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Scientific-clinical letters

# Unusual presentation of Castleman's disease like an upper urinary tract carcinoma

## Presentación atípica de la Enfermedad de Castleman simulando carcinoma de vías urinarias superiores

*Dear Editor,*

The present study describes the case of a 72-year-old male referred to the Urology outpatient clinic from Internal Medicine due to the incidental computed tomographic (CT) finding of an upper right urinary tract tumor mass (renal pelvis and proximal ureter)(the scan originally having been requested for better evaluation of a hilar lesion observed on chest X-rays). The patient reported no hematuria or other specific urological symptoms. The vital signs were found to be normal at exploration. Important hepatosplenomegalia was the only abdominal finding of relevance.

The laboratory tests revealed hemoglobin concentration 8.5 g/dl, erythrocyte sedimentation rate (ESR) 123, a leukocyte count of 1830, and 17% neutrophils. The rest of the parameters were all within normal limits, including usual serological tests, immunoglobulins and urine parameters.

The CT study revealed an apparently infiltrating mass in the right kidney, affecting the renal pelvis and the proximal third of the right ureter (fig. 1).

A right nephroureterectomy was performed, without incidents in the immediate postoperative period, and the patient was discharged in view of the good clinical course. The pathology report on the surgical resection piece described a mass reflecting hilar lymph node pathology of a probably reactive nature (involving intense and massive alterations), with suspected Castleman's lymphadenopathy (plasma cell variant).

During follow-up in Internal Medicine, a new CT study was made, revealing the presence of small adenopathic masses in the mediastinum, both axillary regions, retroperitoneum, abdomen, pelvis and both inguinal regions.

At present, the patient is diagnosed with Castleman's disease (plasma cell variant), and is controlled jointly by Hematology and Internal Medicine due to the presence of pancytopenia requiring regular red cell and platelet transfusions, with treatment in the form of G-CSF. The imaging studies show persistent axillary, mediastinal, retroperitoneal, mesenteric, pelvic and inguinal adenopathies similar to those seen in earlier studies.

Castleman's disease is an infrequent lymphoproliferative disease also known as angiofollicular lymphoid nodular hyperplasia or giant lymphoid nodular hyperplasia. The etiology is unknown, and the condition was first described by Castleman in the form of a mediastinal presentation in 1956.[1]

First manifestation of the disease as an isolated adenopathic mass is common,[2] though renal presentation as in our patient is infrequent. Due to the CT-based suspicion of an infiltrating tumor of the upper urinary tract, surgical resection was decided, and the histopathological study confirmed the diagnosis of Castleman's adenopathy. As reflected by the existing literature, this form of presentation is very infrequent.[2-4]

This disease should be considered in the differential diagnosis of patients with single intraabdominal adenopathic masses or space-occupying masses in the retroperitoneal space – this being a relatively common clinical presentation in urological practice. The patients should be evaluated from a global perspective, with laboratory tests and focusing on possible hematological alterations that may lead us to suspect the disease.

Castleman's disease is classified as an infrequent disorder among the range of atypical lymphoproliferative diseases. In pathological terms, the disease is divided into two histological variants:[2,3] a hyalinovascular form, which is considered to be the most common presentation (90% of all cases), and a less common (10%) plasma cell variant. Clinically, two conditions are established: localized or classical involvement, and multisystemic presentation. The localized form of the disease is usually found in the mediastinal zone or in isolated lymph nodes (intraabdominal, axillary, cervical, etc.). This is the most frequent presentation – the characteristic case corresponding to a young male with an isolated inflammatory lymph node mass. The disorder is practically asymptomatic, though

**Figure 1 – Computed tomographic reconstruction of the renal pelvic lesion described in the text.**

occasionally fever, weight loss or anemia can be observed. The prognosis is good, and treatment consists of surgical removal of the adenopathic mass – this approach being curative in most cases. The multisystemic presentation of the disorder is less common and is also more aggressive. It is seen in middle-aged individuals (about 60 years), and initially manifests as peripheral lymphadenopathy associated to severe constitutional symptoms. The laboratory tests can reveal an increased erythrocyte sedimentation rate (ESR), with hematological alterations such as anemia, leukopenia and/or neutropenia. A characteristic observation is important hepatosplenomegalia, together with large intraabdominal adenopathies. The condition is associated to hematological neoplasms. Renal involvement[5] is not infrequent, and there have been reports of membranous glomerulonephritis, amyloidosis, interstitial nephritis, mesangial interstitial glomerulonephritis, proliferative membranous glomerulonephritis, rapidly progressing glomerulonephritis, minimal change disease, or acute renal failure secondary to thrombotic microangiopathy. The prognosis is not as good as in the localized form of the disease, since no optimum treatment is available. The mortality rate reaches 50%, due to the associated morbidities: renal lesions, infections (of the urinary tract in our patient) and important hematological disorders (pancytopenia in our patient).

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# Collecting Duct Carcinoma. Case report and a review of the Literature

## Carcinoma de los conductos colectores de bellini. Presentación de un caso y revisión de la literatura

*Dear Editor,*

Bellini duct carcinoma (BDC) accounts for 0.3-1% of all primary renal tumors. No more than 120 cases have been documented to date.[1]

We report the case of a 63-year-old male referred to our center after the incidental MRI finding of a renal mass. The physical examination findings proved normal. The study was complemented with doppler ultrasound, CT and urine cytology (negative). A solid renal mass measuring 3×4×3.1 cm