Vascular variations of the kidney, retrospective analysis of computed tomography images of ninety-one laparoscopic donor nephrectomies, and comparison of computed tomography images with perioperative findings

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Background: In this retrospective study, we aimed to determine the variations of kidney arteries and veins in kidney donor patients who underwent preoperative, computed tomography angiography (CTA).

Materials and methods: We analysed kidney CTA findings of 91 donor nephrectomy patients operated from July 2016 through December 2017. Demographics, vascular diameters, abnormalities, numbers, branching variations, routing variations of arteries, and veins were assessed according to CTA images. We also compared the radiological findings with perioperative findings. Two radiologists evaluated CTA images, and the same surgical team performed all donor nephrectomies by laparoscopic approach.

Results: Ninety-one of the 96 patients involved in the study. Forty-six (50.5%) patients were female. Thirty-five (38.4%) of 91 cases had accessory arteries. Seven (7.6%) right, 1 (1.1%) left and 8 (8.7%) bilateral double hilar artery was observed on CTA. No statistically significant difference was observed in the evaluation of the side of accessory/polar arteries (p > 0.05), and in the evaluation of the distribution of arterial/venous variations according to perioperative findings (p > 0.05). However, in the evaluation of CTA images, we found that the diameter of the kidney artery and vein differed according to gender and side.

Conclusions: The knowledge of the vascular variations of the kidney is essential for surgeons performing kidney transplantation. It is also essential for urologist and vascular surgeons. Incompatible with the literature, the right kidney has more vascular variations and, one kidney artery is found in the majority of Turkish kidney donor patients. (Folia Morphol 2020; 79, 4: 786–792)

Key words: accessory, supernumerary, computed tomography, nephrectomy, vascular, variation, radiology, kidney transplantation

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INTRODUCTION

Kidney transplantation is the gold standard treatment option for patients with end-stage kidney disease [24], and vascular variations of this organ are the most critical anatomical variations that should be entirely known by kidney transplant surgeons [29]. According to traditional anatomical knowledge, one single artery originating from the abdominal part of the aorta at the second lumbar vertebral plane and supplies each kidney [2]. However, the vascular net of the kidneys has many variations which are divided into two main topics: early division (prehilar branching) and extrarenal arteries. Prehilar branching is branching of the main artery of the kidney into segmental arteries before entering hilus of the kidney. Extrarenal arteries are classified into two groups: hilar arteries and polar arteries. Hilar artery enters renal hilus with the main artery, whereas polar arteries directly enter the kidney capsule outside the hilus [20]. Accessory arteries of the kidney may falsely be defined radiologically or perioperatively as polar arteries constitute the most prevalent and clinically significant arterial variation of kidneys [15]. The incidence of these accessory arteries varies according to sex and race [15, 29]. Evaluating this complex vascular net with preoperative radiological examinations protects the surgeon from many perioperative difficulties and prevents complications. Besides, the importance of imaging methods for the identification of renal vascular net has become more crucial to obtain more safety and feasibility in the era of laparoscopic surgery. Regarding the increase in the number of kidney transplantations, knowledge of the vascular variations of this organ is essential for transplantation surgeons.

In the present study, we aimed to analyse the variations of renal arteries and frequency of supernumerary renal arteries in kidney donor patients according to preoperative computed tomography angiography (CTA) images and compare this results with perioperative findings.

MATERIALS AND METHODS

Inclusion criteria

The patients who underwent living kidney donor nephrectomy consequently from July 2016 through December 2017 at Istanbul Okan University Hospital and Research Centre were enrolled in this observational cohort study.

Exclusion criteria

The patients who had CTA at another institution, who did not want to participate in the study protocol and deceased kidney donors were excluded from the study (Fig. 1).

Surgical procedure

The same two surgeons performed all surgical procedures by using the video-assisted mini-incision technique, which was described and standardised by Choi et al. [3].

Radiologic evaluation of the individuals

Two different radiologists evaluated CTA images of all individuals. In case of difference of opinion, CTA images were assessed until a consensus was reached. Vascular diameters, abnormalities, numbers, branching variations, routing variations of arteries, and veins were assessed according to CTA images. Diameters of renal arteries (primary or accessory) were measured from the origin of the aorta (Figs. 2, 3), the diameter...
of all renal veins (primary or accessory) was measured from the connection of venae cavae.

