

**American College of Radiology  
ACR Appropriateness Criteria®**

**Clinical Condition:** Renal Trauma

**Variant 1:** Blunt abdominal trauma with microscopic hematuria with no suspicion of associated abdominal injury.

Radiologic Procedure	Rating	Comments	<a href="#">RRL*</a>
X-ray abdomen and pelvis	4		Med
CT abdomen and pelvis with contrast	4		High
US abdomen	3		None
US kidneys and bladder retroperitoneal	3		None
X-ray intravenous urography	3		Med
NUC Tc-99m DMSA scan kidney	1		Med
INV arteriography kidney	1		Med
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

**Variant 2:** Blunt abdominal injury; suspicion of multisystem trauma, with hematuria.

Radiologic Procedure	Rating	Comments	<a href="#">RRL*</a>
CT abdomen and pelvis with contrast	8		High
X-ray abdomen and pelvis	8		Med
X-ray intravenous urography	4		Med
INV arteriography kidney	4	Embolizing bleeders, avulsion of pedicle.	Med
NUC Tc-99m DMSA scan kidney	4	Not commonly used for initial trauma.	Med
US abdomen	3		None
US kidneys and bladder retroperitoneal	3		None
<b>Rating Scale:</b> 1=Least appropriate, 9=Most appropriate			<b>*Relative Radiation Level</b>

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## RENAL TRAUMA

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### **Summary of Literature Review**

No single method of imaging evaluation can be uniformly applied to all patients suspected of suffering abdominal trauma. The exact approach depends not only on the types of injuries the patient has likely suffered, but also on the philosophy of the attending physicians, local practice, and the type of equipment and support available. Moreover, the evaluation of a suspected renal injury cannot be isolated from the evaluation of other suspected intra-abdominal injuries. A variety of different approaches to a given patient may therefore be acceptable.

Most closed urinary tract injury occurs after wide-impact blunt abdominal trauma. Isolated renal injuries after blunt trauma are rare, and the majority are relatively minor in most published series. The amount of hematuria that should trigger radiologic investigation of the urinary tract after localized blunt trauma is controversial. Many authorities feel that any amount of hematuria should be investigated, as it is well known that significant urinary tract injury may be present in patients with little or even no hematuria. Furthermore, there is little correlation between the degree of hematuria and the amount of renal injury that is present.

An oft-cited example is patients suffering from renal pedicle injury in whom hematuria is said to be absent in 25% of cases [1]. Nicolaisen et al [2], however, found that significant renal injury was limited to the group of patients in whom shock and either gross or microscopic hematuria was present among 306 individuals analyzed retrospectively following blunt trauma. There were no significant renal injuries among the 221 patients who had microscopic hematuria but were not suffering from shock. In patients in the same series who suffered penetrating injuries, however, no such discrimination was possible,

and the authors suggest radiologic evaluation of all patients suffering penetrating injury and hematuria. These observations have now been confirmed in multiple additional studies, both retrospectively and prospectively [3-6]. It can therefore be concluded that investigation of hematuria is warranted in patients with suspected isolated renal injury who 1) have penetrating injury, 2) have gross hematuria, 3) have microscopic hematuria with shock, or 4) are suspected of having major associated intra-abdominal injury.

There is no longer much argument that computed tomography (CT) of the abdomen is the screening study of choice for suspected intra-abdominal injury. Many trauma surgeons still regard diagnostic peritoneal lavage (DPL) as a viable method for detecting intraperitoneal hemorrhage [7]. DPL is sensitive, easy to perform, and universally available; however, it does not differentiate inconsequential bleeding from that which requires laparotomy and, more importantly, cannot detect the site of the bleeding [8]. Furthermore, DPL does not detect retroperitoneal injuries and should not be performed in children (because of the risk of injury to the bladder), in those who have had previous laparotomy (because intra-abdominal adhesions may cause false negative results), or in those with retroperitoneal hematomas as a result of pelvic fractures (because of potential false positive results). CT is much more specific than DPL for both intraperitoneal and retroperitoneal injuries and, most importantly, can differentiate trivial injuries from those requiring exploration [9-11]. CT, however, is still not universally available on an immediate basis, is expensive, and is reported to be less sensitive than DPL for detecting injuries to the bowel or mesentery.

Because CT is expensive, not universally available on an immediate basis, and exposes many young patients to ionizing radiation, focused abdominal sonography for trauma (FAST) has been touted by some as an alternative to CT. This method, originally pioneered in Europe, has been now advocated by many in the United States. A sensitivity of 98% for detecting free fluid collections with a specificity of 99% has been reported for US [12]; this same study reported 100% sensitivity and specificity and a positive predictive value for US in detecting renal injuries. The series, however, included only 3 patients with renal injuries.

