Internal ureteral stents are indispensable part of the modern urology. Despite improvements in the ureteral stents some complications are still encountered and the widely usage of them increased the complications especially when selected improperly (1,2). We present a case who demonstrated how serious problems could be concerned when unsuitable internal ureteral catheter was used.

**CASE REPORT**

A 14 year old boy presented with the history of painful micturation and backpain to our clinic in December 1989. He had undergone left ureteroneocystostomy with the diagnosis of right renal agenesis and left hydronephrosis due to vesicoureteral stricture in other hospital 3 years ago.

Physical examination revealed well developed boy with an old phannenstiel incision scar and left costo vertebral tenderness. IVP showed very progressed left hydronephrosis and no function on the right side. Renal scintigraphy revealed right renal agenesis and delayed left renal function. There was no reflux in voiding cystourethrogram.

We performed ureteroneocystostomy in politano-Leadbetter technique and placed double j stent to the left ureter for drainage. He was discharged on the 11th postoperative day in a well situation.

We hospitalized him again with high fever. Costo vertebral pain and pyuria after 3 days from discharge. The double-j catheter was in its proper place on the control X-ray. We began parenteral antibiotic treatment. His complaints decreased but didn’t resolve completely. We discharged him 7 days later and continued peroral antibiotic treatment. He had several fever attacks during follow-up. A soft 20-25cm long catheter fistulised from his left posterior lumbar area (Figure 1,2) on the 20th postoperative day partially and the patient himself pulled it out. Then, he relieved from all his complaints surprisingly. Unfortunately, he didn’t keep the catheter. An X-ray showed the proper placement of double-j stent we placed which was removed ondoscopically 2 months later postoperatively.

**DISCUSSION**

Double-j stents have been advocated for drainage or splintage of the ureter. The daily use of ureteral stents has increased enormously in modern urology. This widely usage of double-j stents in the practise of modern urology has also increased the complications (3). Main complications are migration, reflux, infection, erosion and encrustation, pain and bleeding (4). In addition, we encountered a perforation of the kidney (or collecting system) by a silicone double-j stent that caused recurrent urinary infections in a 32 year old man who underwent balloon dilatation for left vesicoureteral stricture due to previous ureteroneocystostomy (Figure 3). In our report, it was very interesting that the ureteral stent moved through kidney or collecting system and left the body from lumbar area. Since no stent is ideal, it is incumbent on the surgeon to be familiar...
with the various indications for usage, modes of insertion and potential for complications. The surgeon has to select a stent best suited for problem presented by the patients (2,4).

The internal ureteral stent inserted during the first operation was soft, straight and nonopaque in this case. Since the stent was overlooked and not noticed, it should have been pushed upwards during the insertion of double-j in the second operation. After septic pyelonephritis attacks, previously placed stent left the body from lumbar area passing through upper urinary tract. Since the patient had a solitary kidney, it could had been life threatening for him. Furthermore, another exploration should had been necessary if the stent hadn't left the body.

Double-j ureteral stents are indispensable part of modern urology. The surgeon should be familiar with the indications, types of stents and inherent risks atta

REFERENCES


