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

in size was observed in the lower medial region of the left kidney, extending to the renal pelvis (N0M0). A laparoscopic left nephroureterectomy was performed.

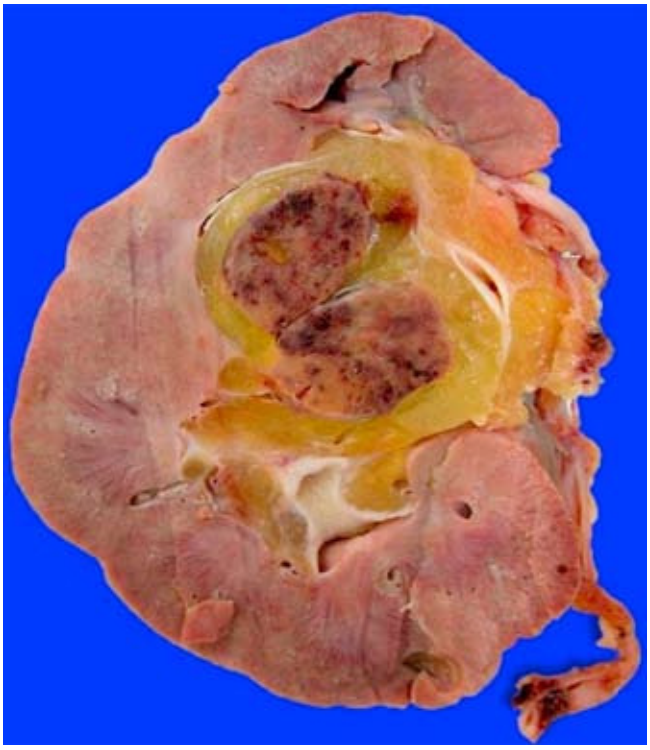

Figure 1 – Right radical nephrectomy piece showing a well delimited rounded tumor measuring 3.5 × 3 cm in size, located in the renal medulla, with a brownish-red color and surrounded by adipose tissue. The renal pelvis, ureter and vessels were compressed and displaced, but showed no tumor infiltration.

Macroscopically (fig. 1), the tumor appeared rounded, well delimited and of a brownish-red color. Although compressed by the tumor, the renal pelvis and ureter showed no lesions. The perirenal adipose tissue and renal hilar structures were not altered. The microscopic study (fig. 2) showed ducts and cysts lined by a cubic or columnar epithelium with cells presenting an eosinophilic cytoplasm, a prominent round nucleus and an eosinophilic nucleolus, with few mitotic figures or atypias. The immunohistochemical study proved positive for CK7 and CK34B, and negative for vimentin. These findings, together with the appearance of dysplastic changes in the intra- and peritumor collector ducts, were suggestive of Bellini duct carcinoma pT1N0M0. After 27 months, the patient remains asymptomatic, with no signs of local or distant disease relapse.

BDC originates in the epithelium of the collector ducts, and in most cases is located in the renal medulla. Alterations have been observed in chromosome 1,[2] and deletions in 8p and 13q, in 50% of all cases of BDC. Deletions of the long arm of chromosome 3, described by Velickovic, have not been evidenced in BDC. Oncogene c-erbB-2 amplification has also been reported in Bellini tumors.[3] An association has been described between BDC and sickle cell anemia.[4]

Most patients with BDC suffer symptoms such as lumbar pain or hematuria at the time of diagnosis. In the review published by Tokuda, 44.2% of the patients presented metastatic adenopathies, 32% systemic spread of the disease, 17% lung metastases, and 16% bone metastases.[1] Peyromaure et al. in turn described 9 cases, of which 77.8% presented metastatic adenopathies and 44% lung metastases.[4] In another of the largest published series, Motzer et al. described 26 patients with BDC, reporting lung metastases in 42% of the cases, retroperitoneal metastatic adenopathies in 46%, and mediastinal metastases

