African Journal of Urology (2014) **20**, 95–98

Pan African Urological Surgeons' Association

African Journal of Urology

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Case Report

Primary urachal adenocarcinoma: A case report

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Received 25 November 2013; received in revised form 25 November 2013; accepted 8 February 2014

KEYWORDS
Urachus;
Adenocarcinoma;
Bladder

Abstract
Primary urachal adenocarcinoma is an aggressive rare cancer that often presents at advanced stages with poor prognosis. We report this case of a 52-year-old patient with a stage-I (Mayo Clinic) primary urachal adenocarcinoma with good outcomes after surgery in a 2-year follow-up period. We analyze epidemiological, clinical and therapeutic features of this disease in the literature review.

Introduction

Primary urachal adenocarcinoma is a rare and aggressive cancer. It often presents at an advanced stage and has a poor prognosis. We report the case of a 52-year-old patient with a stage I (Mayo Clinic) primary urachal adenocarcinoma with good outcomes after surgery with a follow-up of 2 years. We analyze epidemiological, clinical and therapeutic features of this disease in a literature review.

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Peer review under responsibility of Pan African Urological Surgeons' Association.

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http://dx.doi.org/10.1016/j.afju.2014.02.001

Case report

Mr. M.A., a 52-year-old patient, had a history of epileptic disease treated by tegretol. He had a total intermittent hematuria and irritative urinary symptoms for a month. Clinical examination was normal. Ultrasound revealed an echogenic mass localized in the anterior wall of bladder. Hemoglobin was at 11.3 g/dl and renal function was normal. Urine was sterile at the culture.

Uroscan showed a 3 cm dense picture in the dome of the bladder, enhanced after injection of contrast product, which was typical for a urachal tumor (Fig. 1 and Fig. 2).

A rigid cystoscopy was performed under spinal anesthesia. It confirmed the presence of a solid tumor of 3–4 cm developed in the anterior wall of the bladder. Trigon, retrotrigon, lateral walls were normal. Ureteral meatus were free. Then, a transurethral resection was incompletely carried out.

Histology indicated a malignant tumor characterized by a glandular proliferation including well differentiated cells sometimes isolated sometimes grouped in polyadenoid clusters. These were covered by

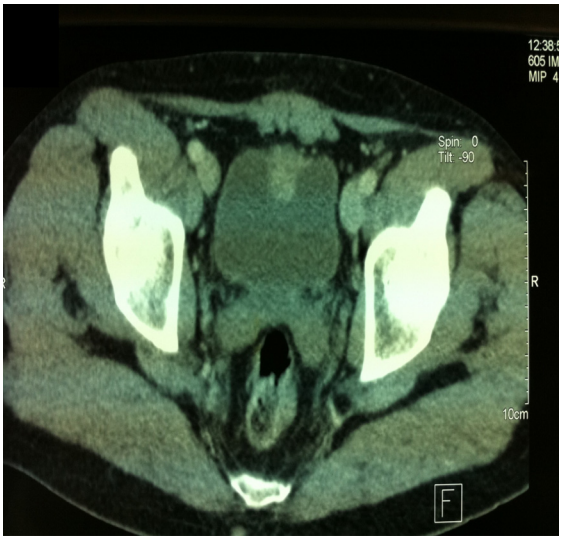

Figure 1 CT scan of the pelvis showing echogenic mass in the bladder dome.

pseudostratified cylindrical epithelium with cytonuclear atypia. The connective stroma was inflammatory. Bladder's muscle was invaded (Figs. 3 and 4).

Immunohistochemistry revealed positive marking for cytokeratin 7 and cytokeratin 20, but negative for β-catenin.

A primary enteroid urachal adenocarcinoma T2 was then concluded.

Prostate specific antigen (PSA) was at 0.66 ng/ml and Carcinoembryonic antigen (CEA) at 2.30 ng/ml (normal value). Colonoscopy has not found any colorectal tumor.

The computed tomography (CT) of chest, abdomen and pelvis showed neither regional nor distant metastasis.