Tomography technique
Nonionic and water-soluble contrast medium were injected intravenously (1 mL per kg) at the rate of 4–5 mL/s with automatic pressure injector. CTA was performed on a 64-slice computed tomography (CT) scanner (Optima CT 660, General Electric Medical Systems, Milwaukee, Wisconsin, USA). The scans were obtained by tube current automodulation (80–450 mAs) with adaptive statistical iterative reconstruction, tube voltage 120 kVp, gantry rotation time 0.6 s, detector coverage 40 mm, slice thickness 1.25 m, and pitch 1.375. Acquired contiguous axial 1.25 mm slice CT images were reformatted in the coronal and sagittal plane as well, and all images were transferred to picture archiving communication systems for further analysis.

Ethical approval and informed consent
All procedures performed in studies involving human participants were following the Helsinki Declaration and its later amendments or comparable ethical standards. The study protocol was also reviewed and approved by the ethics committee of Istanbul Okan University, Istanbul (No: 104, Date: March 13, 2019). All individuals gave written informed consent.

Statistical analysis
Statistical analyses were performed using the Number Cruncher Statistical System 2007 (Kaysville, Utah, USA). The study data were evaluated using descriptive statistical methods (Frequency, Rate). Qualitative data were compared using Pearson $\chi^2$ and Fisher–Freeman–Halton tests. $P < 0.05$ was considered to be significant.

RESULTS

Study population
Ninety-five kidney transplants were performed over 17 months. Four kidney transplantations were cadaveric transplantations, which were excluded from the study.

Demographics
Forty-six (50.5%) patients were Caucasian female, and 45 (49.5%) were Caucasian male. The mean age of the patients was 44.05 ± 13.76 in both genders, 47.8 ± 12.97 in females, 40.2 ± 13.64 in males (Table 1).

Vascular findings according to CTA
Seventy-one (78%) cases had a single right, 70 (69%) cases had single left renal arteries. Thirty-five (38.4%) of 91 cases had accessory arteries, 14 (15.3%) left, 15 (16.4%) right, 6 (6.6%) bilateral accessory arteries were detected in CTA and, the origins of all accessory arteries began from the aorta. Three (3.29%) right, 1 (1.09%) left, 1 (1.09%) bilateral polar arteries which entered the parenchyma of the kidney directly through the kidney capsule were identified. According to gender, no statistically significant difference was observed in terms of side of accessory and polar arteries ($p > 0.05$, $p > 0.05$, respectively; Table 2).

Eighty-five (93.4%) cases had a single right, 8 (87.9%) cases had single left renal veins. Three (3.3%) of 91 cases had double right veins, 1 (1.1%) of 91 cases had triple right veins, and 1 (3.3%) double left renal vein was detected in CTA. Also, 8 (8.7%) left renal veins were a circumaortic route, and 6 (6.6%) left renal veins routed retroaortic. According to gender, no statistically significant difference was observed in terms of side of single or double veins ($p > 0.05$, $p > 0.05$, respectively; Table 2).
The variations of the kidney vascularisation make the preoperative assessment of arterial and venous anatomical conditions critical. The knowledge of these vascular abnormalities, variations or origin diversities preoperatively preserves both patient and surgeon against unexpected surgical complications.
The mesonephric arteries which exist during embryological development create a vascular net named as “rete arteriosum urogenitale” and feeds kidneys, adrenal glands, and gonads. Over embryological development, all mesonephric arteries degenerate except one which creates renal arteries and supplies arterial circulation of the kidneys [8]. Alterations in this embryological development process cause the creation of vascular variants or abnormalities of kidneys.

A single renal artery which takes origin from the abdominal part of the aorta at the level of the second dorsal vertebra on either side and one renal vein which routes anterior to the renal artery is found in the majority of the cases [13]. The inferior positioning of right kidney creates a longer course of the artery. The right renal vein also has a shorter route which is 2–3 cm, and it joins the lateral edge of inferior vena cava. The left renal vein has a more extended course which is 6–10 cm and joins the medial side of inferior vena cava. The left renal vein has a more extended course which is 6–10 cm and joins the medial side of inferior vena cava [20].

