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Methroragies as form of presentation of a ovary metastases from a primary renal cell carcinoma

Metrorragias como forma de presentación de un carcinoma de células renales con metástasis ovárica

Dear Editor,

We present the case of a 52-year-old woman consulting due to repeated metrorrhagic episodes associated to general syndrome in the form of asthenia and anorexia. The examination yielded no findings of note other than hemorrhagic remains at vaginal exploration. Vaginal ultrasound showed the presence of a solid cystic mass dependent upon the left adnexal elements – posteriorly confirmed by computed tomography (CT) (fig. 1) – with a small amount of free intraperitoneal fluid. CT also revealed the presence of a solid mass measuring 6.5 × 6.5 cm in size, dependent upon the lower pole of the right kidney (fig. 2), as well as multiple nodules in the upper pole. Right radical nephrectomy was performed, together with hysterectomy and bilateral oophorectomy. The histological report on the renal piece indicated Fuhrman grade III clear cell carcinoma without invasion of the renal capsule, while the right ovary presented renal clear cell carcinoma metastasis.

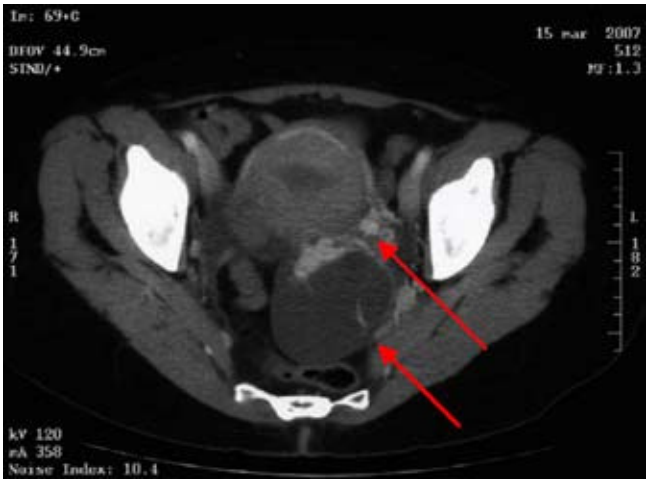

Figure 1 – Computed tomography scan. Solid cystic component of the adnexal mass (arrow).

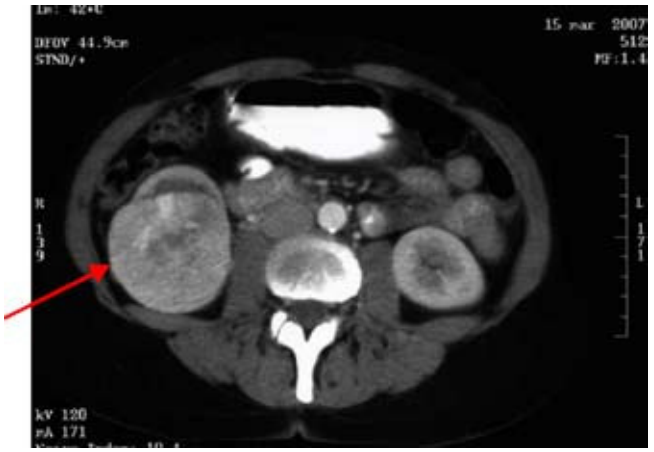

Figure 2 – Computed tomography scan. Complex mass measuring 65 × 65 mm in size, dependent upon the lower pole of the right kidney (arrow).

Ovarian metastasis of renal clear cell adenocarcinoma is extremely rare. The lesions are often mistaken for primary clear cell tumors of the ovary. Approximately one-third of all patients with a *de novo* diagnosis of renal carcinoma present metastatic disease.[1] On the other hand, close to one-half of the patients subjected to nephrectomy with healing intent develop distant metastatic disease over follow-up.[2,3] Of these metastases, 70% are limited to a single organ – generally the lung (40%) or bone (22%) – with single metastatic lesions in 2.3% of the cases.[4] With only 12 cases published in the last 20 years, metastatic invasion of the ovary from a primary renal tumor is extremely rare, though metastatic involvement of a renal carcinoma must be included in the differential diagnosis of ovarian tumors presenting clear cell histological characteristics.[5]

REFERENCES

1. Toyoda Y, Shinohara N, Harabayashi T. Survival and prognostic classification of patients with metastatic renal cell carcinoma of bone. Eur Urol. 2007;52:163-9.
2. Sheth S, Scatarige JC, Horton KM. Current concepts in the diagnosis and management of renal cell carcinoma: role of multidetector CT and three-dimensional CT. Radiographics. 2001;21:237-41.
3. Zisman A, Pantuck AJ, Dorey F. Improved prognostication of renal cell carcinoma using integrated staging system. J Clin Oncol. 2001;19:1649-55.
4. Whelan P. The medical treatment of metastatic renal cell carcinoma. EUA Update Series. 2003;1:237-44.
5. Shinojima T, Nakajima Y, Kiguchi H. Renal cell carcinoma metastatic to the ovary: a case report. Nippon Hinyokika Gak Zass. 2001;92:694-7.

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Phyllodes tumour of the seminal vesicle: case report and revision of literature

Tumor filoide de la vesícula seminal: caso clínico y revisión de la literatura

Dear Editor,

We report the case of an asymptomatic 64-year-old male with a supra-prostatic mass diagnosed at transrectal ultrasound. The serum prostate specific antigen (PSA) concentration was 0.53 µg/l. The pelvic magnetic resonance imaging (MRI) study showed a lesion with regular margins, of a predominantly cystic nature and with a solid internal vegetation in the topographic zone of the left seminal vesicle. The lesion showed no evidence of local or regional aggressive behavior (fig. 1).

Complete resection of the mass was carried out via an infraumbilical midline laparotomy with sectioning of the pouch of Douglas (fig. 2). The lesion was adhered to the prostate, and the left seminal vesicle could not be identified. The postoperative course was without complications.

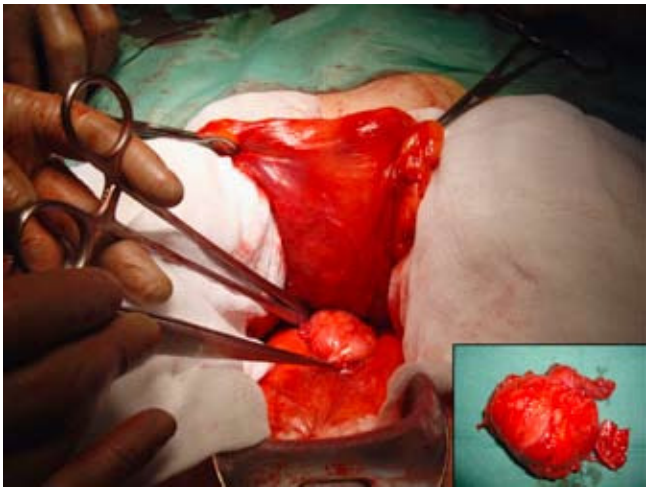

Figure 2 – Surgery: Exposure of the tumor with the bladder displaced anteriorly (small image - surgical piece).

Figure 1 – Axial and sagittal MRI. Left seminal vesicle topographic lesion with regular margins, of a predominantly cystic nature, containing a 5-cm solid vegetation.