revealed left hydronephrosis, adipose tissue opacity around the left kidney, and deviation of the left ureter to the sciatic foramen (Figs. 1 and 2). She was diagnosed with obstructive pyelonephritis associated with septic shock due to a ureterosciatic hernia. She was admitted to our intensive care unit for further treatment with resuscitative fluids, vasopressors, and antibiotics. As the patient was hemodynamically unstable, placement of a ureteral stent was attempted for relieving the herniation-associated structural obstruction. On a retrograde ureteral catheter insertion, the ureteral incarceration reduced, and we were able to place a double-J ureteral stent in situ (Figs. 3 and 4).

Initially, she required 0.35µg of noradrenaline and resuscitative extracellular fluids to maintain hemodynamic status. However, the day after the stent placement, she gradually recovered from septic shock and was tapered off vasopressors by day 4. Both blood and urine cultures revealed *Escherichia coli* with good antimicrobial sensitivity.

She continued to receive antibiotic treatment and underwent rehabilitation, with the goal of discharge and continued outpatient care. Unfortunately, she experienced exacerbation of respiratory failure and died on the 32nd day of hospitalization.

Discussion And Conclusions

While ureteral herniation is relatively uncommon, ureter prolapse into the inguinal canal and in the femoral canal may be observed, though occurrence of sciatic herniation is extremely rare.³ Elderly women are more susceptible, possibly because they experience increased abdominal pressure due to conditions such as history of childbirth, wide pelvic opening, pregnancy, constipation, and age-related piriformis muscle atrophy and weakening.⁴ In Japan, which has a sizeable elderly female population, it is necessary to distinguish this condition in elderly patients presenting with hydronephrosis and pyelonephritis. While computed tomography is useful for diagnosing ureterosciatic herniation, considering that it is a rare condition, the cause of obstruction may not be identifiable without including it in the differential diagnosis.

On searching the PubMed database using the keywords "ureterosciatic hernia" or "uretero sciatic hernia" we identified 30 reported cases of ureterosciatic hernia since 1999, from English-language papers (Table 1)^{1-3,5-31}. The median patient age was 75.5 (57-97) years; all were female. The left side was affected in 22 (one bilateral disease) patients. We speculated that the laterality was observed as the left ureter tends to be anatomically longer than the right ureter³². The initial therapeutic approaches used were stent placement in 21 patients, surgical repair in 6 patients, manual reposition in 1 patient, and simple observation without any treatment procedures in 2 patients. The initial attempt at ureteral stent placement was successful in 18/21 patients. Of these, 11 patients did not need additional procedures, while 7 required further surgical treatment (in one case, surgery was planned in advance). Two patients treated solely with ureteral stenting relapsed after stent removal and also required surgical management. Of the total 16 patients who finally underwent surgical treatment, 12 and four patients underwent laparoscopic (four robot-assisted procedures) and open surgery, respectively.

Table 1
Clinical review of reported cases of ureterosciatic hernia.

| Case No. | Author | Age | Sex | L/R | UTI | Shock | Initial treatment | Result of stent placement | Definitive treatment |
|----------|----------------------------------|-----|-----|------|-----|-------|--------------------|--------------------------------|-------------------------|
| 1 | Gee, et al. ⁵ | 60 | F | L | - | - | stenting | recurrence after stent removal | laparoscopic surgery |
| 2 | Weintraub, et al. ⁶ | 87 | F | R | + | - | stenting | repaired | stenting |
| 3 | Noller, et al. ⁷ | 62 | F | L | - | - | stenting (failure) | - | open surgery |
| 4 | Touloupidis, et al. ⁸ | 61 | F | R | - | - | surgery | - | open surgery |
| 5 | Loffroy, et al. ¹ | 81 | F | L | + | - | surgery | - | open surgery |
| 6 | Tsai, et al. ⁹ | 91 | F | L | - | - | observation | - | observation |
| 7 | Hsu, et al. ¹⁰ | 69 | F | L | - | - | stenting | repaired | stenting |
| 8 | Clemens, et al. ¹¹ | 80 | F | L | - | - | stenting | not repaired | stenting (not repaired) |
| 9 | Sugimoto, et al. ¹² | 76 | F | L | - | - | stenting | repaired | stenting |
| 10 | Whyburn, et al. ¹³ | 74 | F | both | - | - | stenting | recurrence after stent removal | laparoscopic surgery |
| 11 | Singh, et al. ¹⁴ | 75 | F | L | - | - | stenting | removed due to discomfort | laparoscopic surgery |
| 12 | Tsuzaka, et al. ¹⁵ | 78 | F | L | - | - | surgery | - | laparoscopic surgery |
| 13 | Kato, et al. ¹⁶ | 72 | F | L | - | - | stenting | repaired | stenting |
| 14 | Salari, et al. ¹⁷ | 87 | F | R | - | - | stenting | repaired | stenting |
| 15 | Yanagi, et al. ³ | 92 | F | L | - | - | stenting | repaired | stenting |
| 16 | Regelman, et al. ¹⁸ | 60 | F | L | - | - | surgery | - | laparoscopic surgery |
| 17 | Demetriou, et al. ¹⁹ | 76 | F | L | - | - | observation | - | observation |
| 18 | Wai, et al. ²⁰ | 68 | F | L | - | - | surgery | - | laparoscopic surgery |
| 19 | Lin, et al. ²¹ | 81 | F | R | - | - | stenting | not repaired | open surgery |
| 20 | Nakazawa, et al. ²² | 92 | F | L | - | - | stenting | repaired | stenting |

