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

Figure 2 – Image showing an atrophic testicle secondary to testicular trauma with untreated testicle rupture.

Figure 1 – Signs of testicle rupture and bleeding evidenced by MRI.

signal intensity, due to hemorrhagic material. In turn, in T2-weighted acquisitions mixed signal intensity was noted in the mentioned zone, together with a marked hypointense line along the testicle parenchyma (fig. 1).

Follow-up was carried out after 3, 6, 12 and 24 months with MRI. After 24 months the left testicle was seen to be destructured and atrophic, reflecting the natural course of testicle rupture not subjected to surgical treatment (fig. 2).

Closed trauma is the most common form of testicle trauma (sports accidents, traffic accidents, etc.). Up to 80% of all patients with closed scrotal trauma present testicular or paratesticular lesions (contusions, hematocele, testicle torsion, testicular hematoma), with testicle rupture in over 40% of the cases. At present, the diagnosis is established by ultrasound – this being the technique of choice for evaluating the condition of the testicles and adjacent tissues.[1,2] The rapid diagnosis of rupture, based on the ultrasound identification of discontinuity of the tunica albuginea, is critical in such cases, since immediate surgical management allows the rescue of the damaged testicle in 80-90% of all cases. However, MRI may be a clearly indicated alternative in those cases where ultrasound is unable to sufficiently clarify the diagnosis, or the findings prove incompatible with the clinical manifestations. MRI affords a clear and detailed image of the anatomy, and helps assess the extent of the lesion, determined by the presence or absence of intratesticular bleeding, with the provision of information of prognostic value. This could reduce the number of exploratory surgeries in the context of testicular trauma.[3,4]

Scrotal ultrasound, with the observation of a heterogeneous echogenic pattern in the testicular parenchyma and the loss of contour, is very sensitive and specific in diagnosing testicle rupture.[4] Immediate diagnosis and prompt repair condition testicle viability, with

the preservation of testicular parenchyma and hormone function, and also contribute to reduce late complications such as chronic pain, testicle atrophy and ultimately also the indication of orchiectomy.

In the absence of signs of severity, medical treatment with periodic monitoring may be justified. However, in the presence of suspect clinical manifestations or doubtful ultrasound findings, most authors recommend exploratory surgery.[5]

In the absence of hematocele, large intratesticular hematoma or rupture of the tunica albuginea, medical treatment consists of rest, the administration of antiinflammatory drugs, and testicle suspension.[6]

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Prenatal hydronephrosis due to congenital ureteral valves

Hidronefrosis prenatal secundaria a válvulas ureterales

Dear Editor,

Ureteral valves are a rare cause of upper urinary tract obstruction. Since they were first described by Wolfler in 1877, very few cases have been reported in the medical literature,[1] and in isolated cases they have been diagnosed prior to surgery.[2] In the case described in our study, suspicion arose before birth, when ureteral valves were considered in the differential diagnosis of antenatal hydronephrosis.

We present the case of a four-month-old boy showing severe right renal hydronephrosis and dilatation of the upper third of the ureter at control prenatal ultrasound exploration. The urine sediment and urine culture findings were normal. The diagnosis of hydronephrosis was confirmed at ultrasound exploration performed 15 days after birth. Hydronephrosis was ratified by intravenous urography (fig. 1) and diuretic renography (DTPA-Tc99m/furosemide), which showed diminished function and delayed drainage of the affected kidney. Cystourethrography discarded the presence of vesicoureteral reflux.

Percutaneous anterograde pyelography (fig. 2) confirmed and precisely located the stricture in the proximal ureter, suggesting the diagnosis of ureteral valve.

In view of the severe hydronephrosis, surgery was decided. Dilatation was observed of the proximal third of the right ureter; as a result, a 2-cm length of ureter was removed, covering the extent of the different-caliber zone, followed by end-to-end ureteroureteral anastomosis. Histological examination of the resected ureteral segment revealed the presence of transverse fibers of ureteral mucosa, containing smooth muscle bundles.

One month after surgery, control examination through the percutaneous nephrostomy revealed restenosis of the ureter at the level of the ureteroureteral anastomosis. The restenosis was subjected to pneumatic dilatation, with a satisfactory outcome. Three years later, diuretic renography (DTPA-Tc99m/furosemide) showed complete resolution of the hydronephrosis, without obstruction.

Congenital ureteral stenosis and ureteral valves are the main causes of congenital ureteral obstruction.[3] Ureteral valve embryogenesis remains unclear, and three