Dialysis after Bilateral Nephrectomy

A Case Report

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Dear Sir,

Recently Black et al. [1] reported 6 cases of patients with bilateral renal cell cancer treated 'successfully' with total nephrectomy followed by maintenance dialysis. We report here a case of transitional cell cancer (TCC) and colon polyps (urothelial and adenocarcinoma), that underwent the same treatment plus endoscopic resection of intestinal tumors with similar results.

A female Caucasian first presented in 1970 at the age of 40 with gross hematuria. She was diagnosed of TCC of the bladder. Six transurethral resections followed by intravesical chemotherapy with thiotepa were done without success. Seven years later cystectomy and bilateral ureterosigmoidostomy were performed and the tumor was classified as low grade and noninvasive (Pa G-I). A year later, an intravenous urography (IVU) revealed filling defects in medium and inferior calices in the left kidney. The patient remained asymptomatic and the lesion unmodified for 2 years. In the 3rd year, a radical left nephroureterectomy was done finding TCC of the renal pelvis, again low grade and noninvasive. Ten years after cystectomy, when the patient was 56, a new IVU showed moderate dilation of calices, pelvis and ureter and renal parenchymal atrophy. A colonoscopy apparently discarded extension of the tumor in sigmoid colon, so it was decided to include the patient in a periodic hemodialysis program (HD), and in July 1987, a right nephroureterectomy was carried out. The histologic study confirmed a TCC of the pelvis infiltrating renal parenchima. One regional node out of nine was affected (positive for tumor). Four days after surgery, the patient presented with profuse rectorrhagia. A new colonoscopy revealed a bleeding sessile polyp located at the colonsigmoid union and a second one near the ureteral stump. Both were removed by cautery snare. The anatomopathologic study disclosed urothelial carcinoma and colon adenocarcinoma, respectively. A year later, our patient is doing well on chronic hemodialysis. Her only complication has been a brief episode of rectorrhagia. The origin of bleeding was located by colonoscopy at the remnant of the colon sigmoid union polyp. Coagulation was effective. No evidence of metastases has been found to date.

Due to the low grade and noninvasiveness of TCC, we think it seems reasonable to propose these patients for inclusion in a HD program. However, it is always mandatory, as it was done in our case, to rule out first the presence of metastases and discard the coexistence of adenocarcinoma of the colon. The later is known to be a complication in

ureterosigmoidostomies [2–5]. The mechanisms more commonly advocated are mechanical irritation [4], and conversion of an urinary precarcinogen [5]. The finding of a sessile polyp, urothelial in origin, away from the ureteral stump is very unusual [3,4]. In our patient only a second look found the presence of these tumors.

Our case stresses the need for a whole exploration of the colon in these patients [2] before choosing among the treatment options. Fortunately, although the first colonoscopy was uneventful, the second look was therapeutic.

References

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