diagnosis of cavernous body rupture may reasonably be suspected, urgent surgical examination is indicated (1,3,7).

In our case, despite its atypical presentation, the large hematoma and penile deformity led us to doubt about the integrity of cavernous bodies. Surgical review allowed for ruling out rupture of cavernous bodies, draining the hematoma, and resolving bleeding from the superficial dorsal vein. Despite the invasive approach chosen, total cosmetic and functional recovery was achieved in only 2 weeks. According to the literature reviewed on the subject, surgery may be considered in these patients as a treatment option because it causes minimal morbidity, barely requires hospital admission, and recovery is very quick (5,8).

**CONCLUSIONS**

Rupture of the superficial dorsal vein of penis is an uncommon condition considered in differential diagnosis of penile hematoma. Doppler ultrasound of the penis may allow for its diagnosis and for excluding rupture of cavernous bodies. Although conservative management appears to be of choice, surgical examination, providing good cosmetic and functional postoperative results, is indicated when a reasonable doubt exists about diagnosis.

**REFERENCES AND RECOMMENDED READINGS**

(*of special interest, **of outstanding interest)


**GROSS CALCIFICATION ON DISTAL END OF URETERAL STENT**

Miguel Angel Arrabal Polo, Mercedes Nogueras Ocaña, Miguel Arrabal Martín, Sergio Merino Salas, Jose Luis Mijan Ortiz and Armando Zuluaga Gomez.


**Summary.-** OBJECTIVE: The commonest indications for ureteral stent placement are: obstructive nephrolithiasis, renoureteral surgery, urologic oncology, endourology and extrinsic ureteral compression.

METHODS: We report the case of a 77-year-old male patient with a DJ ureteral catheter placed for an 8-month period and history of nephrolithiasis; the stent showed a 60 mm x 30 mm calcification on its distal end.
RESULTS: Open cystolithotomy and removal of stent resolved the clinic symptomatology.

CONCLUSION: A prolonged indwell time of stents, as well as a history of nephrolithiasis and urinary infections may on many occasions result in calcification and encrustation of ureteral stents, and will lead to the use of endourology techniques, extracorporeal lithotripsy or open surgery to resolve these conditions.

**Keywords**: Ureteral stent. Lithiasis. Calcification. Encrustation.

**Case Report**

We describe here the case of a 77 year-old male, with a personal history of Alzheimer type dementia under treatment with rivastigmine, who underwent Extracorporeal Shock Wave Lithotripsy to manage a nephrolithiasis five years earlier. Eight months ago, the patient presented with a colic-type pain localized on left renal fossa that irradiated to genital region; urinary sediment exhibited microhematuria; simple radiography displayed a lithiasis located on left renal pelvis, which was subsequently confirmed through abdominal TAC with intravenous contrast. Since the patient showed an associated septic symptomatology, it was decided to place a DJ type ureteral catheter. Once this associated-to-urinary-obstruction infectious symptomatology was solved, we determined to perform an Extracorporeal Shock Wave Lithotripsy (ESWL), 1 cm in maximum diameter, on left renal pelvis; the patient was scheduled for a next session as a result of an incomplete fragmentation of the calculus. The patient did not attend the scheduled session, and 4 months later he presented with hematuria, weight loss and an irritative urinary syndrome. It was then decided to perform an ultrasonography on both kidneys and on bladder-prostate region that revealed a big-sized vesical lithiasis, normal size and normal morphology for both organs, with no dilatation of urinary excretal pathways. Before the suspicion of a calcification of the distal end of the DJ ureteral catheter, it was decided to perform both a cystolithotomy and removal of the catheter, since simple radiography of the urinary system did not show calcifications on its proximal end or on ureteral pathway. A great vesical lithiasis mass, 60 mm x 30 mm, was removed during the intervention, while DJ ureteral catheter extraction did not result difficult.

The composition of the calculus was calcium oxalate-phosphate

From the urologic point of view, the patient is currently doing well, with no symptomatology, and last checkups did not reveal any lithiasic process.

**Discussion**

As a rule, calcification on both the proximal and distal ends of ureteral catheters is not a frequent complication in the daily practice despite the high amount of stents that are currently placed (4). In general, stent calcification is attributable to indwell times that exceed 6 months, when extraction or replacement have been forgotten (1).

The treatment of calcified and embedded ureteral catheters includes ESWL, ureteroscopy, and endoscopic lithotripsy, percutaneous nephrolithotomy, laparoscopic surgery, or open surgery depending on calculus features (3).
Monga M. et al report 31 cases referring complications subsequent to ureteral stent insertion. In 22 cases, the stent was absentmindedly left indwelling for more than 6 months, although 9 cases exhibited migration. Ureteroscopy and ESWL were the procedures more frequently used for extracting catheters, while 6 patients required more than a single intervention (1).

Andriole et al described 87 patients, out of which 10% exhibited catheter embedding due to calcification, which originated 2 months after placement (5). Other authors refer calcified ureteral stents after a single month of insertion (6).

Matthew et al published a series consisting of 41 patients that exhibited 49 calcified ureteral stents. Calcifications took place during the first 6 months after catheter placement in 37 cases, while 21 cases reported calcification in the first 4 months subsequent to placement. Mean time of calcification was 5 months. Lithotripsy on calculi and ureteroscopy for catheter removal, alone or associated with ESWL, were the more efficient treatments used. Percutaneous nephrolithotomy or open surgery was necessary in some other case (3).

On the other hand, Vanderbrink et al established that the risk of calcification and embedding of ureteral stents is related both with long indwell times and patient’s history of nephrolithiasis. It seems, though, that state-of-the-art stents containing oxalate-degrading antibiotics and enzymes show fewer complications. In most cases, calcifications can be treated with ureteroscopic laser lithotripsy, although those exceeding 2 cm will require percutaneous surgery (7).

The management of calcifications through ureteroscopy and laser fragmentation, in addition to the subsequent removal of indwelling stents, has proved to be the most efficient practice; it has also rendered lower rates of re-treatments and provided more benefits to patients. As for those selected cases that include ureteral stent calcifications less than 1 cm, and in others where ureteroscopic procedures may fail, the use of Extracorporeal Shock Wave Lithotripsy and subsequent Ureteroscopy removal of catheters may be the treatment of choice. Percutaneous lithotomy is suggested in proximal calcifications exceeding 2 cm, and when anatomical conditions are favorable. Open surgery is only recommended when patients exhibit large lithiasic masses or when previous treatments have failed (3).

As for our case and in view of the large lithiasic mass observed, we decided to perform an open cystolithotomy and remove calculus, since we determined this would be the definitive treatment and would not require new re-treatments.
CONCLUSION

Retrospective studies found in the literature prove that cases referring ureteral stents with indwell times beyond 6 months, and a history of nephrolithiasis and infection represent a risk factor for stent calcification. Laser fragmentation of calcified stents through ureteroscopy is currently regarded as the treatment of choice for most patients.

REFERENCES AND RECOMMENDED READINGS

(* of special interest, ** of outstanding interest)


VILLOUS ADENOMA IN AUGMENTATION COLOCYSTOPLASTY ASSOCIATED TO INFILTRATING UROTELIAL CANCER IN BLADDER REMANENT


Summary.- OBJECTIVE: To report a new case of villous adenoma developed in augmentation colocystoplasty.

METHODS: Characterization of a new case and review of the literature published to date.

RESULTS: We report the case of a 66 year-old man with a villous adenoma and synchronic infiltrating transitional cell carcinoma of the bladder after augmentation colocystoplasty. The latency period until the development of villous adenoma after surgery is long. Treatment consisted of transurethral resection.

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