into IJV [Figure 1b-c]. The TCC was subsequently removed. Cephalad migration of catheter immediate post insertion has been reported earlier in the literature.[3] But delayed migration could be a rarity. Our current case highlights this rare occurrence of delayed cephalad migration of TCC and also the importance of the need of re-imaging whenever encountered with non/poorly functioning TCC.

Conflicts of interest

There are no conflicts of interest.

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How to cite this article: Jaryal A, Vikrant S, Bansal V, Akanksha, Sharma S, Aneja R. Spontaneous Intravascular Cephalad Migration of Tunneled Cuffed Catheter – An Unusual Late Complication and Role of Re-Imaging. Indian J Nephrol. 2025;35:110-1. doi: 10.25259/IJN_264_2024

Received: 29-05-2024; **Accepted:** 01-06-2024
Online First: 22-08-2024; **Published:** 04-01-2025

DOI: 10.25259/IJN_264_2024

Pancake Kidney: A Rare Case of Renal Ectopia

An 11-year-old male presented with a 1-month history of lower abdominal pain, accompanied by fever and burning micturition for the past 7 days. Abdominal examination was unremarkable, with no tenderness at the bilateral renal angles. Urine microscopy revealed pyuria, though kidney function tests and X-rays of the kidney, ureter, and bladder (KUB) were normal. Ultrasonography of the KUB region identified an abnormally located kidney in the pelvis. Computed tomography (CT) urography further revealed that both kidneys were fused in the pelvic cavity at the midline, with a single mega ureter on the left side, suggestive of a pancake kidney [Figure 1]. He was prescribed a course of antibiotics based on urine culture and sensitivity test results, which successfully relieved his symptoms.

Pancake kidney is an exceptionally rare form of fused renal ectopia. Looney and Dodd were the first to define and describe this condition.[1] It is characterized by a renal mass in the pelvis resulting from the complete medial fusion of the renal parenchyma without an intervening septum. Typically, each lobe has a separate pelvicalyceal system, but in our case, the kidneys had a single megaureter entering the bladder at the left vesicoureteral junction.

This anomaly can predispose to recurrent urinary tract infections and stone formation due to probable rotation anomalies of the collecting system and short ureters, which are prone to stasis and obstruction. Congenital renal malformations are often incidentally detected and asymptomatic; in such cases, a conservative approach with long-term follow-up is recommended.[2]

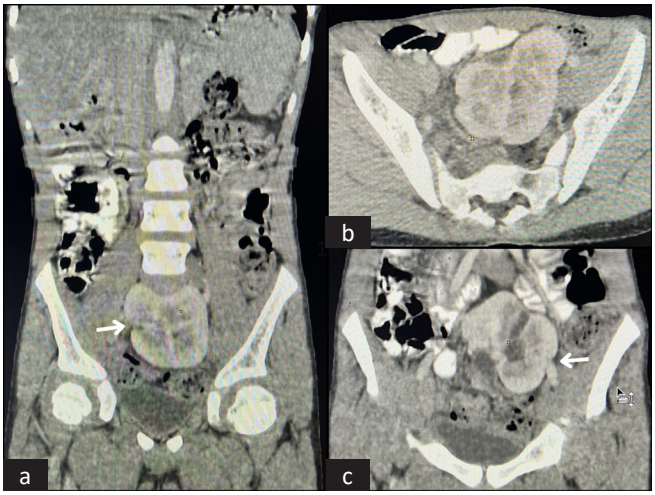

Figure 1: (a-b) Computed Tomography (CT) urography images showing (white arrow in a) the complete medial fusion of the renal parenchyma, located ectopically in the pelvic cavity at the midline. (c) CT urography image (white arrow) showing a single megaureter originating from the left side of the fused renal mass.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

Conflicts of interest

There are no conflicts of interest.

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How to cite this article: Singh AP, Beniwal P, Malhotra V. Pancake Kidney: A Rare Case of Renal Ectopia. Indian J Nephrol. 2025;35:111-2. doi: 10.25259/IJN_401_2024

Received: 20-07-2024; **Accepted:** 21-07-2024;
Online First: 12-09-2024; **Published:** 04-01-2025

DOI: 10.25259/IJN_401_2024