presence of margins, the histological classification, and time to adjuvancy. PNET is an aggressive tumor that tends to recur locally and to metastasize to lymph nodes, lung, liver, bone, and bone marrow, which entails a worse prognosis.[8] The five-year disease-free survival rate for all stages is 45-55%.[3] Patients with a disseminated disease at diagnosis have a mean survival of only two years.[3] Polychemotherapy with high doses of vincristin, adriamycin, and cyclophosphamide has yielded good outcomes.[3,8] However, due to the rarity of the tumor, no randomized studies on the efficacy of different chemotherapy regimens have been published.[3]

We conclude that renal PNETs are an uncommon condition characterized by aggressivity and local and distant recurrence capability, which causes them to have a poor prognosis. This entity must be considered in the differential diagnosis of renal masses in young patients, especially those presenting with a disseminated disease at onset. The diagnosis is reached by exclusion of other small cell renal tumors. An accurate anatomopathological diagnosis is very important clinically because it may determine which of the various chemotherapy regimens will control the disease better.

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Sclerosing sertoli cell tumor. An infrequent type of testicular neoplasm

Tumor de células de sertoli esclerosante. Un subtipo infrecuente de neoplasia testicular

Dear Editor,

Sex cord-gonadal stromal, or non-germ cell neoplasms of the testes account for approximately 5% of testicular tumors, and most of them are Leydig cell tumors.[1] Pure Sertoli cell testicular tumors are uncommon and account for approximately 1% of testicular tumors.[2] Because of their histological and clinical variability, these tumors, usually considered benign, are a heterogeneous entity. They are classified according to their histological characteristics in the following subtypes: classic (unspecified), large cell calcifying variant, and sclerosing variant.[3]

We present the case of a 30-year-old male patient with a history of renal colics and sinusitis who complained of slight enlargement of his left testicle associated with testicular pain. The physical examination revealed a left testis tender upon palpation especially in the tail of the epididymis, with no masses. A testicular ultrasound (fig. 1) showed an 11-mm

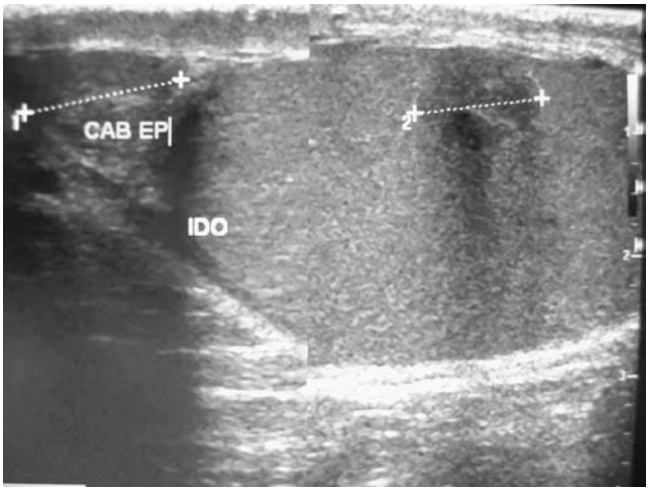

Figure 1 – Testicular ultrasound showing a hypoechoic node with regular borders and posterior acoustic shadowing.

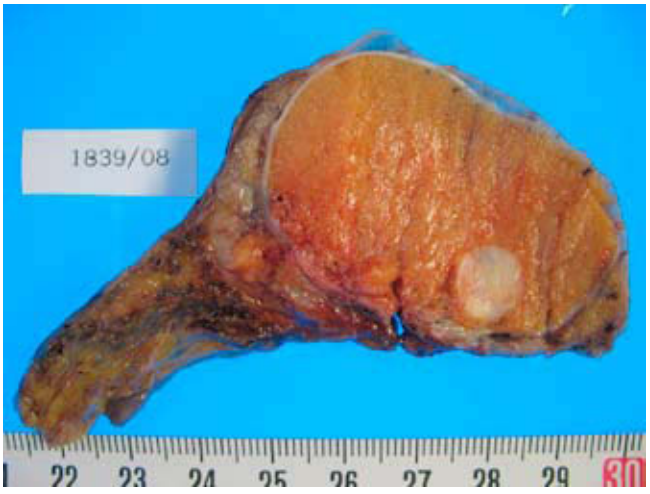

Figure 2 – Surgical piece with a well-delimited, whitish-gray node measuring 11 mm in its longest diameter.

hypoechoic node with posterior acoustic shadowing and increased blood irrigation suggestive of testicular cancer. The serum tumor markers α-fetoprotein, β-HCG, and LDH were normal, and the CT scan did not reveal pelvic or retroperitoneal lymphadenopathies.

A left inguinal orchiectomy under general anesthesia was performed. The gross histopathological examination revealed a left testicle measuring 5.5×3.5 cm; at the level of the lower pole, a well-delimited, whitish-grayish, elastic node measuring 11 mm in its longest diameter was found (fig. 2). The microscopic analysis showed a well-delimited, non-encapsulated node consisting of a proliferation of cord elements and to a lesser extent tubular elements that were immersed in densely sclerosing stroma. The cells were small, with light cytoplasm, and did not display mitoses; the tumor was completely intratesticular. The immunohistochemical tests revealed expression of neuron-specific enolase and vimentin; the diagnosis was sclerosing Sertoli cell tumor. The patient is currently disease-free and in follow-up.