Abbreviations: F, female; L, left; R, right; UTI, urinary tract infection.

| Case No. | Author | Age | Sex | L/R | UTI | Shock | Initial treatment | Result of stent placement | Definitive treatment |
|--|---------------------------------------|-----|-----|-----|-----|-------|--------------------|---------------------------|----------------------|
| 21 | Fadel, et al. ² | 65 | F | R | + | + | stenting | repaired | stenting |
| 22 | Destan, et al. ²³ | 80 | F | R | + | - | stenting + surgery | performed before surgery | laparoscopic surgery |
| 23 | Moon, et al. ²⁴ | 72 | F | R | + | - | stenting (failure) | - | laparoscopic surgery |
| 24 | Kimura, et al. ²⁵ | 86 | F | L | - | - | manual reposition | - | manual reposition |
| 25 | Nagasubramanian, et al. ²⁶ | 57 | F | L | - | - | stenting | not repaired | laparoscopic surgery |
| 26 | Kubo, et al. ²⁷ | 85 | F | L | + | + | stenting | removed due to discomfort | laparoscopic surgery |
| 27 | Kim, et al. ²⁸ | 68 | F | L | - | - | stenting | repaired | stenting |
| 28 | Kamisawa, et al. ²⁹ | 70 | F | R | - | - | surgery | - | laparoscopic surgery |
| 29 | Rose, et al. ³⁰ | 68 | F | L | - | - | stenting (failure) | - | laparoscopic surgery |
| 30 | Chan, et al. ³¹ | 97 | F | L | + | - | stenting | repaired | stenting |
| Abbreviations: F, female; L, left; R, right; UTI, urinary tract infection. | | | | | | | | | |

In our case, ureterosciatic herniation of the left ureter occurred in an elderly woman, which was consistent with previously reported clinical characteristics. Since the patient was elderly, had baseline respiratory dysfunction, and was hemodynamically unstable at the time of admission, she was considered a high-risk surgical candidate and was therefore treated using a stent. The ureteral obstruction improved after stenting. As the patient had chronic respiratory failure at baseline, the chronic increase in abdominal pressure due to respiratory failure may have contributed to the development of the ureterosciatic hernia.

In conclusion, we report the case of a patient presenting with ureterosciatic herniation and urosepsis, who improved after ureteral stent placement; and review existing literature on this rare type of hernia. It is necessary to distinguish this underlying condition in elderly women with hydronephrosis and pyelonephritis. Although there is no established treatment strategy, we believe that stent placement is a better approach in comorbid, elderly patients who may be hemodynamically unstable at presentation and may therefore be unable to tolerate corrective surgery.

Declarations

Ethics approval and consent

The patient/relative provided informed consent for the publication of medical information in this case report.

Competing interests

Not applicable

Funding

Not applicable

Authors' contributions

All authors meet the International Committee of Medical Journal Editors (ICMJE) authorship criteria. MH, JY, and KS were involved in the treatment and clinical management decision-making. KK wrote the manuscript and reviewed the published literature, and MH revised and edited the manuscript. KN, JY, KS, and YH critically revised the manuscript contents. All authors approved the final version of the manuscript for publication.

