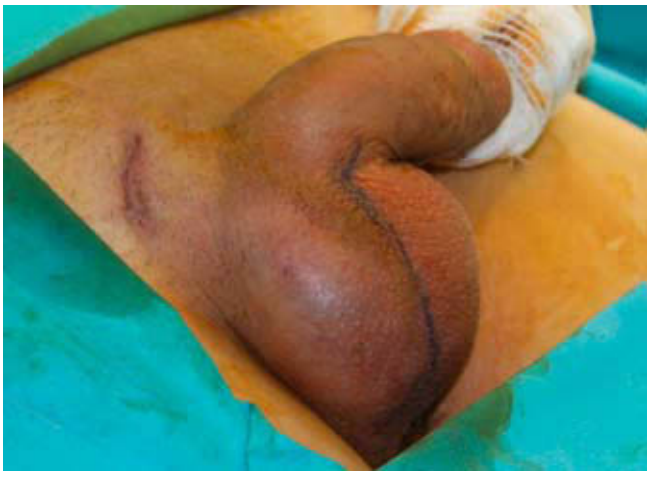

Figure 2 – Final result. Correct implant positioning and adequate size and symmetry.

lower portion of the scrotum by digital eversion of the latter and exposure through the incision. An implant measuring 4.5×3×2 cm in size was placed. The incision was sutured with reabsorbable 4/0 suture for the subcutaneous layer, and loose nylon 5/0 stitches were applied for the skin. By affixing the prosthesis with this technique we ensured correct positioning and prevented possible elevation, while also improving the final result obtained (fig. 2).

The use of this technique, combining the suprascrotal incision with the Foley catheter for correct estimation of the implant size, allows us to ensure adequate positioning, size and symmetry of the testicular prosthesis. Contact between the scar and the prosthesis may result in contamination of the latter. Such contact tends to occur with either an inguinal or a scrotal incision. The aesthetic results of these approaches likewise do not tend to be optimum. However, the suprascrotal approach has the advantage of being hidden by the pubic hair, and leaves the scrotum free of scars. Fixation of the prosthesis to the scrotum prevents its elevation and ensures correct positioning of the implant. The Foley catheter offers a simple and practical system for measurement and ensures correct selection of the implant size - thus resulting in improved patient satisfaction.

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Solitary fibrous tumor of the kidney (a case report)

Tumor fibroso solitario renal (reporte de caso)

Dear Editor,

Solitary fibrous tumors (SFTs) are mesenchymal tumors of probable myofibroblastic nature exhibiting a characteristic ramified hemangiopericytoid vascular pattern, that usually develop at pleural level.

Up to 30% of all cases have been reported in soft tissues and solid organs. Few have been described in the kidney[1-8].

The present study describes the case of a 39-year-old woman with dysuria and pollakiuria, diagnosed with urinary tract infection. The CAT study revealed a solid, hypodense mass with heterogeneous contrast uptake, measuring 2.3 cm in greater diameter, and infiltrating the adjacent collector system. Left radical nephrectomy and para-aortic lymphadenectomy were performed.

At renal pelvis level a nodular, solid, light brownish lesion with expansive margins and measuring 2.5 cm in greater diameter was identified. The rest of the kidney showed no significant alterations.

Microscopically (fig. 1), the tumor showed a fusocellular pattern, with moderate cellularity, hyaline collagen bands, no nuclear atypia and a low mitotic index. The renal parenchymal was focally affected. The immunohistochemical profile was found to be: CD34(+) (fig. 2), Bcl-2(+), CD99(+), S-100(–), desmin (–), actin (–), HMB-45(–), CD117(–), and with a low proliferative index (Ki67) of 2-3%.

