The loin pain–hematuria syndrome

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It may seem unfair to be critical of a surgical procedure that "bats a thousand" (four cases, four successes), adds to 130 cases already reported, reinforces comparably good results in 10 cases reported from another Canadian university centre[1] and relieves patients of unrelenting pain as described by Karvelas and Ramsey on pages 121 to 125 of this issue of the Journal. Would it not be sadistic to deny the patients the benefit of such treatment? And yet . . . .

The problem with the so-called loin pain–hematuria syndrome is that the major symptom is pain, and pain is always highly subjective. It is not as if an architectural problem was corrected or an abnormality of body chemistry addressed. If denervation can relieve the pain, why shouldn't mobilization of the renal artery suffice? How about a trial of dopamine infusion? Why not transect the renal artery and reanastomose it or carry out an orthotopic transplantation? Why is it necessary to transplant the kidney into the pelvis? Would not a capsulotomy or a sham operation achieve the same result?

Drs. Ramsey and Chin (the urologist from London, Ont., who reported on 10 cases of loin pain–hematuria syndrome in 1992) have unblemished reputations within the academic urology community in Canada. Undoubtedly they both reached the decision to carry out this formidable undertaking after much soul-searching.

I remain skeptical. I have never seen a case of this syndrome nor heard it discussed at rounds in Montreal during the past 30 years. I did once have a nurse patient referred to me because she was taking far too much narcotic analgesia for presumed renal colic. Neither a stone nor delayed dye excretion was ever demonstrated. I suggested placing a J tube to determine if unseen stones or "sand" could be causing the pain. She tolerated the J tube for 1 day and had it removed at another hospital. Could this have been a case of loin pain–hematuria syndrome? I do not recall if she had microhematuria. She certainly did not have gross hematuria.

Transplantation for the loin pain–hematuria syndrome calls to mind nephropexy for Dietl's crisis, a procedure that was fairly common in the 1960s. It was presumed that a redundant ureter could kink, obstruct the flow of urine and cause pain like that of renal colic. Surgical fixation of the kidney to the psoas muscle was carried out to eliminate the kink and cure the pain. The diagnosis is no longer made and the procedure no longer performed.

Is the loin pain–hematuria syndrome a true entity or a fad? When the main problem is pain, the value of a corrective procedure is hard to prove or disprove.

Reference

1 Chin JL: Loin pain–hematuria syndrome: role for renal autotransplantation. *J Urol* 1992; 147: 987–989

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