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Figures

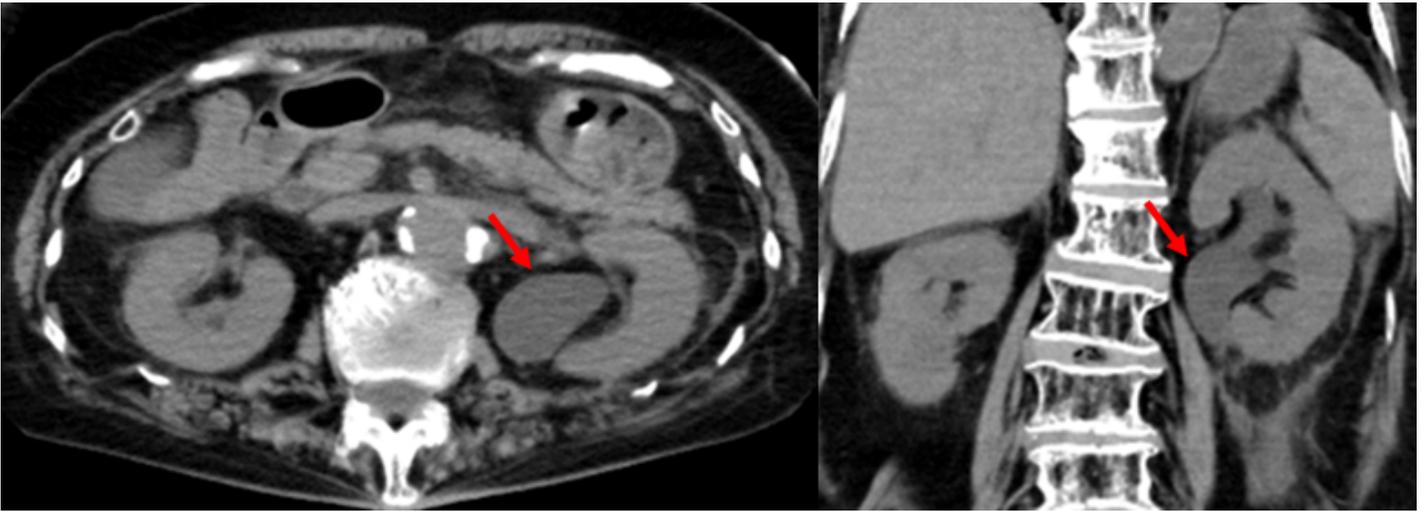


Figure 1

Computed tomography reveals left hydronephrosis with adipose tissue opacity around the left kidney.

