Asemptomatik dev üreteral polip: Olgu sunumu

Asymptomatic giant ureteral fibroepithelial polyp: A case report

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Özet

Fibroepitelyal polipler (FEP) üriner kanalın mezodermal dokusundan kaynaklanan iyi huylu tümörlerdir. Fibroepitelyal poliplerin etyolojisi bilinmemektedir. Hematüri ve obstrüktif üriner semptomlar en sık rastlanan bulgulardır. Üreterde dev bir polip olmasına rağmen, biz vakamızda herhangi bir semptom tespit etmedik. Ultrasonografi ile rastlantısal olarak sağ üreterde tespit edilen asemptomatik fibroepitelial polip odusunu sunuyoruz.

Anahtar Kelimeler: Ureter, fibroepitelyal polip, tedavi, dev

Abstract

Fibroepithelial polyps (FEPs) are benign tumors of the urinary tract, arising from the mesodermal tissue. Etiology of fibroepithelial polyps is unknown. Hematuria and obstructive urinary symptoms are the most common findings. Although there was a giant polyp in the ureter in our case, we did not observe any symptom. We report a case of asymptomatic fibroepitelial polyp of the right ureter incidentally detected with ultrasonography.

Key Words: Ureter, fibroepithelial polyp, treatment, giant

Introduction

Fibroepithelial polyp is a benign neoplasm of mesodermal origin that arises in the wall of the renal pelvis, ureter, bladder or urethra. The etiology of FEP is unclear, congenital factors may play a role in children and chronic infection in adults. The most common symptoms are hematuria and obstructive urinary symptoms. It can be treated by endoscopicially or open surgery (1).

Case report

A 73-year-old woman was admitted to our clinic with incidentally detected bladder mass on ultrasonography. Her physical examination was normal. She had history of breast cancer treated with right radical mastectomy and chemotherapy. Hemogram, blood biochemistry and urine analysis were in normal ranges. Abdominal ultrasound examination demonstrated a mass at the right side of the bladder wall. Intravenous urography was normal. (Figure1) Ureteral dilatation, filling defects and hydronephrosis were not detected. Cystoscopic examination was planned. There was a polypoid mass, in white color, about 3 cm long and 1 cm wide, prolapsing into the bladder from the right ureteral orifice with ureteric jetstream on cystoscopic examination.(Figure 2) Then the ureteroscope was inserted into the right ureter there was a stalked polyp and the polyp was grasped with forceps and excised (Figure 3). After this procedure double J stent was placed for 6 weeks. She was discharged on postoperative 1'st day. Histopathologic examination of the tissue specimen revealed a fibroepithelial polyp. A double J stent removed 6 weeks postoperatively. At follow-up, the patient was asymptomatic and had no evidence of disease on cystouretroscopy after three months.

Discussion

Fibroepithelial polyps are considered the most common benign neoplasms of the ureter among other benign lesions such as lymphangiomas, leiomyomas and neurofibromas. They are often smoothly marginated, cylindrical and sessile (2). Because of their histologic organization, FEPs are classified as benign hamartomas; however, malignant degeneration and cystic transformation have also

Geliş tarihi (Submitted): 29.07.2011 *Kabul tarihi (Accepted): 01.08.2011*

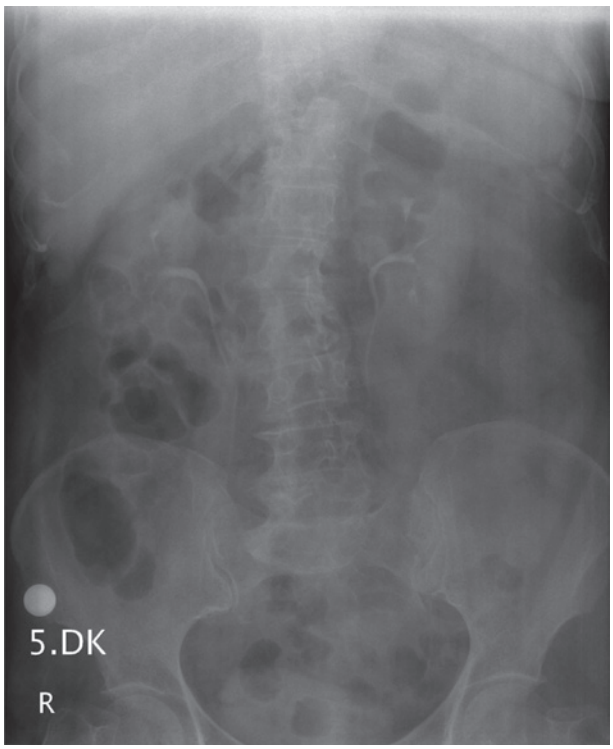

Figure 1: Intravenous urography of the patient which is normal.

been reported (3).

Fibroepithelial polyps commonly present in adults in the third to fifth decades. Male-to-female ratio of 3:2. In adults, most FEPs occur in the ureter; 62% of these polyps are located in the upper ureter or ureteropelvic junction, 15% are in the renal pelvis, and a small percentage is in the bladder or posterior urethra. In our case fibroepihelial polyp was in the right middle ureter. Fibroepithelial polyps of the lower urinary tract usually occur in the posterior urethra, most often in children. (2) Kara et al reported incidentally detected ureteral fibroepithelial polyps in children (4). Fibroepithelial polyps usually appear as solitary polyps; however, rare cases of multiple and bilateral appearances have been reported (3, 5) The typical length is not more than five centimeters (6).

