Abdominal Ultrasound – Kidneys

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Abdominal Ultrasound
Kidneys
Curved transducer 3-6 MHz
Supine, decubitus or prone
Assess entire organ in longitudinal and transverse
Longitudinal section, transducer aligned with the long axis of the kidney
Transducer rotated 90 degrees for transverse section
Deep inspiration to move the kidney downwards to avoid ribs
Adult kidneys 9-13cm
Renal asymmetry is common, 1-1.5cm difference
Right kidney 1-2cm lower due to liver
Oblique lie, black line is orientation of kidney in longitudinal and transverse
Normal renal cortex echogenicity equal to, or less than the liver
Hyperechoic renal cortex is abnormal
Medullary pyramids have the lowest echogenicity and may appear as hypo- or anechoic
Perinephric fat may be seen, do not mistake for fluid
Longitudinal and transverse normal right kidney
Pelvic/ectopic kidney, if renal fossa is empty, check pelvis
Not always conventional shape, may be mal-rotated and difficult to measure
Congenital abnormalities are common
Unilateral renal agenesis, absence of one kidney. Contralateral kidney is usually larger than normal, known as compensatory hypertrophy
Longitudinal of a solitary kidney, (left agenesis) measuring over 13cm
Horseshoe kidneys 1 in 400, lower poles of the kidneys connected by isthmus of renal tissue crossing the midline anterior to aorta and inferior vena cava (IVC)

Easy to miss on ultrasound, suspect when lower poles of both kidneys are difficult to see clearly

Confirm by scanning transversely across the midline to see isthmus.

Image 1 - longitudinal right kidney, poorly visualized lower pole.

Image 2 transverse midline, isthmus anterior to the spine and great vessels
Hypertrophied Column of Bertin
- renal cortex tissue indents deeply into the renal sinus fat
- some more spherical in shape
- no clinical significance
- can mimic renal tumours
- should measure less than 3cm
- isoechoic to cortex
- no effect on the external renal contour
- no vascular pattern disruption
- may contain a renal pyramid

Longitudinal right kidney, hypertrophied column of Bertin. Note apparent mass effect of renal sinus, but renal contour remains normal.
Lobular irregularity of renal outline
-extremely common
-known as persistent fetal lobulation
-no clinical significance
-may mimic renal tumours or scarring.

Dromedary Hump
-common variant of left kidney
-humped or slightly pyramidal shape
-due to extrinsic pressure from the developing spleen

Longitudinal left kidney, prominent cortical outline of a dromedary hump.
Longitudinal left kidney

Area between calipers (3.15cm) most likely hypertrophied column of Bertin, but recommended that lesions over 3cm have other imaging such as CT
Renal calculi range in size from the very small to very large staghorn calculi.

Image 1 - ultrasound image, staghorn calculus in right kidney.

Image 2 corresponding x-ray
All renal calculi if large enough will cast acoustic shadow (less than 5mm difficult to detect)

Vessel walls at the corticomedullary junction may mimic a stone but will not cast an acoustic shadow in two planes.

Calculus will shadow in all planes and angles.

Longitudinal of small calculus in lower pole with acoustic shadow behind it.
Colour Doppler can detect small stones with twinkle artefact.
Longitudinal of small stone in lower pole with twinkle artefact.
Hydronephrosis
-distension of renal pelvis and calyces with urine
-anechoic fluid
-easy to recognize.

Longitudinal hydronephrosis, mild, moderate, severe

Common causes of hydronephrosis include:

- Urinary tract obstruction
  - Renal stones
  - Abdominal or pelvic tumours
  - Retroperitoneal fibrosis
  - Pelvic inflammatory masses (e.g. diverticular abscess or tubo-ovarian abscess)
  - Endometriosis
  - Transitional cell tumours of the bladder or ureter
  - Bladder outflow obstruction
  - Pregnancy

- Reflux nephropathy
- Post-obstructive dilatation
- Congenital megacalycies
If hydronephrosis assess for:

- Bilateral or unilateral
- Dilated ureters, stone proximal or UVJ
- Distended bladder, urinary retention, postvoid, does the hydronephrosis resolve postvoid
- Abdominal or pelvic pathology causing urinary obstruction, mass effect

Longitudinal images with calculus in proximal ureter and UVJ
Normal renal cortex
- iso- or hypoechoic to liver
- hypoechoic to spleen.

Increased cortical echogenicity is non-specific finding, implies renal disease

Longitudinal right renal cortex hyperechoic compared to liver
Renal cysts
- more common in older patients
- generally no clinical significance unless polycystic kidney disease
- may arise from renal cortex or renal sinus (parapelvic)

Criteria for simple cyst:
- Anechoic with posterior acoustic enhancement
- No internal septa or solid elements
- Thin imperceptible wall

Longitudinal, small simple cyst with posterior enhancement
Renal cysts with a single thin septum is acceptable, cysts with more complexity require further imaging to establish the risk of malignancy.

In the septic patient, a renal abscess will be the differential diagnosis.

Longitudinal left kidney, cystic mass, multiple thick septa and solid elements, higher risk of malignancy
Angiomyolipoma
- most common benign renal tumour
- uniformly hyperechoic
- well-defined
- no internal blood flow
- above 5cm increased risk of hemorrhage which needs urology referral

Image 1-2 – longitudinal right kidney, with large, uniformly hyperechoic renal lesion
Image 3 - CT shows fat within the lesion, confirming angiomyolipoma.
Parapelvic Cysts
-can mimic hydronephrosis
-longitudinal cystic spaces do not interconnect
-no true renal pelvis visible,
Longitudinal right kidney with several parapelvic cysts not hydronephrosis
Longitudinal image, fluid within the renal sinus is interconnecting which differentiates from parapelvic cysts. The kidney is hydrenephrotic.
Nephrocalcinosis
- multiple hyperechoic foci outside of the renal sinus within the medullary pyramids
- acoustic shadowing confirming calcification
- may occur due to medullary sponge kidney, hyperparathyroidism and renal tubular acidosis

Longitudinal left kidney
Summary

- Ultrasound is an excellent modality for examining renal anatomy and pathology.
- Accurate interpretation of renal ultrasound examinations requires good knowledge of normal anatomical variants.
- It is important to understand the limitations of renal ultrasound.
- Interpretation is best performed in conjunction with knowledge of the clinical status of the patient and the results of the other laboratory investigations.
- The practitioner should be aware of other imaging modalities and how these fit in with overall patient management.
Thank You