

The more common diagnoses include:

1. Pelvi-ureteric junction obstruction (called simply PUJ)

This refers to a narrowing of the ureter at the junction with the kidney causing a blockage of the flow of urine. This increase in the size of the pelvis of the kidney is what we call hydronephrosis.

2. Multicystic dysplastic kidney (MCDK)

This term refers to many cysts in an abnormal kidney. It usually occurs because the ureter does not join with the kidney during development and the kidney never really works as normal. Most MCDK's disappear with time.

3. Vesicoureteric junction obstruction (VUJ)

As with the PUJ, but the narrowing is at the lower junction of the ureter with the bladder. Urine is held up in the ureters and the kidneys, causing enlargement of the ureters and hydronephrosis.

4. Vesicoureteric "reflux" (or simply "reflux")

This is due to a weakness at the point where the ureter(s) enter the bladder, allowing urine to pass back up towards the kidney.

5. Posterior Urethral Valves (PUV)

A rare blockage in male infants where the tube below the bladder is narrow and the bladder and both kidneys can be affected.

The problem may affect one or both of the kidneys. If it is mild or moderate we will **watch** your child's progress in the out patient clinic.

If the problem is 'severe' we will discuss the options with our surgical colleagues and an operation may be necessary.

Reference: Mallik M Watson A R Antenatally detected urinary tract abnormalities: more detection but less action *Pediatr Nephrol* 23:897-904 2008

Contact Numbers

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**KIDNEY AND BLADDER
PROBLEMS DETECTED
BEFORE BIRTH BY
ULTRASOUND**



This leaflet is to provide you with some further information as to why you have been referred to see a children's kidney specialist (nephrologist) before your baby is born. We hope that the information will add to the explanation that you will already have received.

The detailed ultrasound carried out in pregnancy will give us a GOOD IDEA of the problem affecting your child's urinary tract (kidney, bladder and ureters - see diagram). We are always cautious to say that we never know PRECISELY what the problem is until baby is born and we have completed our investigations on baby after birth.

We will explain to you what we think the most likely diagnosis is and how it is likely to be managed. As long as your baby is:-

- growing well in the womb, and
- no other abnormalities have been found, and
- the volume of the liquor (womb fluid) is normal

then overall your child's kidneys are **NOT** likely to be significantly damaged. Few children require an operation after birth.

What happens at delivery?

Your labour and delivery will usually proceed as **normal** and only in very special circumstances will the obstetrician suggest early delivery or other treatment.

What happens after baby is born?

Unless your baby has a major problem after birth then you will be allowed home at the usual time. The nephrologist may see you after baby is born if there is a major problem. Otherwise the doctors on the baby unit will inform the nephrologist who will arrange:-

- 1 the initial **ultrasound** usually a few weeks after birth. The doctor will then see the family in the clinic to discuss if other tests are necessary - such as:
- 2 a **bladder x-ray** (called a micturating cystourethrogram) which requires your child to have antibiotics for 2 days. Please ensure your baby is given the prescribed Trimethoprim 2 mg/kg twice a day starting on the day of this test to prevent any infection
- 3 a **renal scan** (called DMSA or MAG 3 scan) which involves attending the renal ward and the baby having an injection to show how well the kidneys are working. This usually takes place by the time the baby is 3 months old.

We will review your child again in the clinic when the tests are completed. Always feel free to ask any questions that worry you or where the information is unclear.

Possible Problems

(see next page)

