Case Report

Received: August 8, 1994

Accepted after revision: June 15, 1995

Urol Int 1996;56:55-56

Metastatic Ureteral Tumour

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Key Words

Renal carcinoma
Ureteric tumour
Survival
Surgical intervention

Abstract

We report a case of renal carcinoma which presented initially with lymphatic spread. Five years later, a contralateral ureteric tumour was excised, with to date, 2 years of disease-free survival. Isolated ureteric metastases are very uncommon.

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Introduction

The propensity for renal cell carcinomas to metastasise is well recognised. Lung, bone and lymph nodes are the most common metastatic sites. Metastasis to other parts of the urinary tract is uncommon. We report a case in which an isolated contralateral ureteric metastasis occurred several years after nephrectomy. 'Cure' was achieved by resection of the lesion. excised and ureteric continuity restored by an end-to-end anastomosis. Histology demonstrated a 2 × 1 × 1 cm polypoid tumour within the ureter. Within the ureteric submucosa, a deposit of clear cell carcinoma consistent with a metastasis from the previous renal carcinoma was observed (fig. 1). No evidence of further metastatic disease was found. He remains well 2 years later, with urea being 14.3 mmol/l and creatinine 185 mmol/l.

Case Report

A 62-year-old man presented with a 2-year history of a right axillary lump and night sweats. At surgery, a lymph node was excised, the histology of which was reported as metastatic renal cell carcinoma. Subsequent urinary tract imaging revealed a mass in the upper pole of the left kidney. He underwent a radical left nephrectomy. Histo-logical examination confirmed a 7-cm well-prescribed clear cell renal carcinoma. The capsule was intact and there was no evidence of intravascular spread. Following the procedure the night sweats ceased. For the next 4 years he remained asymptomatic with no evidence of further metastatic disease. Five years after nephrectomy, he presented with haematuria, renal failure and a right loin mass. The urea was 47.5 mmol/l and creatinine 973 mmol/l. A nephrostogram and retrograde ureteropyelography revealed an obstructing lesion in the upper right ureter. The right kidney was hydronephrotic but with no evidence of tumour. At subsequent surgery a ureteric tumour was

Fig. 1. Ureteral tumour demonstrating clear cell carcinoma. Solid nests of eosinophilic and clear tumour cells. HE. $\times 220$.

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Discussion

Metastatic tumours of the ureter are rare. The most common primary sites of these secondary ureteral tumours include kidney, stomach, prostate, breast and lung [1]. Reported cases involve patients at all ages and all parts of the ureter [2]. These metastatic tumours are thought to reach the ureter via the blood vessels and lymphatics [1,3]. In 1948 Presman and Ehrlich [4] suggested criteria for secondary tumours of the ureter to be labelled as true metastases. These included malignancies that involved the ureter by growth within the wall; the presence of tumour within periureteral lymphatics and no involvement of the ureter by direct extension or contiguity [4]. In a post mortem study of 1,451 cases of renal adeno-carcinoma, Saitoh [5] reported the incidence of ureteric metastases as 1 %. There was only 1 case with an isolated ureteric metastasis. Some 50 cases of ureteric involvement in renal adenocarcinoma have been reported in the literature.

A review of the literature suggests that metastatic ureteral involvement indicates widespread metastatic disease. Thus the prognosis is usually poor. However, should investigation fail to reveal evidence of spread, then solitary urinary tract metastases should be surgically resected as long-term survival can result [6].

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Urol Int 1996;56:55-56

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