Ex-vivo Surgical Repair of a Renal Artery Aneurysm with Kidney Autotransplantation

Cirurgia Ex-vivo para Tratamento de Aneurisma da Artéria Renal com Autotransplante Renal

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ABSTRACT

Renal artery aneurysms are rare. They are most commonly degenerative, congenital or due to medial fibroplasia. Proximal aneurysms can be repaired by endovascular and in-situ surgical techniques. However, aneurysms of the distal renal artery and its branches require ex-vivo surgical repair, also known as auto-transplantation: the kidney is removed, dissected and reconstructed in cold ischemia, and put back in place.1,2 Proximal aneurysms can be repaired by endovascular and in-situ surgical techniques. However, aneurysms of the distal renal artery and its branches require ex-vivo surgical repair, also known as auto-transplantation: the kidney is removed, dissected and reconstructed in cold ischemia, and put back in place.2

INTRODUCTION

Renal artery aneurysms are rare. They are most commonly degenerative, congenital or due to medial fibroplasia.1 Proximal aneurysms can be repaired by endovascular and in-situ surgical techniques. However, aneurysms of the distal renal artery and its branches require ex-vivo surgical repair, also known as auto-transplantation: the kidney is removed, dissected and reconstructed in cold ischemia, and put back in place.2

CLINICAL CASE

A 69-year-old Caucasian female presented with controlled hypertension (on four anti-hypertensive drugs), dyslipidemia, acute myocardial infarction (with a normal coronary angiography one year before), obesity, obstructive sleep apnea syndrome treated with continuous positive airway pressure (CPAP). She had a 40 pack-year smoking history until the age of 44. In the workup for bilateral low back pain, a computed tomography angiography (CTA) revealed bilateral renal artery aneurysms (Fig. 1). Glomerular filtration measured by renal scintigraphy with 99mTC-DTPA was 54 mL/min (right), 46 mL/min (left) and there was right excretory delay without significant mechanical obstruction. Serum creatinine was 0.90 mg/dL and hemoglobin was 10.3 g/dL. The ultrasound scan of the carotid and vertebral arteries showed no changes.

Ex-vivo surgical repair of the right renal aneurysm was carried out because the aneurysm involved the branches of the renal artery. This technique has been described in detail.2–5 A right retroperitoneal flank lazy-S shaped incision, extending from the tip of the 11th rib to an area just medial to the McBurney point was used. The kidney was removed without dividing the ureter, encompassing a small ellipse of vena cava patch with the renal vein (which was closed longitudinally) to allow for a patch anastomosis, placed on the patient’s abdomen, immersed in ice slush and perfused with Celsior® solution at 4°C. The hilum was dissected and three branches distal to the aneurysm were identified. The two cephalic branches were syndactylized and the combined tube anastomosed to an autologous right hypogastric artery graft. The caudal branch was sewn end-to-side to this conduit (Fig. 2). The kidney was placed in its anatomical position (orthotopic). The reconstructed renal artery with hypogastric artery graft was routed posterior to the inferior vena cava and anastomosed to the distal abdominal aorta. The renal vein was anastomosed to the distal inferior vena cava.

Keywords: Aneurysm/surgery; Kidney Transplantation; Renal Artery/surgery; Transplantation, Autologous


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The serum creatinine was 0.9 mg/dL in the preoperative period, 1.3 mg/dL on the third postoperative day and 0.8 mg/dL at discharge on the sixth postoperative day. The histopathological examination of the surgical specimen revealed medial fibromuscular dysplasia and a calcified macroaneurysm (Fig. 3). Postoperative CTA showed adequate right kidney reconstruction (Fig. 4). At 1-year follow-up, creatinine remains at 0.9 mg/dL on the same four anti-hypertensive drugs.

DISCUSSION

This case report shares many of the well-known epidemiological features of renal aneurysm due to medial fibromuscular dysplasia: higher incidence in females (4:1), Caucasians and smokers, more common involvement of the right renal artery (3:1), bilateral involvement (25% of cases), and coexistence of macroaneurysms of the renal artery (9.2% of cases). The age of diagnosis was 69, later than usual (20 – 60 years), although the disease presumably existed before, as shown by the size and calcification of the aneurysm and the previous existence of hypertension, which is present in 81% of cases of renal artery aneurysm. Renal artery aneurysms are usually asymptomatic and therefore an incidental finding during the investigation for low back pain. However, the CTA and renal scintigraphy showed a slight right pelvicalycal dilatation that subsided after surgery and was most likely caused by aneurysm compression. The involvement of the carotid, coronary and vertebral arteries, which occurs in 20% – 30% of the cases of arterial fibroplasia, was excluded by vertebral and carotid ultrasonography and coronary angiography. Renal artery aneurysms rupture occurs in probably less than 3% of cases and is associated with a mortality rate of 10% in men and in non-pregnant women. Pregnancy is associated with increased risk of rupture, maternal mortality rate of 55% and fetal death rate of 85%. Renal artery aneurysm repair is recommended where size exceeds 2 – 3 cm or of any size in pregnant women or women of childbearing age.