In 95% of cases, primary testicular tumors originate in germ cells; only 5% are from sex cord-stromal cells. Stromal tumors are classified as Leydig, Sertoli, Sertoli-Leydig, granulosa, and mixed cell tumors.[4,5] Sertoli cell tumors are very rare and represent less than 1% of all testicular tumors. They contain Sertoli cells organized in tubules, cords, or irregular aggregations. They are classified in three histologic subtypes: classic type, large cell calcifying tumor, and sclerosing tumor.[3] The latter was described by Zukerberg et al in a review of approximately 200 cases of sex cord-stroma tumors of the testis; in this series, the sclerosing variant was observed in 10 cases and had similar histological and clinical characteristics.[6] The sclerosing variant is hypocellular with a diffuse sclerotic stroma and no necrosis or vascular or lymphatic invasion. These tumors are usually asymptomatic, small (0.5-2 cm, rarely measuring more than 5 cm in their longest diameter), well delimited, white or gray, with a solid surface. While they can occur at any age, the peak incidence is between 35 and 50 years.[5] In contrast to the large cell calcifying variant associated with bilaterality and multifocality, the sclerosing variant is unilateral, and affects either testis at the same rate. Another difference between subtypes is that only the large cell calcifying tumor is associated with the Peutz-Jeghers syndrome and the Carney complex (skin, breast, and heart mixoid tumors).[7] In general, approximately 25% of Sertoli cell tumors have estrogen-producing activity manifesting as gynecomastia,[8] and this feature is absent in the sclerosing variant. Currently, in the absence of radiologic signs of invasion of lymph nodes or distant metastasis, radical orchiectomy is the recommended treatment. Although these tumors are usually benign, a long-term follow-up is recommended, as there are few cases recorded in literature, and isolated cases with histological characteristics suggest a more aggressive behavior.

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Giant fibroepithelial polyp of the ureter: treatment with ureteral resection and intestinal substitution

Pólipo fibroepitelial ureteral gigante resuelto con resección y sustitución intestinal

Dear Editor,

Ureteral fibroepithelial polyps are rare mesenchymal tumors. The first case was described by Boross in 1929.[1] Due to the benign nature of the lesions, most authors recommend conservative surgery with minimally invasive techniques; however, open surgery is occasionally necessary if the size and location of the polyp so require.

We present the case of a 42-year-old woman with an unremarkable history who experienced left renal colic. The ultrasound showed left hydronephrosis, and no cause was identified. The intravenous urography (fig. 1) revealed functional delay of the left kidney and severe hydroureteronephrosis with numerous folds extending to the iliac ureter. The CT scan and MRI showed a possible tumor in the left ureter. A ureteroscopy was inconclusive due to interpretation difficulties. The ureteral mucosa biopsy showed normal urothelium with slight edema and inflammation of the underlying chorion. Urine cytology was negative.

A midline exploratory laparotomy revealed that the left ureter was occupied by a soft tumor measuring several centimeters in thickness from the crossing of the iliac vessels to the yuxtapyelic ureter (fig. 2); the entire affected ureteral segment was resected and an intraoperative anatomopathological assessment was requested in order to decide the course of action regarding the kidney.

The intraoperative analysis reported a fibroepithelial polyp; an ileal replacement segment was used in order to preserve the kidney. The final anatomopathological examination confirmed the diagnosis of ureteral fibroepithelial polyp.

Two months later, when the patient was asymptomatic, an intravenous urogram showed improved dilatation and function of the left excretory system.

Ureteral tumors are not frequent; they account for fewer than 1% of all urogenital tumors. Only 20% are benign, the fibroepithelial polyp being the most common.[2] Benign ureteral tumors may be epithelial or nonepithelial; the latter derive from mesodermal elements of the ureteral wall and include leiomyomas, fibroepitheliomas, lymphangiomas, neurofibromas, hemangiomas, endometriomas, fibromas, and fibroepithelial polyps.[1]

They are usually congenital or inflammatory, but the etiology is not yet established. Most polyps are small, but large ones have been described too. They are often single polyps, but occasionally may be multiple.

Macroscopically, these polyps are filiform projections measuring from a few millimeters to several centimeters. Upon anatomopathological examination they are seen as a thick fibrous stalk with numerous vascular canals and lined with a layer of normal or hyperplastic transitional epithelium.[3]

While these polyps can appear at any age, they usually affect adults between the third and fifth decades of life, and show a preference for males.[1] They are more common on the left side, and may be found in any point in the ureter, but are more common in the upper third.

Symptoms include flank or abdominal pain, urinary tract infection, and gross or microscopic hematuria; our patient experienced pain secondary to obstructive uropathy.

Radiologic techniques do not distinguish them from malignant transitional cell tumors, and urine cytology occasionally yields false positives.[4] While this was not the case with our patient, historically many patients have undergone unnecessary nephroureterectomy.[5] Therefore, ureteroscopy with biopsy is considered the best diagnostic procedure,[6] although in our case it was inconclusive.