

Endoscopic Treatment Of Fibroepithelial Polyp Coexisting Ureter Stone

Üreter Taşı İle Birlikte Seyreden Fibroepitelyal Polibin Endoskopik Tedavisi

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Although ureteral tumors are rare both in children and adults, fibroepithelial polyp is the most common benign tumor of the ureter. Fibroepithelial polyps are traditionally treated with open surgery. By the introduction of ureteroscopy, the treatment of these lesion is achieved by endoscopic manner. We report a case of fibroepithelial polyp associated with ureteral stone treated endoscopically.

Key Words: **Endoscopy, Fibroepithelial polyp, Stone disease, Treatment, Ureter**

Fibroepitelyal polip üreterin en sık görülen tümörü olmasına rağmen, üreteral tümörler çocuklarda ve erişkinlerde nadir görülür. Geleneksel olarak fibroepitelyal tümörler açık cerrahi ile tedavi edilir. Üretroskopun ürolojiye girişil ile bu lezyonların tedavisi endoskopi olarak yapılmaya başlanmıştır. Biz üreter taşı ile beraber izlenen bir fibroepitelyal polip olgusunun endoskopik tedavisini sunuyoruz.

Anahtar Kelimeler: **Endoskopi, Fibroepitelyal polip, Taş hastalığı, Tedavi, Üreter**

Ureteral fibro epithelial polyp was first reported in 1932. Although rare, it is the most common benign tumor of the ureter (1). Histologically these polyps are composed of stroma derived from the mesoderm and covered by a layer of normal transitional epithelial cells (2). Although fibroepithelial polyps are traditionally treated resection by open surgery; the introduction of the endoscopic instruments to urology enables to treat these pathologies endoscopically. We report our experience on ureteroscopic treatment of a fibroepithelial polyp coexisting mid ureteric stone.

Case Report

A 66 years old woman admitted with right flank pain, dysuria. She has had colic pains intermittently for 5 years but she has not admitted to any health center till the pain worsened in last month. The complete blood count, biochemical data revealed no abnormality. The urine

analysis revealed red and white blood cells but the urine culture was clear. The direct radiography revealed a calcification about 1,5 cm in diameter located on the sacroiliac joint. No excretion of the radioopaque element on excretory urography on the right side (Figure 1). USG revealed pelvicaliceal dilatation and dilated right proximal ureter. DTPA scintigraphy was performed and GFR of the right kidney was 24.8 ml/min.

The bladder was observed normal on cystoscopy. For the treatment of the stone ureteroscopy was performed by using a 7.5 F semi-rigid ureteroscope without dilatation. Smooth, regular surfaced polypoid structure obstructing ureteral lumen was observed just proximal to the stone (Figure 2). This structure was not allowing the instrument pass to its proximal. The polyp was grasped by a 4 wire stone basket and resected over the root area. The stone was successfully defragmented with pneumatic lithotripter. Pathologi-

Received: 05.10.2006 • Accepted: 30.12.2006

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Figure 1: Intravenous pyelogram showing non-visualized right kidney and radiopacity on the sacroiliac joint

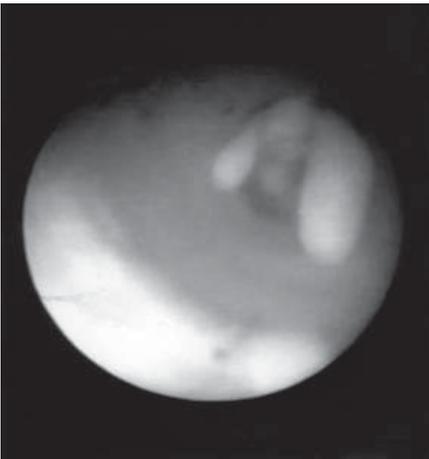


Figure 2: Ureteroscopic appearance of fibroepithelial polyp revealing grayish-white colored and smooth regular surfaced finger like projections

cal examination revealed the features of fibroepithelial polyp consisting of loose fibroconnective and

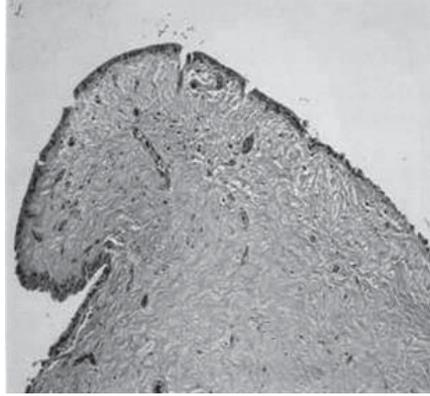


Figure 3: Photomicrograph of fibroepithelial polyp, loose fibroconnective and fibrovascular tissue covered by normal-appearing urothelium. H.E: X10

fibrovascular tissue covered by normal-appearing urothelium, being evident. (Figure 3).

Discussion

Fibroepithelial polyps are the most common benign tumor of the ureter and pelvis of adults and children, but most commonly present in third and fourth decades, and more common in males (1,2). They are typically present as a smooth, mobile, pediculated mass with multiple finger like projections arising from the submucosa of the ureter. They are grayish-white in color and multiple tenacles are attached to a single base. Congenital factors, urinary calculi, infection, inflammation and obstruction are considered to cause ureteral fibroepithelial polyps (2, 3).

Most frequent clinical findings are hematuria (%58) and flank pain (%79) (4). Urinary frequency, dysuria and pyuria are less common findings. The pain is usually intermittent and colicky due to partial obstruction, as in the present case.

The diagnosis of the fibroepithelial polyps usually established with excretory urography and/or antegrade and or retrograde pyelography. Radiographic features of the polyps varied but mainly grouped into two categories. First long cylindrical a filling defect mostly located in the proximal ureter. The second type of polyp is shorter, wider and more likely causes obstruction. But when the fibroepithelial polyp is associated with a stone and/or if the kidney doesn't excrete radioopaque substance there might be confusion as in the present case.

There's no malignant transformation of a fibroepithelial polyp, but transitional cell carcinoma coexistent with fibroepithelial polyp (3). Debruyne et al. reported that unnecessary nephroureterectomies were performed in 41 (37%) of 112 cases of fibroepithelial polyp (4). Bahnson et al. stated that ureteroscopic appearance of a fibroepithelial polyp as a smooth, regular surface and can be easily differentiated from the irregular appearance of the urothelial carcinoma (5). The ureteroscopic appearance of the present case was the grayish-white in colored and smooth regular surfaced finger like projections that was typical for fibroepithelial polyp. So we totally resected the polyp endoscopically end left the open procedure to an secondary section in case of malignancy in pathological examination of the specimen.

It's evident that conservative management is preferable to open surgery and ureteroscopy allows accurate diagnosis and effective treatment in the treatment of ureteral polyps.

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