Many studies show a wide distribution in the prevalence of supernumerary renal arteries (9–76%) [1, 4, 11, 15, 18–20, 26, 28]. A recent study published by Sośnik and Sośnik [31] revealed that renal arterial variations were prevalent in the Polish population. Staśkiewicz et al. [32] also observed that the incidence of multiple renal arteries was 27%. Staśkiewicz et al. [32] also found that the incidence of supernumerary renal arteries is more common on the right kidney. Another morphometric study of Satyapal et al. [28] demonstrated that single renal arteries were more common on the right kidney. In contradistinction to Satyapal et al. [28] and Staśkiewicz et al. [32], Ozkan et al. [20] and Dogra et al. [8] reported single renal arteries were more common on the left kidney. Our study is compatible with the study of Ozkan et al. [20] and Dogra et al. [8]. The majority of the analysed cases were African American and Indian in the study of Satyapal et al. [28]. Unlike the Satyapal et al. [28], all cases were the Caucasian race in our study. Also, according to the study of Saldarriaga et al. [25], high frequency of supernumerary arteries is reported in Caucasian and African (30–40%), as opposed to Indian population (13.5%). Similar to our results, Saldarriaga et al. [25] and Staśkiewicz et al. [32] did not observe gender differences in frequency of supernumerary arteries. There may be vascular variations according to races, but further studies are needed on this topic. In any event, preoperative identification of renal arteries is crucial for a safe and feasible nephrectomy procedure. Nowadays, supernumerary renal arteries are no longer contraindication for laparoscopic donor nephrectomy procedure. However, awareness of supernumerary arteries may help to obviate possible complications [12, 32].

Prehilar or double hilar branching is a standard variant in which the main artery of the kidney subdivides into segmental arteries at a more proximal level before entering the hilum of the kidney. Prehilar branching is momentous for donor nephrectomy procedure because most surgeons need at least 1.0 cm arterial length for anastomosis without stricture and good blood supply of the transplanted kidney [26]. Double hilar branching was reported in many studies and ranges between 10% and 25% [9, 19, 23, 27]. The present study observed double hilar branching in 17.6% of cases.

The accessory arteries of the kidney mostly begin from the abdominal part of the aorta and supply the bloodstream of the inferior and superior pole of the kidney [10]. In the study of Kumar and Prabha [17], the incidence of these arteries reported as 19%, and Weld et al. [34] observed the frequency as 24.7%. In the presented study, 35 (38.4%) of 91 cases had accessory arteries.

In comparison with the perioperative findings, we found a precision rate of 94.5% with CTA describing vascular anatomy of the transplanted kidney. Our results are compatible with the previous literature, which reports a concordance rate of 87–97% [5–7, 14, 21, 22, 30, 33]. Only 5 of our cases have different vascular findings on CTA compared to perioperative findings. Platt et al. [21] and Del Pizzo et al. [7] which are the two most extensive series about this topic reported the concordance rate of 95% and 93%, respectively. Although different perioperative findings do not result in catastrophic outcomes to any of our patients, we think that preoperative imaging of the kidney donor can be improved. This improvement could be accomplished by improved communication between radiologist and surgeon.

Surgeons should be careful in dissecting the fat to avoid accidental injury to these arteries; they supply a particular segment of the kidney and do not anastomose with adjacent arteries. Accidental damage of these arteries during fat dissection over the kidney leads to necrosis of a kidney segment as these arteries are end arteries and can increase the failure rate due to renal vascular thrombosis [16].
Limitations of the study

The study limitations include its retrospective nature, and the limited number of patients makes it difficult to draw firm conclusions. Also, not to evaluate small vessels that cannot be seen on CTA or non-preserved arteries that are too small to be anastomosed by the surgeon is another critical limitation of the present study.

CONCLUSIONS

The knowledge of the vascular variations of the kidney is essential for surgeons performing kidney transplantation. Incompatible with the literature, the right kidney has more vascular variations and, one renal artery is found in the majority of Turkish kidney transplantation patients. Each artery should be preserved to prevent segmental ischaemia. Due to technical simplicity, left donor nephrectomy is preferred. To prevent segmental ischaemia. Due to technical

REFERENCES


