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SIMULTANEOUS BILATERAL URETHELIAL TUMORS
(Case Report)

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ÖZET: Simultane bilateral üretelial tümörler. Başlangıçta sağ nonfonksiyone böbrek öntanısı alan simultane bilateral üretelial tümörleri olan bir olgu sunulmuştur. Üretelial tümörlerin multifokal karakteri ve intravenöz ürografinin dikkatli incelenmesi gereği vurgulanmıştır. İVU ve ultrasonografinin ürolojik teşhisteki yerleri çok önemlidir. Ancak çok dikkatli incelenmeleri gerekir, aksi halde patolojileri tespit etmek mümkün olmayabilecektir. Biz burada böyle bir olguyu sunduk.

ABSTRACT: Erden AYAZ, Çoşkun BÜYÜKSU, Arif Kutsi GÜDER, Murat SADE, Nejat KAPLANOĞLU, Department of Urology, Faculty of Medicine, Dokuz Eylül University, İzmir. Simultaneous Bilateral Urethelial Tumors.

A case with simultaneous bilateral urethelial tumors who was misdiagnosed initially as a non functioning right kidney is presented. Multifocal nature of the urethelial tumors and the need of careful examination of IVU are stressed. IVU and ultrasonography are very useful means in urological diagnosis. However they should be interpreted very carefully otherwise one may miss existing pathologies. Herein we report such a case.

Anahtar sözcükler: Bilateral üretelial tümörler, IVU
Key words: Bilateral urethelial tumors, IVU

A 60 year old women was hospitalized with 6 months history of hematuria. Physical examination was completely normal. Pathologic laboratory examination were as follows: WBV 12.600/ml, sedimentation rate 24mm/hr Microscopic examination of the urine sediment: 8-10 leucocyte per field and microscopic hematuria. Urine culture yielded E.coli one million bacteria/ml. Intravenous urogram revealed non-functioning right kidney and afilling defect in the left ureter at L_4 level which was first overlooked and attracted our attention at the subsequent examination of the films (Figure 1).

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Chest X-ray was normal. Ultrasonography showed a very thinned parenchyma of the right kidney. At cystoscopy a tumor 0.5 cm in diameter protruding from the right ureteric orifice was seen. Left orifice and the rest of the bladder was normal. Left retrograd ureterography confirmed the filling defect (Figure 2). Left ureter was explored via a flank incision and IXI cm polipoid structure attached to ureter with a thin stalk was excised and the base fulgurated with a low frequency current. Then a 0 degree lens was introduced into the ureter through the ureterotomy site, and advanced as far as possible. Examined parts of the ureter displayed no tumorous structure (As we did not have a ureteroscope 0 degree lens was used instead). Histopathological diagnosis was papilloma. At another session right nephroureteroctomy was done easiy and a cuff of the bladder was also removed. Pathologic examination revealed a tumor in renal pelvis measuring 1X2.5 cm which was diagnosed as grade 4 transitional cell carcinoma and a grade 2 transitional cell carcinoma in the lowermost ureter. Post-operative course was uneventful and she was discharged from the hospital on the tenth post-operative day. Two months later, we were informed that she had passed away all of a sudden.

COMMENT: Bilateral simultaneous urethelial tumors have been reported to occur in 1-11 % of the cases (1,2). This case once again demonstrates the multifocal nature of urethelial tumors and emphasizes the need of screening the whole urinary tract by all available means in cases of urethelial cancer. Our incomplete ultrasonographic diagnosis did not affect the course of the case adversely as we were going to perform nephroureterectom anyway. Secondly we must stress the point that IVU should be examined very carefully. One may overlooks the existing pathology (as we did initially) especially if some other pathology is detected at the same time (which was right non-functioning kidney in our case).

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Figure 1

Figure 2.