Although the etiology of FEPs is unclear, they are thought to be either congenital slow-growing lesions that develop as a result of chronic urothelial irritants, such as infection, inflammation, calculi, or obstruction. The most common symptoms of the polyps are hematuria and flank pain (2). Although there was a giant polyp in the right ureter in our case, we did not observe any symptom. The pain is characteristically intermittent and colicky due to partial obstruction. Urinary frequency, dysuria, and pyuria are other less common findings (2). Sometimes the pain may be severe, torsion of the polyp, resulting in painful ischemia or infarction (7).

Fibroepithelial polyps appear to be long, smooth ureteral filling defects and hydronephrosis on intravenous urography or retrograde urograms (8). In our case ureteral filling defects and hydronephrosis were not detected by intravenous urography. We believe that this giant FEB did not cause hydroneprosis because it did have an obsructive effect since it was moving in and out with urine efflux. It is important to distinguish FEPs from upper urinary tract carcinomas because management and prognosis can be significantly different. Debruyne et al reported that unnecessary nephroureterectomies were performed with FEP due to an uncertain pre-operative diagnosis (9). However, the definitive diagnosis can only be made by ureterorenoscopy and histopathologic examination

Management of ureteral FEPs include local coagulation by laser, polypectomy by ureteroscopy, and segmental resection with ureteroureterostomy or nephroureterectomy. In the past, treatment of FEP was excision of the polyp and reanastomosis with an open surgary. Recently endoscopic treatment with the ureteroscopes has become more popular. Usually, the polyps are grasped with forceps and resected through the ureteroscope. The holmium: YAG laser is another modality for endoscopic resection (3). Carey and Bird successfully ablated multiple polyps in ureter by using the holmium laser, and removed each polyp from the ureteral wall with grasping forceps

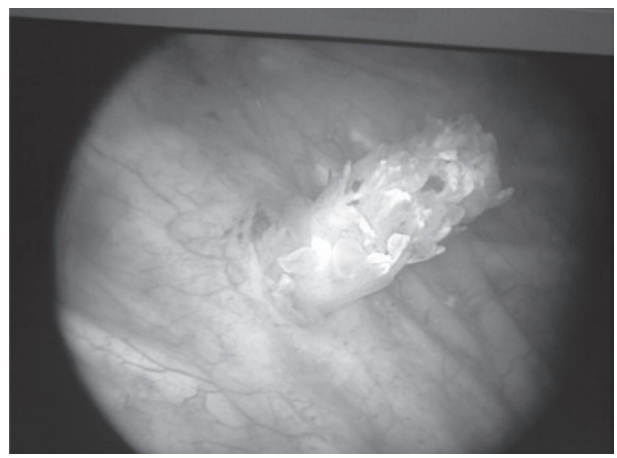

Figure 2: Polypoid mass prolapsing into the bladder from the right ureteral orifice

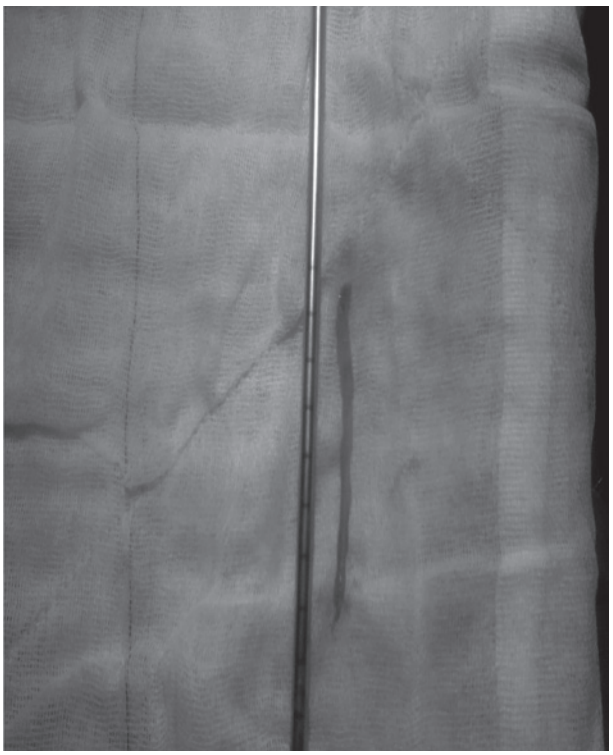

Figure 3: The mass was about 7 cm long and 1 cm wide

(10). Also ureteral stones are removed concurrently with a basket and a ureteral access sheath is used to facilitate the multiple passes of the ureteroscope and the removal of the polyps and stones from the proximal ureter. Percutaneous antegrade excision should be available for treating polyps in the upper urinary tract (3). Laparoscopic surgery might be preferred when the polyps are too large. When malignancy is suspected or when an endoscopic approach is not adequate, segmental resection of the ureter, ureteroureterostomy, pyeloplasty, or nephroureterectomy may be needed (4) The risk of recurrence, and frequency of follow-up are not clear. But some studies have suggested urine cytology, control ureteroscopy and intravenous urography in the follow up (4).

Conclusion

Fibroepithelial polyps of the ureter are rare benign neoplasm that can mimic other ureteral pathologies and lead to inaccurate diagnosis and treatment. Fibroepithelial polyps are commonly symptomatic and rarely asymptomatic that can be detected incidentally as in our case. Fibroepithelial polyps appear as ureteral filling defects and hydronephrosis on intravenous urography or retrograde urograms but rarely it can be normal as in presented case. Fibroepithelial polyps should be considered in the diagnosis of ureteral filling defects to prevent agressive treatments.

Kaynaklar

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