of a solid nature with soft tissue density, and the absence of contiguous invasion. Since conservative surgery is a feasible alternative to radical nephrectomy in the treatment of patients with putative unilateral renal cell carcinoma measuring under 4 cm in size, a diagnosis of leiomyoma or angiomyolipoma could be established in the piece obtained from such partial surgery (as in our case). Nevertheless, considering the difficulty of clinical suspicion of these tumors, it is not uncommon for the diagnosis to be established from the histological evaluation of a radical nephrectomy piece.

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Late relapse of stage I testicular seminoma after 11 years: successful treatment with chemotherapy alone

Recidiva tardía de seminoma testicular en estadio I a los 11 años: tratamiento satisfactorio con quimioterapia sola

To the Editor,

Approximately 45% of all germ cell tumors are seminomas, and are identified in stage I in most patients.

Radiotherapy – the most common treatment after orchiectomy – affords a relapse-free healing rate of 95% and a global healing rate of 99-100%. Nevertheless, as a result of the systematic use of radiotherapy, many patients receive unnecessary treatment, and concern over the long-term clinical effects of irradiation has led to the application of vigilance protocols in males with stage I disease.

About 15-20% of all patients subjected to vigilance suffer relapse after a median of 15 months, though relapses may occur as long as 10 years after orchiectomy.

Late relapses of germ cell tumors (GCTs) are infrequent. In these cases it has been reported that chemotherapy offers only moderate success, and that surgery may be the preferred treatment option.

The present report describes the case of a male with seminoma relapse 11 years after the initial diagnosis, in which complete remission was achieved with rescue chemotherapy alone.

A 36-year-old male presented in September 1990 with hard swelling of the right testicle during the last month. The lesion was not painful in response to palpation. Serum tumor markers proved negative, and computed tomography (CT) revealed no chest, abdominal or pelvic anomalies.

The patient preferred an intensive vigilance protocol during 5 years after orchiectomy.

Physical examinations were made, together with serum tumor marker tests and chest X-rays every month for one year after surgery, every two months during the second year, every 4 months during the third year, and every 6 months during the fourth year. CT scans were made every three months during the first postoperative year, every 4 months during the

second year, and posteriorly only when indicated.

The patient remained free of disease until October 2001, when a left supraclavicular lymphadenopathy was noted. In addition, CT revealed a 9-cm longitudinal retroperitoneal mass adhered to the abdominal aorta, though no other lesions were observed.

The neck lymph node biopsy study indicated seminoma.

The serum tumor markers proved negative. Treatment was provided in the form of 4 cycles of 20 mg/m^2 of cisplatin via the intravenous route for 5 days, and 100 mg/m^2 of etoposide via the intravenous route on a daily basis for 5 days, repeated every three weeks.

Repeat disease staging after 4 chemotherapy cycles revealed complete remission.

On occasion of the last follow-up visit in June 2009, the patient remained well and without disease relapse.

The introduction of cisplatin-based chemotherapy for the management of GCTs in the late 1970s spectacularly improved the results obtained in patients with tumors of this kind.

However, 10-30% of all patients suffer relapse after initial treatment. Relapse tends to occur in the first two years after treatment, and most such cases are resolved with rescue therapy. Recently, a limited number of patients (about 1-4%) have been found to develop late disease relapse[1-5].

The most common location of relapse is the retroperitoneum, though there have been descriptions of late GCT relapse in the chest, neck, pelvis, brain and liver[3-4].

Baniel et al.[1] reported complete response in only 17 of 65 patients (26%) subjected to chemotherapy, and only two of these individuals were healed with chemotherapy alone. In contrast, 11 of 16 patients (69%) subjected to surgery alone remained disease-free after a median follow-up of 14 months. The authors concluded that surgery is the treatment of choice, and that chemotherapy plays only a marginal role in the management of late disease relapse.

In the analysis published by Dieckmann et al.[6], chemotherapy alone was used to treat 46% of the patients, while 34% received combination surgery and chemotherapy. Eighty-four percent of the patients achieved complete remission after treatment.

Gerl et al.[2] reviewed a series of 25 patients with late relapse and reported a disease-free survival rate of 36% after a median follow-up of 38 months. A total of 20 males underwent chemotherapy for late relapse.

Most of the published series show surgical resection to be associated with improved results, though only modest success has been recorded with chemotherapy alone.

We consider that chemotherapy can be used to treat patients that have not received such therapy before, without the need for surgery, if complete remission is achieved.

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Solitary fibrous tumor of the prostate

Tumor fibroso solitario de la próstata

To the Editor,

A 65-year-old patient presented with urinary obstruction problems for the previous 6 months. Rectal digital exploration of the prostate revealed a gland of fibroelastic consistency, without nodules. The serum total prostate specific antigen (PSA) concentration was 7.52 ng/ml, with a free PSA level of 2.61 ng/ml, and a ratio of 0.35. The abdominal and pelvic ultrasound study confirmed prostate gland enlargement. The clinical diagnosis was grade I-II benign prostate hyperplasia. Suprapubic prostatectomy was carried out based on the