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CLINICAL CASE

Urachal adenocarcinoma – an athypical mestastasis from a rare tumor

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KEYWORDS
Hematuria;
Kidney;
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Urachus

Abstract
We present the clinical case of a 74-year-old woman with an urachal tumor diagnosed in 2004. The patient underwent a partial cystectomy of the dome with remotion of the urachal remnant and the umbilicus. She had been clinical well until 2011 when she had a kidney metastasis from the urachal tumor.
Urachal tumors are very rare, comprising 0.17-0.34% of all bladder cancers. The most common sites of distant metastases are: lung, lymph nodes, bone, intestine, brain, liver, peritoneum, skin and spine. We describe an extremely rare case of a renal metastasis from an urachal cancer, seven years after the initial diagnosis.
Usually, patients with localized disease have a good prognosis when treated with surgery. The prognosis gets worse for patients with metastases or local recurrence because a standard chemotherapy regimen does not exist.

PALAVRAS-CHAVE
Hematúria;
Rim;
Mestástase;
Neoplasia;
Úraco

Adenocarcinoma do úraco – metástase atípica de um tumor raro

Resumo
Apresentamos o caso clinico de uma doente com 74 anos diagnosticada com tumor do úraco em 2004. A doente foi submetida a cistectomia parcial da cúpula vesical com excisão do úraco e do umbigo. Esteve clinicamente bem até 2011 quando lhe foi diagnosticada uma metástase renal do tumor do úraco.
Os tumores do úraco são muito raros, compreendendo 0,17-0,34% de todos os tumores da bexiga. Os locais mais comuns de metastização à distância são: pulmão, gânglios linfáticos, osso, intestino, fígado, peritoneu, pele e coluna. Descrevemos um caso extremamente raro de uma metástase renal de um adenocarcinoma do úraco sete anos após o diagnóstico inicial.

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Habitualmente, os doentes com doença localizada apresentam um bom prognóstico quando tratados com cirurgia. O diagnóstico é pior para doentes com metástases ou recorrência local uma vez que ainda não existe um regime de quimioterapia estabelecido.

Introduction

Urachal adenocarcinomas are very rare tumors, usually diagnosed at an advanced stage because the lack of symptoms. We present a rare case of a renal metastasis developed seven years after the first treatment.

Case report

We present the case of a 74-year-old woman that was sent to the urologist in 2003 to investigate gross hematuria. She did a computed tomography (CT) scan that showed a proliferative mass of the anterior bladder wall. The cystoscopic evaluation confirmed a lesion at the bladder dome. The lesion was ressected and the histology revealed infiltration of the bladder mucosa by mucinous adenocarcinoma.

Gynecology and General Surgery excluded secondary adenocarcinoma of the bladder.

A partial cystectomy of the dome was performed with remotion of the urachal *remnant* and the umbilicus. The histology revealed infiltration of the bladder mucosa by mucinous urachal adenocarcinoma (Fig. 1).

The follow-up was maintained and the patient had been clinically well until November 2011, when the CT scan of the abdomen and pelvis revealed a renal mass involving the lower pole of the left kidney. This mass had 75×41×54 mm and its appearance was suspicious for a proliferative lesion. There was no evidence of lymphadenopathies.

The patient underwent a laparoscopic radical nephrectomy of the left kidney on January 2012.

The histology showed infiltration of the renal parenchyma from the Gerota fascia to the calyces by mucinous adenocarcinoma (Fig. 2). Imunohistochemical staining showed that cells were positive to CK20 but negative to CK7. Neural invasion was present and the margins were positive. The histologic exam concluded secondary infiltration of the kidney by mucinous adenocarcinoma similar to the analyses performed in 2003.

The gynecologic exam and the colonoscopy did not reveal alterations. It was concluded that the kidney mass was a metastasis from the urachal tumor.

On May 2012, the patient had an episode of intestinal subocclusion and was admitted in the General Surgery's Department. During this period she underwent a virtual colonoscopy that did not reveal polipoid images. The CT scan of the thorax, abdomen and pelvis showed a latero-aortic lymph node and a heterogeneous lesion in the renal fossa sugestive of local relapse.

The serum levels of carcinoembryonic antigen (CEA) were elevated.

With evidence of disease progression the patient was sent to the Oncologist. She began salvage chemotherapy with *Gemcitabine*, once a week.

A CT scan performed on February 2013 showed volume reduction of the residual mass and of the latero-aortic lymph node. However it was also documented progression of the disease with identification of a lumbar vertebral sinking.

The patient died on March 2013.

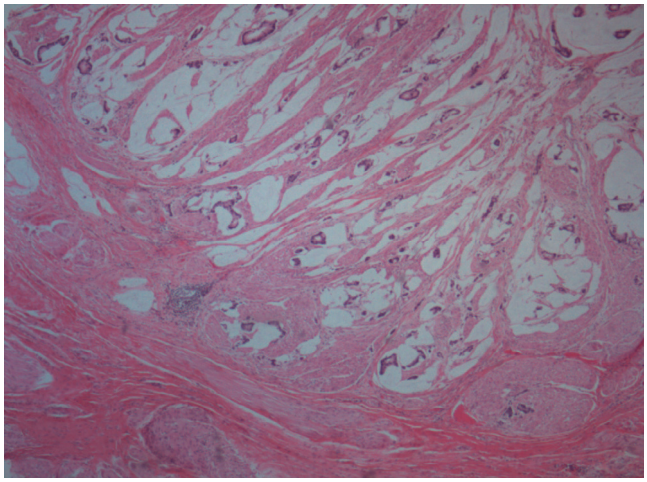

Figure 1 Infiltration of the bladder mucosa by mucinous adenocarcinoma. (Hematoxylin-eosin, 40×).

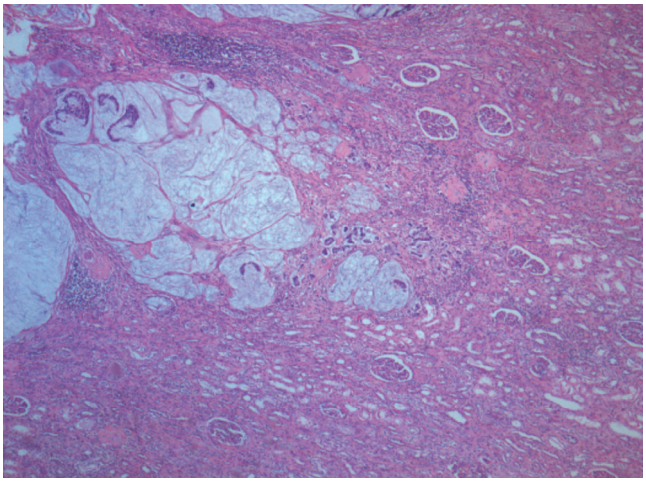

Figure 2 Infiltration of the renal parenchyma by mucinous adenocarcinoma. (Hematoxylin-eosin, 40×).