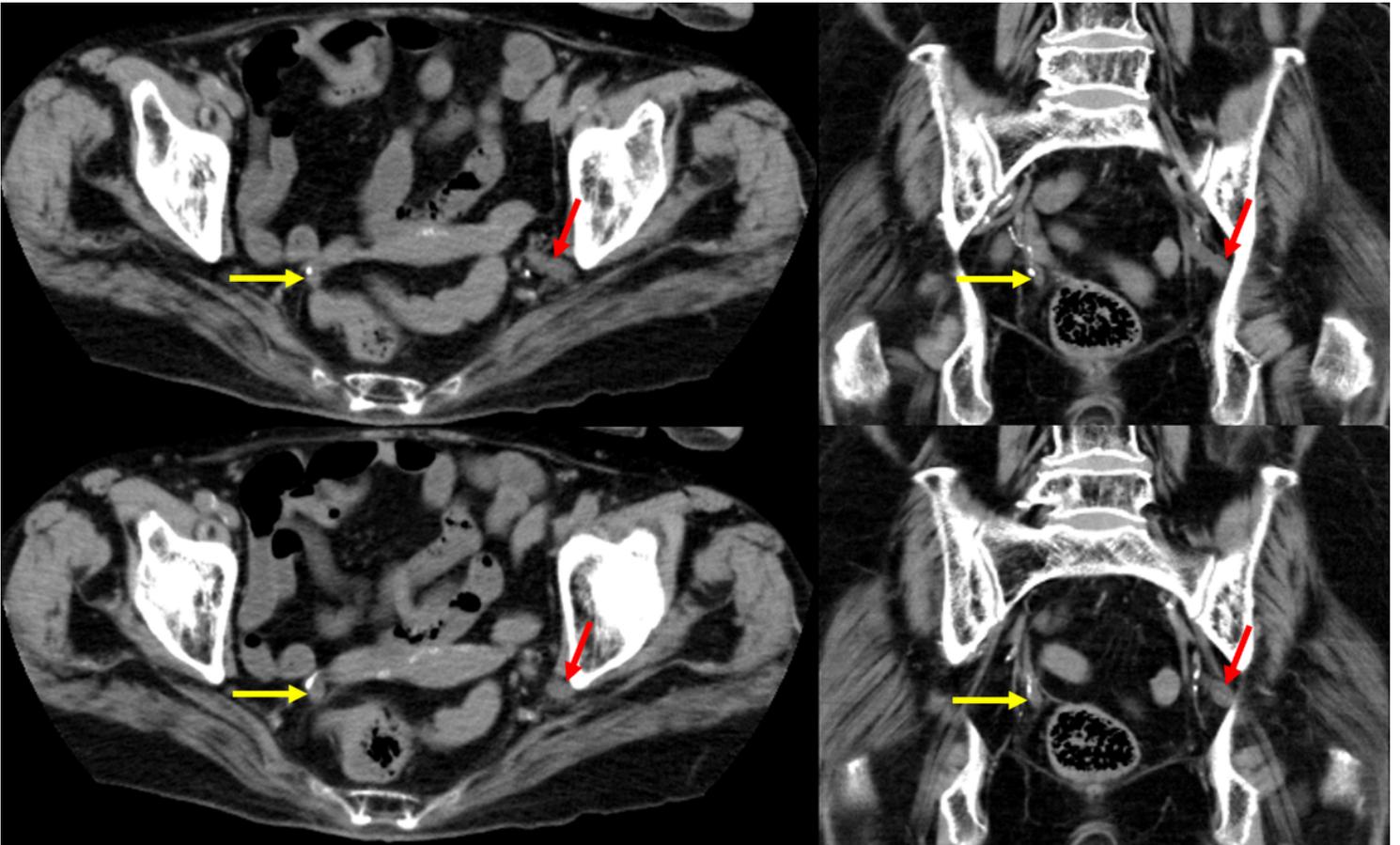


Figure 2

Computed tomography reveals deviation of the left ureter (red arrows) to the sciatic foramen. The right ureter is indicated by yellow arrows.

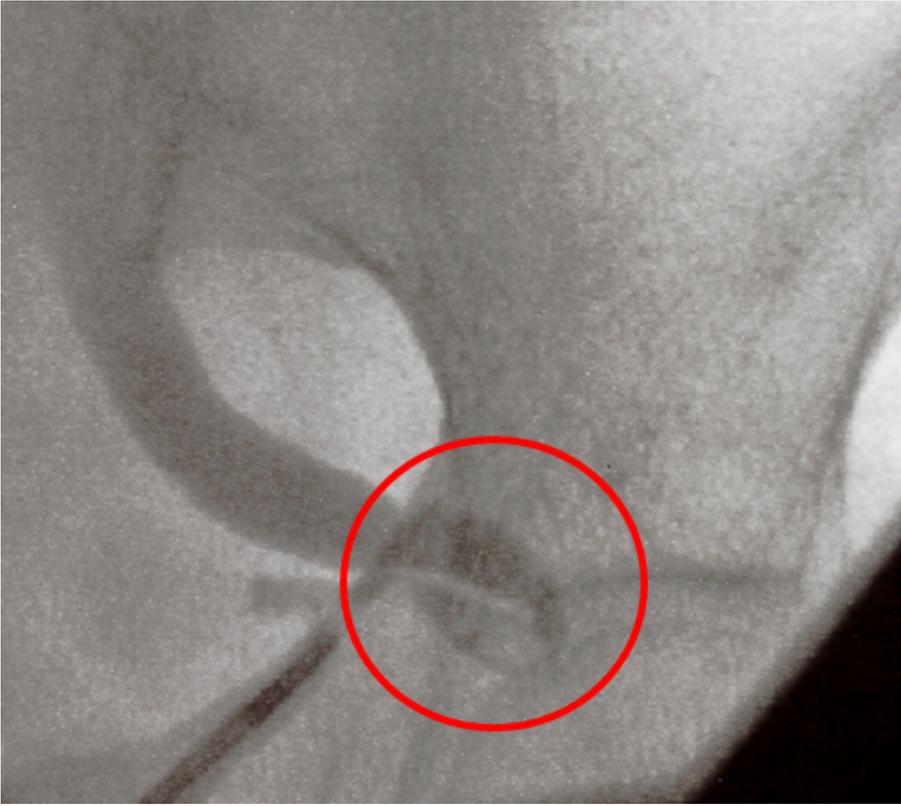


Figure 3

Retrograde urography reveals deviation of the left ureter into the sciatic foramen.