SFTs are mesenchymal tumors described in soft tissues and in different organs. They are primary myofibroblastic mesenchymal lesions with multiple differentiation characteristics[9]. At renal level, their place of origin has been

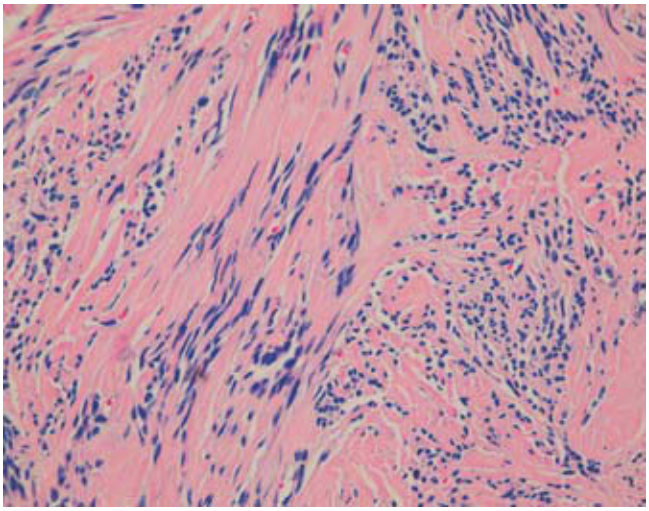

Figure 1 – Neoplasm showing a fusocellular pattern, with dense hyaline collagen bands.

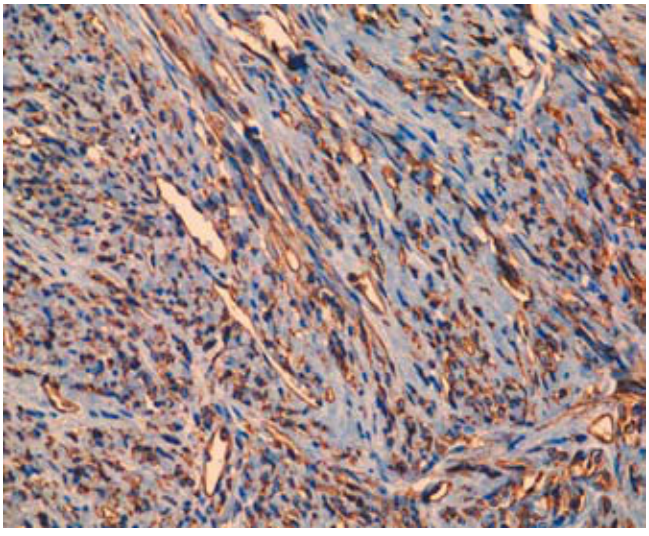

Figure 2 – Diffuse immunohistochemical positivity for CD34.

the subject of debate, and different locations have been suggested, such as the capsule, interstitial and/or peripelvic connective tissue, or renal parenchyma[3].

Clinically and in the imaging studies, SFTs can be confused with renal cell sarcomas or carcinomas, and the presence of painless hematuria can contribute to such confusion[2]. The tumors can be uni- or bilateral[8]. Macroscopically, the lesions are well circumscribed and are pseudoencapsulated, lobulated, form or elastic, with a white or grayish surface upon sectioning. In turn, they may contain cystic hemorrhagic or necrotic areas[3]. The size is variable.

The definitive diagnosis is established by microscopic study. SFTs show a predominantly fusocellular pattern, and the distribution of the cells varies from one area to another. In some zones the cells may form small, poorly defined fascicles, while in others the cellular distribution may be disorderly. Another characteristic is the notorious "keloid" type hyalinization, with the cells usually distributed isolatedly or in small parallel groups close to the dense collagen bundles. The cell margins are poorly defined, and the cytoplasm is scarce. Focal myxoid changes and dystrophic calcifications may be seen. The vascular pattern is characteristically pericytic (hemangiopericytoid), with variable perivascular hyalinization[1-3,9].

As regards the immunohistochemical findings, these tumors are positive for CD34 in 80-95% of the cases. Positivity can also be found for CD99 (70%), Bcl-2 (50%), EMA (30%) and actin (20%). Focal positivity occasionally may be seen for S-100 protein, cytokeratins and/or desmin, though the latter generally prove negative.

