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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.

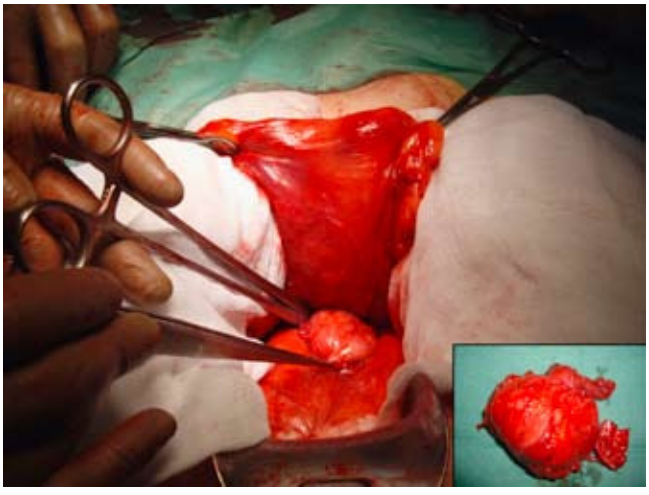

Figure 2 – Surgery: Exposure of the tumor with the bladder displaced anteriorly (small image - surgical piece).

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.

The histological study revealed a cystic formation with a papillary solid nodule. Upon sectioning, the lesion was found to be compact and elastic, with the observation of prostatic tissue and seminal vesicle at the periphery. The microscopic study showed the tumor to contain stromal and glandular areas with a layered architecture – the diagnosis being phyllodes tumor. There was no evidence of aggressive behavior, and the lesion was thus regarded as being of low grade. Immunohistochemistry proved negative for both PSA and prostatic acid phosphatase (PAP) – thus reinforcing an origin in the seminal vesicle.

One year after surgery, the patient is asymptomatic, with no evidence of residual tumor or disease relapse in the imaging studies.

Phyllodes tumors are neoplasms with an epithelial and a stromal component[1] that often develop within the sinus. They rarely develop in the prostate, and about 15 cases involving a seminal vesicle origin have been published to date. These tumors often manifest with lower urinary tract symptoms, hematuria, hematospermia or the presence of a mass at rectal exploration.[1-3] The imaging study findings are typical but not pathognomonic of the disease.[4]

Surgical resection is the indicated treatment. There is evidence that even in the least aggressive presentations, disease relapse is the rule,[1] with some documented cases of the development of sarcoma,[1,5] local invasion and pulmonary metastasis[1,2,6,7] – fundamentally in the high grade lesions (with hypercellularity, nuclear atypias, mitotic activity or an increased stromal/epithelial ratio)[1] – even after radical surgery. Since no lymphatic metastases have been reported, lymphadenectomy has not been indicated.[8]

The roles or radiotherapy and chemotherapy[2,4,7] remain to be defined, despite the existence of a case of remitting lung metastases.[7]

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Renal artery pseudoaneurysm after partial nephrectomy. Diagnosis, treatment and literature review

Pseudoaneurisma de arteria renal tras nefrectomía parcial laparoscópica. Diagnóstico, tratamiento y revisión bibliográfica

Dear Editor,

Between May 2006 and December 2008, we performed 9 laparoscopic partial nephrectomies (LPNs) in our Department. We report the case of a 61-year-old male incidentally diagnosed with a 2.5-cm tumor located in the lower pole of the right kidney.

LPN was performed with a duration of surgery of 220 min., an ischemia time of 32 min., and a bleeding volume of 200 ml. Resection was performed with a cold scalpel, and leaving a 1-cm safety margin. Posteriorly, the urinary tract and surgical bed were sutured with polyglactin 3-0, adding Floseal® to the resection bed and placing a Surgicel® membrane. Parenchymal suturing was carried out with polyglactin 1-0 sutures and Hemo-locks® to maintain tension.

The histopathological diagnosis was clear cell carcinoma with areas of papillary growth, corresponding to Fuhrman grade II. The tumor measured 2.7 cm in size, and the surgical margins, capsule and perirenal adipose tissue were free of tumor invasion.

After surgery the patient presented mild hematuria which intensified 24 hours later, coinciding with the start of walking – requiring continuous lavage and the transfusion of two red cell concentrate units. The patient was discharged on the fourth postoperative day without a catheter.