Renal and urological tract injury

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In physiologically non-compromised patients, CT scanning with contrast is the investigation of choice. For assessment of bladder injury a cystogram should be performed at the time of CT . A minimum of 300 /uni00A0 mL of contrast is instilled into the bladder via a urethral catheter. The large volume is essential because a small volume may not distend the bladder enough to produce a leak from a small bladder injury , once the cystic muscle is contracted. Generally , renal injury is managed non-operatively unless the patient is physiologically compromised. The kidney can be angioembolised if required. Henri Albert Charles Antoine Hartmann , 1860–1952, Professor of Clinical Surgery , Faculty of Medicine, University of Paris, Paris, France. - Ureteric injury is rare and is generally due to penetrating trauma. Most ureters can be repaired or diverted if necessary , or may even be ligated as part of damage control procedures. Intraperitoneal rupture of the bladder, usually from direct blunt injury , will require surgical repair. Extraperitoneal rup - ture is usually associated with a fracture of the pelvis and will heal with adequate urine drainage via the transurethral route . Suprapubic drainage is reserved for when this is not possible. - Summary box 29.7 Injuries to structures in the abdomen /uni25CF - /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

2 2 3 Figure 29.10 The zones of the retroperitoneum. Zone 1, central; zone 2, lateral; zone 3, pelvic. In children, splenic injury can be managed non-operatively in most cases, but not if physiologically compromised Duodenal injuries are often associated with pancreatic trauma Bowel injuries need urgent de /f_i nitive repair, or isolation using resection or by stapling Rectal injuries are managed depending on whether intra- or extraperitoneal Kidney and urinary tract injuries are best diagnosed with contrast CT scanning Intraperitoneal bladder tears need formal repair and drainage

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