Our patient showed important diffuse positivity for CD34, CD99 and Bcl-2, and proved negative for actin and desmin. CD34 positivity may not be specific, though in combination with negativity for the other markers and the microscopic findings, a differential diagnosis can be established.

No typical cytogenetic alterations have yet been identified. A broad range of genetic changes has been suggested for SFT, though no consistent or specific aberration of use in diagnosing the disease has been established[10].

The behavior of SFT is unpredictable[5,9], with possible aggressive features characterized by local recurrence and distant metastasis. This biological behavior is not correlated to the atypical histological features[9]. The criteria widely described as indicating malignancy are a sarcomatoid pattern, increased cellularity, cell pleomorphism, increased mitotic activity (over 4 mitotic figures per high magnification field), and necrosis.

The differential diagnosis of SFT comprises a large number of conditions, including benign fusocellular lesions that may present a hemangiopericytoid pattern such as fibroma, hemangiopericytoma, inflammatory myofibroblastic tumor, angiolipoma, leiomyoma and schwannoma; most sarcomas (leiomyosarcoma, synovial sarcoma, fibrosarcoma, malignant tumor of the peripheral nerve sheath, and malignant gastrointestinal stroma tumor); and sarcomatoid renal cell carcinoma. As a result, immunohistochemical evaluation is essential for the definitive diagnosis of the tumor.

Treatment is surgical, and all lesions are to be removed with adequate resection margins. Resectability is the most important factor for preventing recurrence. Careful clinical follow-up is advised in all cases. The role of adjuvant therapy has not yet been established.

Our patient presented a good course, with no evidence of recurrence one year after surgery.

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Extrusion of a testicular prosthesis: Presentation of a clinical note and review of the literature

Extrusión de prótesis testicular: presentación de un caso y revisión de la literatura médica

Dear Editor,

We present the case of a 23-year-old male admitted to the emergency service of our hospital with a left hemiscrotal mass accompanied by intense pain that had been present for the last two days. The personal history revealed left testicular trauma at 9 years of age, followed by surgical treatment two months later.

Two days before reporting to our hospital, the patient visited his primary care physician due to the presence of a left hemiscrotal mass measuring about 0.5 cm in diameter, and accompanied by cutaneous inflammation. A complicated scrotal sebaceous cyst was diagnosed, and treatment was provided in the form of antibiotics and antiinflammatory medication. Twenty-four hours after starting such treatment, a black scab appeared in the center of the lesion, increasing in size within a few hours; upon detachment of the scab, the testicular prosthetic material was found to be visible.

At physical examination the patient showed no fever and presented normal blood pressure. Partial extrusion of the testicular prosthesis was noted in the upper-external region of the left hemiscrotum, with no signs of inflammation or bleeding (fig. 1). Surprisingly, the patient was unaware that he had undergone left orchiectomy with the implantation of a silicone testicular prosthesis in childhood. The rest of the examination proved normal.

The entire prosthesis was removed under local anesthesia, followed by cleansing of the cavity with 0.1% chlorhexidine and suturing of the skin margins. During the operation, a smooth-surfaced fibrous pseudocapsule was observed surrounding the location of the prosthesis. After 7 days, the surgical wound was found to be in excellent condition. After two months the patient was free of symptoms. He rejected placement of a new prosthesis.

The absence of a testicle may be a traumatic experience for the patient from the psychological perspective, with feelings of inferiority, altered sexual function and effects upon psychosocial development. Such problems in turn are more likely in patients who have lost a testicle than in individuals born without a testicle.

The relative ease of testicle prosthesis implantation, its similarity with the normal testicle, and the few complications involved make it possible to reconstruct an apparently normal scrotum in patients who have either lost a testicle or have been born without a testicle[1].

Indications for testicle prosthesis implantation

The most common causes for indicating prosthesis implantation are testicle agenesis or atrophy. In patients with cryptorchidia, testicle atrophy or agenesis can be seen in up to 10% of all cases. According to a survey of urologists of the western section of the AUA conducted in 1986[2], the indications for orchiectomy and prosthesis implantation are testicle atrophy or failed testicular descent (35%), testicle