Interactive case report

70 year old man with scrotal swelling, abdominal aortic aneurysm, and renal lesions: case outcome

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Four weeks ago we presented the case of Mr Mahon, who presented with scrotal swelling (15 April, *BMJ* 2006;332:899). Computed tomography showed that he had a renal tumour that required urgent removal and he also needed repair of an abdominal aortic aneurysm that had a risk of rupture of over 40% (22 April, *BMJ* 2006;332:959). Mr Mahon's management was discussed at a multidisciplinary team meeting between the radiologist, urologist, and two consultant vascular surgeons. The team agreed that a combined approach involving repair of the abdominal aortic aneurysm and left partial nephrectomy offered the best possible outcome for this patient. The results of the computed tomography and various investigations were explained in detail to Mr Mahon and his family, and the need for urgent surgery was outlined. The risks and benefits of surgery for the aneurysm and the renal tumour, both in isolation and via a combined approach, were discussed.

Mr Mahon was scheduled for an abdominal aortic aneurysm repair and a possible partial left nephrectomy. The operation was done through a long midline incision with a transperitoneal approach. The vascular surgeons dealt with the aneurysm first, by clamping the abdominal aorta infrarenally, bypassing it with a 20 mm Dacron graft. The urologist then explored the left kidney to assess the morphological nature of the tumour and the feasibility of a partial nephrectomy. He found an asymmetrical enlargement with no clearly differentiating mass; the renal artery and vein did not show any tumour extension. He concluded that a partial nephrectomy would not be possible.

At this stage the team had to decide whether to go ahead with a total left nephrectomy, considering Mr Mahon's age, his comorbidity, the likely adverse effect of aneurysm surgery on overall renal function, the differential renal function, and the small size of the tumour. The unquantified risk of postponing nephrectomy, the inconvenience of regular surveillance, and the possible psychological trauma for the patient related to uncertainty about his future, were all factors

Renal oncocytoma

in favour of proceeding to a total nephrectomy. On the other hand, nephrectomy would put Mr Mahon at increased risk of postoperative acute renal failure, with a subsequent requirement for haemofiltration. As he already had seriously compromised cardiovascular and respiratory function, which could give rise to further postoperative complications culminating in multi-organ failure, the anaesthetist, urologist, and vascular surgeon agreed to postpone the nephrectomy.

Mr Mahon recovered uneventfully from his surgery. Postoperatively, his renal function (urea 4.5 mmol/l, creatinine 92 μ mol/l) remained satisfactory. He was discharged home on the eighth postoperative day. Mr Mahon and his family expressed appreciation of the decisions reached during the operation.

Mr Mahon had a left total nephrectomy six months later. His recovery was uneventful and his renal function stabilised at a creatinine concentration of 180 μ mol/l. The histology report showed that the tumour was an oncocytoma.

Competing interests: None declared.

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This is the final part of a three part case report, which describes the outcome and summarises the comments made by readers during the case presentation. Further responses are welcome through bmj.com