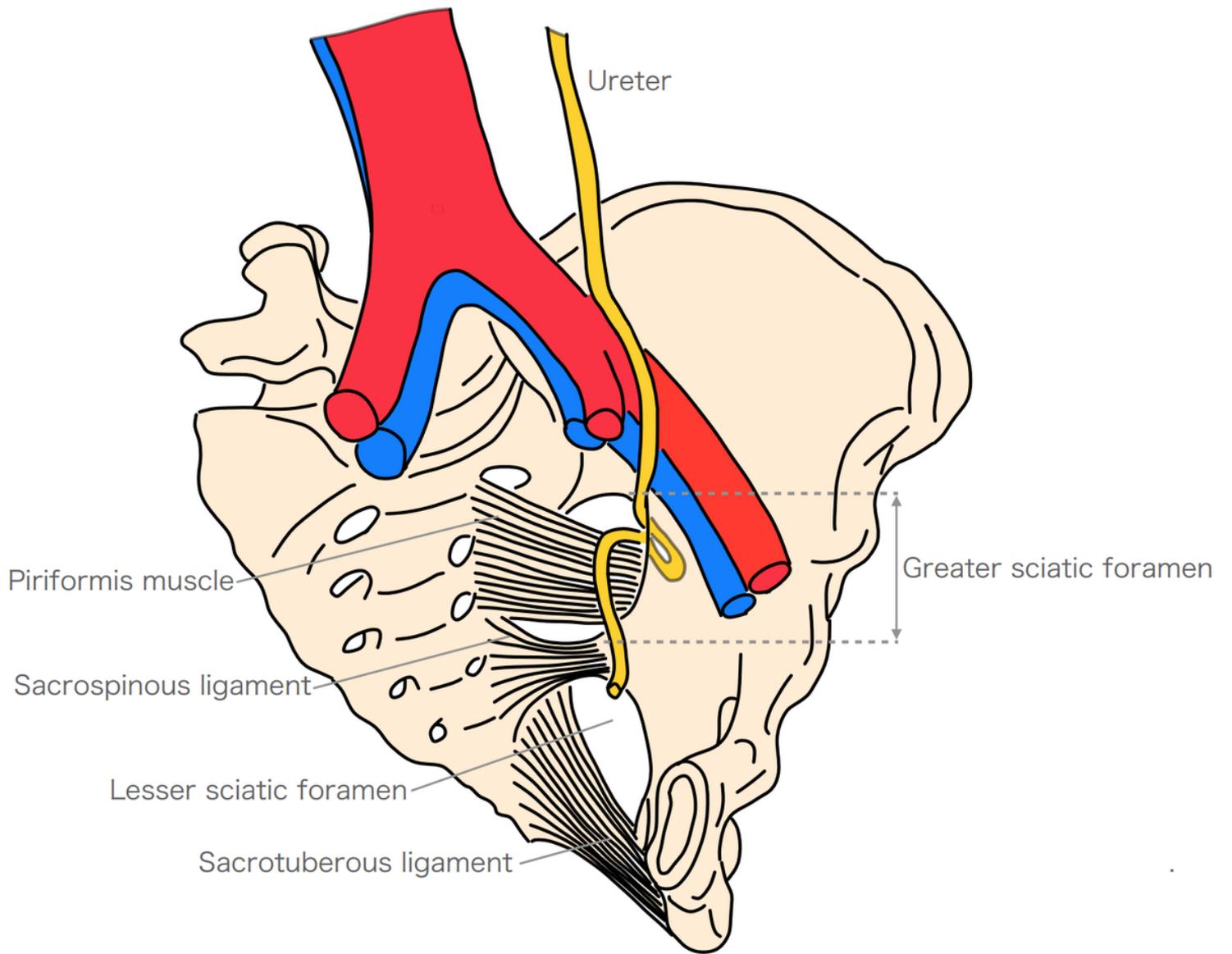


Figure 4

Ureterosciatic herniation, oblique view.