

Case Report



Ureteral Transitional Cell Carcinoma With Supraclavicular Lymph Node Metastasis: Case Report

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ABSTRACT

Primary transitional cell carcinoma (TCC) of the ureter is an uncommon urogenital tract tumor. According to our knowledge; metastasis of ureteral TCC in supraclavicular lymph nodes had only been reported for two times in the literature. In this case, a 57 year-old male patient who had a primary ureteral tumor with supraclavicular lymph node metastasis was reported.

Key Words: Transitional cell carcinoma, Ureter, Metastasis, Supraclavicular lymph node.

ÖZET

Üreteral Değişici Epitel Hücreli Karsinomun Supraklavikular Lenf Bezine Metastazı: Olgu Sunumu

Üreterin primer değişik epitel hücreli karsinomu oldukça nadir görülmektedir. Bilgilerimize göre; üreterin değişik epitel hücreli karsinomunun supraklavikular lenf noduna metastazı literatürde daha önce sadece iki kez bildirilmiştir. Bu olguda, supraklavikular lenf nodu metastazı olan primer üreteral tümörlü 57 yaşında erkek hasta sunulmaktadır.

Anahtar Kelimeler: Değişici epitel hücreli kanser, Üreter, Metastaz, Supraklavikular lenf bezi.

Gross hematuria is the most frequent symptom of the ureteral tumors (1). Ninety-nine percent of ureteral tumors are transitional cell carcinoma (TCC) which develops by 5% from the renal pelvis and ureteral epithelium (2). Primary ureteral TCC forms a part 1% of the genitourinary tract malignities (3). The lymph node metastases of ureteral TCC occur in paraaortic, paracaval, ipsilateral common iliac and pelvic lymph nodes. Present case employed a male patient who had with primary ureteral TCC with including supraclavicular lymph node metastasis.

CASE REPORT

A 57 years old male patient has been presented with painless gross hematuria together with clots. The multiple and fixed lymphadenopathies at the supraclavicular region extending to lower and middle jugular region (5x5 cm diameter) was clarified during the medical examination. The hydronephrosis in the right kidney, and a hyperdense soft tissue mass in the distal section of the right ureter was appeared with using the method of abdominopelvic tomography. Mass was seen as protruding in the polypoid form from

the base of the bladder, through to the lumen (Figure 1). Multiple lymph nodes in the right inferior jugular chains, bilateral submandibular and submental, left jugular and posterior cervical region determined by cervical tomography. The biggest lymph node (a diameter of 33x16 mm) was in the left submandibular region (Figure 2).

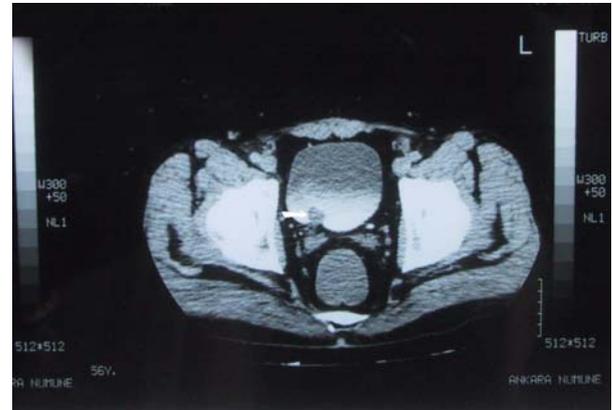


Figure 1: Abdominopelvic tomography; a hyperdense soft tissue mass protruding in the polypoid form from the base of the bladder towards to the lumen.



Figure 2: Cervical tomography; left jugular and posterior cervical region. The biggest lymph node in a diameter of 33x16 mm in the left submandibular region

A polypoid tumoral formation (diameter of 2x3 cm) extending from right ureter orifice towards to the bladder lumen was established. Right nephroureterectomy with bladder cuff resection, and excisional biopsy from supraclavicular lymphadenopathy were performed during operation. These pathologic specimens exhibited as TCC with Grade II involving all layers of the ureter which invades the vascular spaces. The excisional biopsy obtained from supraclavicular lymphnode region was reported as TCC metastasis (Figure 3).

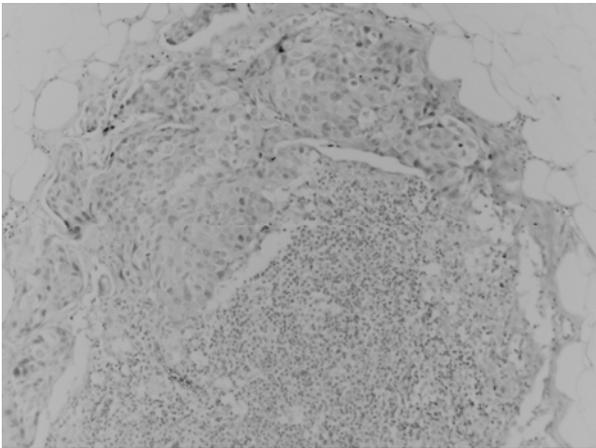


Figure 3: Lymph node specimen; transitional cell carcinoma metastasis that was detected by excisional biopsy from supraclavicular lenf node region.

The adjuvant methotrexate, vinblastine, epirubicin, cisplatin (MVEC) chemotherapy was administered to the patient in the post-operative period. In the tomographic assessment multiple lymph nodes in with different sizes were shown in supraclavicular, hilar, paratracheal, axillar, paracaval, paraaortic and parailiac regions. The maximum size of lymph nodes was in 32 x 29 mm. The patient received salvage chemotherapy, including gemcitabine plus cisplatin cures as three times and died due to widespread metastases 15 months later.

DISCUSSION

Ureteral tumors commonly be present with painless gross hematuria together with clots while its evaluation for the diagnosis and staging is recommended by using IVP, retrograde pyelography, computerized tomography, cystoscopy, and ureterorenoscopy. It is noted that ureteral obstruction can lead an impairment in the function of ipsilateral kidney. To date, ureteral TCC has a poor prognosis when compared with the renal pelvis TCC, while the anatomical barriers could prevent the invasion of the tumor into the kidney parenchyma. These tumors generally are associated with regional lymph node metastases. Ureteral TCC induces initial lymph node metastases in paraaortic, paracaval, ipsilateral common iliac or pelvic lymph nodes depending on their localization. The involvement of regional lymph node which impact the survival has been declared at 16-58.6% in earlier studies. (4).

Although urogenital tract tumors with cervical lymph node metastasis are not common, the frequent metastasis location is mostly supraclavicular lymph nodes (5). Hesan et al. (6) documented that the ratio of metastasis of urogenital tract tumors to the head-neck region was 3.7%, and a cervical lymph node metastasis ratio was 2.4% of 845 patients. So far, we know two published data related to ureteral metastasis, which is associated with supraclavicular lymph node metastasis (7,8). Current finding strongly provides more clinical trial in regard to supraclavicular lymph node metastasis of ureteral TCC. Furthermore, this and former case indicated that unexpected lymph node metastasis could be seen in ureteral tumors, especially TCC.

KAYNAKLAR

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Gönderilme Tarihi: 08.03.2011