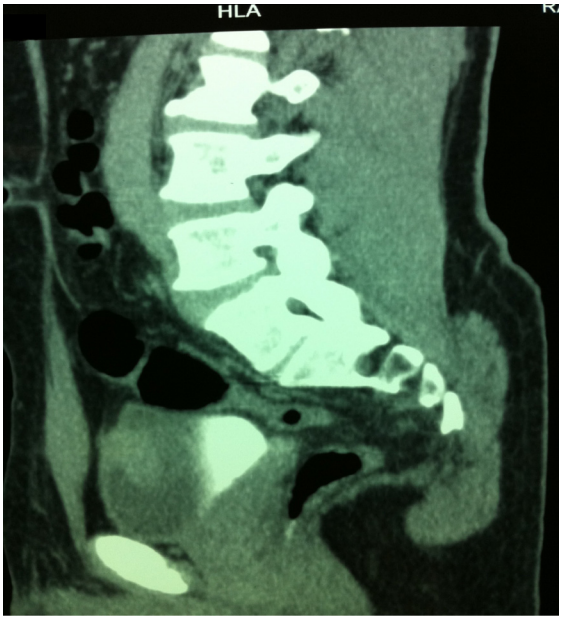

Figure 2 CT scan of the pelvis coronal view showing urachal tumor.

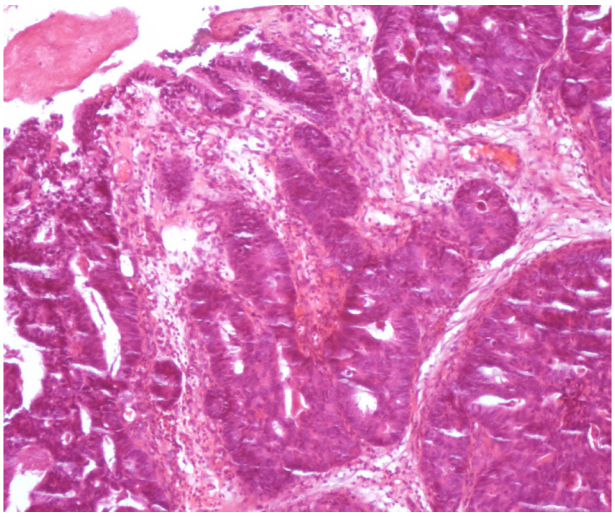

Figure 3 Histogram showing well differentiated adenocarcinoma with glandular proliferation.

A median laparotomy was performed. Perioperatively, a circumscribed and irregular mass of 5 cm × 4 cm originated from the urachus and extended to the dome of the bladder.

Partial cystectomy, with en bloc urachectomy up to the umbilicus, excision of the parietal peritoneum, and bilateral pelvic lymph node dissection, were performed.

Histology confirmed the diagnosis of enteroid adenocarcinoma T2 N0 with negative margins.

No adjuvant treatment was proposed.

The patient is still living free from disease after 2 years, as assessed by cystoscopy and CT of chest, abdomen and pelvis performed every 6 months.

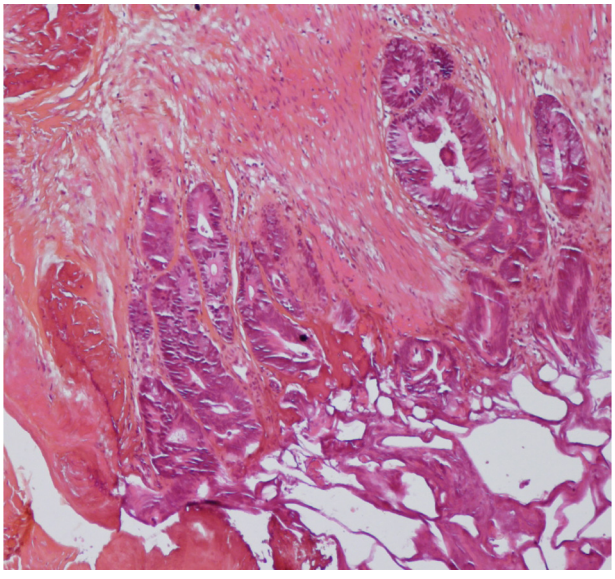

Figure 4 Histogram showing adenocarcinoma with infiltration of detrusor.