A significant limitation of US for imaging of renal trauma is that no functional information is provided. Its value in screening abdominal trauma patients has been recently confirmed in a large study. Sirlin et al [13,14] reported that among 3,679 patients with negative findings on US, 99.9% were confirmed as true negative by clinical or radiographic follow-up. Of 38 patients with false negative

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studies, the most commonly missed injuries were retroperitoneal hematomas and injuries of the spleen or liver with little hemoperitoneum. Patients considered at high risk for a false negative study include those with hematuria, fractures of the lower ribs or lumbar spine, and pelvic fractures. There is little information concerning the use of color Doppler for assessing renal blood flow after trauma.

Most blunt renal injuries (75%) occur in patients suffering multisystem trauma. In a series from Cass et al [15], 241 of 831 patients had what were considered to be solitary renal injuries; however, the vast majority (98%) was minor injuries. Therefore, only five patients in the entire series suffered significant isolated renal injury. There were 33 significant renal injuries in the group of 590 patients with hematuria who suffered multisystem trauma.

Other injuries associated with injury of the kidneys following multisystem blunt trauma include (in order of decreasing frequency): fractures of the extremities, thoracic injury, pelvic fracture, intra-abdominal injury, head injuries, and diaphragmatic rupture. In the abdomen, injuries to the liver and spleen are most commonly associated with renal injury, followed by injury to the pancreas, the colon, and the small bowel.

Studies have shown there is a strong association between the presence of gross hematuria and nonurologic intra-abdominal injury from blunt trauma. Knudson et al [16] found that 24% of patients with gross hematuria after blunt trauma had a significant intra-abdominal injury. This percentage increased to 65% when shock was also present.

In patients who are hemodynamically unstable, only limited information about the status of the urinary tract can generally be obtained. A single view of the abdomen following a large dose of intravenously administered contrast material (“one-shot IVP”) is generally all that can be obtained; such a study is insufficient to diagnose a renal injury but can give information about the location and status of the uninjured kidney(s). Similarly, most patients suffering from an anterior gunshot wound of the abdomen will require surgical exploration; the goal of imaging in such cases is to establish the gross functional status of the kidneys. The renal injury, if present, will generally be assessed intraoperatively. The value of these limited “one-shot” studies in unstable patients has been questioned [17]; a retrospective review of 239 such studies showed that the preoperative urographic assessment of contralateral renal function played no role in the management of a renal injury. The authors of this study felt that delaying definitive therapy merely to obtain the urographic study was not justified.

In patients who have suffered suspected penetrating renal injury, CT is also the method of choice for assessment [18]. Some urologists will argue that CT is unnecessary

since they believe that all such patients should have renal exploratory surgery; in such cases, the goal of imaging is to exclude an abnormality of the contralateral kidney.

In patients with limited posterior stab wounds, however, CT should be performed for assessment, since exploratory surgery is not mandatory.

In recent years, there has been an increasing trend toward conservative (nonoperative) management of major renal injuries following blunt trauma. At least part of the impetus for this development has been the accurate staging of such injuries that is provided by CT [19,20]. Erturk et al [21] reported that early CT evaluation allowed confident nonoperative management in 17 of 22 patients with renal injuries. Bozeman et al [22] found nonoperative management was effective in 50% of patients with Grade IV or V injuries who were hemodynamically stable. Many authorities now believe that with accurate preoperative CT, renal exploration need not be performed unless there are major devitalized fragments with associated bowel or pancreatic injury [23] or unless the patient becomes hemodynamically unstable from a major renal laceration and is not manageable by angiographic embolization.

The Societe Internationale D’Urologie recently published a consensus document on issues concerning the diagnosis and management of renal injuries [24]. Its recommendations are not substantially different from those in this summary.

### Summary

Assessment of the nature and extent of the renal injury is most important in those patients in whom there will be an attempt to avoid exploratory surgery. In hemodynamically stable patients being assessed for wide-impact blunt injury in a major trauma center where CT is available immediately on a 24-hour basis, this goal can most efficaciously be met by abdominal and pelvic CT. In institutions where there would be a significant delay in obtaining high-quality CT, it is perfectly acceptable to use DPL to assess the intraperitoneal viscera and high-dose urography, preferably with tomography, to assess the kidneys. In patients who suffer suspected anterior penetrating renal injury, CT should be used as a first-line study if radiographic assessment is desired. Similarly, CT is the study of choice to evaluate the effect of limited posterior stab wounds.

The preferred treatment of patients with suspected isolated blunt renal injury is perhaps the most controversial issue. Most such patients do not have evidence of multisystem trauma but are suspected of renal injury because of hematuria. Studies have demonstrated that the incidence of significant renal injury in this group of patients is low; those with microscopic hematuria alone do not need any radiologic evaluation.

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## Anticipated Exceptions

In pregnant patients, US should be considered as a first-line study.

## Relative Radiation Level Information

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® [Radiation Dose Assessment Introduction](#) document.

Relative Radiation Level Designations	
Relative Radiation Level	Effective Dose Estimate Range
None	0
Minimal	< 0.1 mSv
Low	0.1-1 mSv
Medium	1-10 mSv
High	10-100 mSv

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