Nephrectomy was not a good option in a 69-year-old patient with a contralateral renal artery aneurysm, despite good clearance of both kidneys determined by renal scintigraphy. The endovascular approach, with embolization or stent placement, would exclude two of the three branches of the renal artery and was not considered. The hilar involvement would preclude adequate surgical exposure with in-situ surgery and a complex vascular reconstruction was anticipated to exceed 40 minutes of renal ischemia. An ex-vivo renal artery surgery was performed because it obviates the constraints of in-situ renal artery surgery: surgical access for dissection and reconstruction becomes possible and cold perfusion allows for lengthy reconstructive times. The orthotopic auto-transplantation has advantages over the less invasive laparoscopic nephrectomy with auto-transplantation of the repaired kidney in the iliac fossa: 1) the arterial reattachment is in the aorta which is less prone to atherosclerosis 2) the venous reattachment in the inferior vena cava obviates the need for right renal vein elongation 3) the ureter is not divided and does not require reimplantation 4) a single surgical retroperitoneal approach, even though it is more extensive, allows for both nephrectomy and auto-transplantation. The advantages of the hypogastric artery graft are durability without aneurysmal degeneration and the possibility of individual anastomoses to the branches of the renal artery, although this was not required on this occasion.

Crutchley reported a series with 77 patients, 78 surgeries for branches of the renal arteries, of which 50 were aneurysm, 49 by ex-vivo and 29 by in-situ surgery. There was no mortality and the primary patency at 1 year was 85%. Among patients with hypertension 15% were cured, 65% were improved and 20% failed. Early renal function was improved in 35%, unchanged in 48% and worse in 17%. Duprey reported a series with 67 patients, treated for 87 renal artery branch aneurysms by ex-vivo surgery. There was no mortality, the primary patency at 8 years was 88%. There was benefit in the control of hypertension (43% cure, 18% improvement) and preservation of the renal function.

Ex-vivo renal artery surgery is the treatment of choice for distal renal artery lesions and its branches, which are not amenable to endovascular approach or in-situ surgery. It eliminates the risk of aneurysm rupture, improves the control of hypertension and preserves renal function that is important in young patients with bilateral and progressive disease in which one kidney may prove insufficient, or in patients with a single kidney.

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PROTECTION OF HUMANS AND ANIMALS

The authors declare that the procedures were followed according to the regulations established by the Clinical Research and Ethics Committee and to the Helsinki Declaration of the World Medical Association.

DATA CONFIDENTIALITY

The authors declare having followed the protocols in use at their working center regarding patients’ data publication.

INFORMED CONSENT

Obtained.
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REFERENCES

Figure 1 – (A, B) Abdominal computed tomography (CTA). Right renal artery hilar aneurysm 3.4 x 2 cm in diameter and calcified. Distal left renal artery aneurysm 1 cm in diameter. The size of the kidneys, parenchymal thickness and contrast opacification were normal. There was also slight right pelvicalyceal dilation and a normal ureter. (C) Right renal artery angiography. Renal artery aneurysm at the hilum and ‘string-of-beads’ morphology in the remaining artery.
Figure 2 – Surgical reconstruction of the renal artery. (A) Proximal renal artery; (B) Aneurysm; (C) Hilar branches; (D) Hypogastric artery graft
Figure 3 – Histopathological examination. (A) Renal artery macroaneurysm; (B) Longitudinal view of the renal artery with areas of stenosis and microaneurysms; (C) Histopathological examination of the renal artery with thickening and disorganization of the elastic and muscular tissue of the tunica media and microaneurysm (Verhoeff, x400).

Figure 4 – Postoperative abdominal CTA (A, B). Right kidney with more caudal location, patency of the right renal artery reconstruction and absence of the hypogastric artery which was harvested and used as a graft. The minor preoperative right pelvicalyceal dilation subsided.