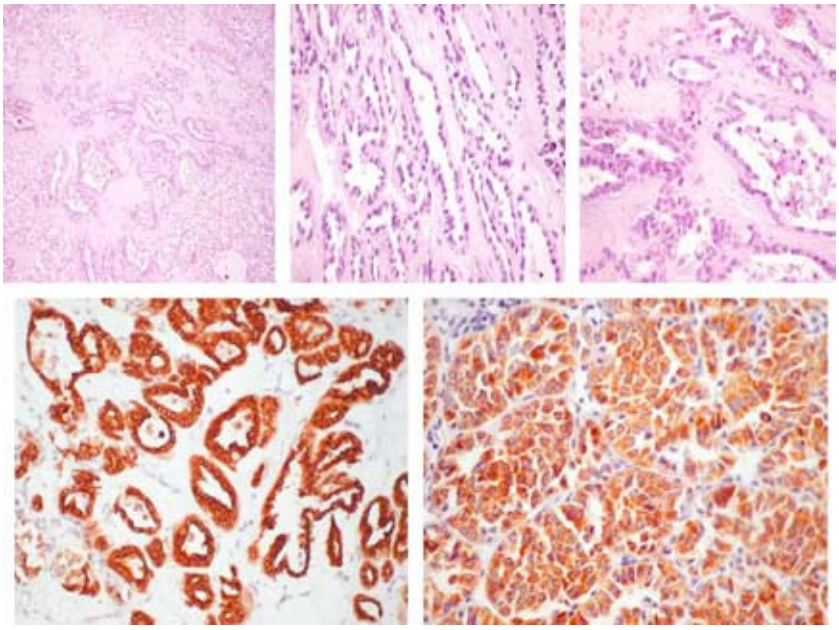

Figure 2 – Hematoxylin-eosin preparations showing ducts and cysts lined by a cubic or columnar epithelium with cells presenting an eosinophilic cytoplasm, a prominent round nucleus and an eosinophilic nucleolus, with few mitotic figures or atypias. The immunohistochemical study proved positive for CK7 and CK34B, and negative for vimentin.

in 38%.[5] These are invasive tumors showing rapid systemic spread. We have only found 14 cases of low grade BDC similar to our own case.[6] In the high grade lesions, the cancer specific survival rate after three years is 45.3%, and mean survival after nephrectomy is 10.5 months.[1,7] The histological study shows BDC to be composed of tubulo-papillary structures. The location, epithelial hyperplasia of the collector ducts adjacent to the tumor, and the immunohistochemical characteristics of the latter establish the diagnosis. This has led some authors to regard BDC as an entity independent of the renal cell tumors, and probably closer to transitional cell tumors of the upper urinary tract.

The current tendency is to administer chemotherapeutic regimens similar to those applied in cases of infiltrating transitional cell tumors.[4] Recently, the results of a phase II clinical trial have been published involving gemcitabine and cisplatin, in which one complete remission and 5 partial remissions has been recorded (disease-free survival 7.1 months and overall survival 10.5 months).[7]

The embryological, histological and immunohistological characteristics of BDC in most cases define it as an aggressive tumor manifesting in advanced stages, where nephrectomy proves insufficient. The current tendency is to administer chemotherapeutic regimens similar to those applied in cases of infiltrating transitional cell tumors. However, in some low grade cases the prognosis after surgery has been good, with no need for adjuvant therapy of any kind.

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Delayed scrotal trauma consultation

Consulta diferida de un traumatismo escrotal

Dear Editor,

The present study reports the case of a 30-year-old male with testicle pain and an elevated left testicle. He reported having suffered an accidental kick to the scrotum one month before, while playing with his one-year-old daughter. The patient initially treated the symptoms on his own accord with diclofenac. A few days later he noted a self-limiting episode of hematospermia.

Since this medication initially proved sufficient to control the symptoms, he sought no medical help at the time.

Physical examination revealed an irregular, indurated and enlarged left testicle (compared with the right testicle), with slight pain in response to palpation. There was minimal scrotal inflammation and no signs of hematomas.

Scrotal ultrasound showed a slightly enlarged left testicle. The parenchyma exhibited a heterogeneous echogenic pattern, together with loss of contour, with no clear discontinuity of the tunica albuginea. There was no associated hematocele. Based on these findings, testicle rupture was diagnosed. The patient preferred to avoid surgery, and conservative management was therefore decided.

As an alternative to surgical exploration, and considering the decision of the patient, scrotal MRI was carried out for more exact evaluation of the lesion (fig. 1). In T1-weighted sequencing, the left testicle showed an area of increased