

## A rare cause of renal colic pain: Chilaiditi syndrome

Murat Tuncer, Cahit Sahin, Ozgur Yazici, Alper Kafkaslı, Kemal Sarica

Dr. Lutfi Kirdar Training and Research Hospital Urology Clinic, Istanbul, Turkey.

### CASE REPORT

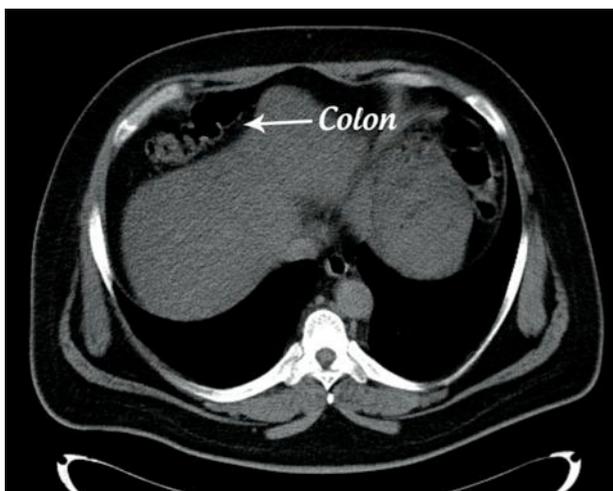
A 46-year old man was admitted to the emergency service with an acute onset of severe right flank pain, inguinal pain, nausea and vomiting. Physical examination revealed tenderness at right upper quadrant of abdomen without any signs of defence or rebound in the abdomen. *Costo-vertebral angle (CVA)* tenderness was present on the right flank region. Complete clinical examination showed that auscultation of the lung bases did not show any sign of pneumonia, palpation of ribs did not reveal any osseous abnormality and there was again no specific pathologic finding in other organ systems which may led us to think about other possible causes of our findings. Our case did not have fever and/or chills, blood pressure was high (140 /90 mmHg) and no sign of trauma in any system was found.

Laboratory studies revealed the following findings: *white blood cell (WBC)* count was 10.800 cells without any shift, *red blood cell count (RBC)* was 4.870 cells, serum creatinine was 1.03 mg/dl, the values of liver function tests AST, ALT and alkaline phosphatase were 22 U/L, 27 U/L and 58 U/L respectively. Lastly values of renal function tests BUN and GFR were 13.6 mg/dl and 125 ml/min respectively. Urine analysis revealed a RBC count of 45 cells/HPF with no signs of infection. Apart from

diabetes mellitus and hypertension, the patient had no history of urinary stone disease and previous history of surgery. There were only oral antidiabetic and anti-hypertensive medication in his current treatment chart. On radiological evaluation non-contrast spiral abdominopelvic CT (NCST) revealed no calculus or dilatation in the urinary system. On the contrary, ascending colon has been found to be interposed between the liver and the diaphragm (Figure 1). In the light of clinical radiological findings (particularly findings of CT) and symptoms, patient was diagnosed as *Chilaiditi syndrome*. Following a consultation of gastroenterology department the patient was managed conservatively and discharged with the proposal of taking lots of liquid and roughage, bed rest and laxative drug. At the end of the first month of follow up, we ascertained that he followed our suggestions and was free of symptoms.

### CONCLUSIONS

As a rarely encountered pathology, *Chilaiditi syndrome* is usually asymptomatic in the majority of the cases. However, in symptomatic cases the clinical diagnosis could be mixed with some certain diseases requiring surgical treatment. In the light of the literature data and of our findings we believe that *Chilaiditi syndrome* must be considered in the differential diagnosis of the patients referring with urinary colic symptoms with no urinary pathology on radiologic imaging.



**Figure 1.**

Interposition of colon between diaphragm and liver: the Chilaiditi sign.