

tumour, arguing against a systemic hormonal mechanism of pathogenesis. Furthermore, in the three of our cases in which ER and PR were sought immunohistochemically, these were not expressed in the endothelial cells of the haemangiomas, although there was some reactivity in mesenchymal cells. In three of our cases, the haemangiomas were strictly confined to the ovarian medulla and hilum, as were most of the previously published cases. It is possible that their hilar location alone may be sufficient to induce hyperplasia of surrounding hilar cells, a phenomenon not unique to haemangiomas. Rete cysts, which predominantly occur in the ovarian hilar region, are typically associated with hyperplasia of hilar cells.^{14,15} The relationship between the stromal changes and the vascular lesion remains to be defined, but we propose the stromal changes to be a combination of the frequently hilar location of the haemangiomas and a local, paracrine induction not dissimilar to that observed in a wide range of primary and secondary ovarian neoplasms.

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A case of ureteric polypoid endometriosis presenting in a post-menopausal woman



Sir,

Typical endometriosis is commonly seen in daily practice of gynaecological pathology and the diagnosis is straightforward. However, polypoid endometriosis, which may mimic a malignant neoplasm on clinical and intraoperative findings, is a rare tumour-like form of endometriosis. Since it was first reported by Mostoufzadeh and Scully¹ in 1980, a few case reports have been published.^{2–8} To date, only one large series of cases (24 cases) has been studied and the locations of the majority of cases involved the female reproductive system and pelvic walls. Recently, we have encountered an unusual case presenting in the ureter in a post-menopausal woman.

A 62-year-old female presented with haematuria and some rigors. There was no significant past history of infection. A computed tomography (CT) scan was suggestive of a left hydronephrosis with distal left ureteric obstruction. Ureteroscopy revealed a distal ureteric smooth polypoid lesion which was most likely a benign urothelial polyp. It was excised by ureterectomy along with partial cystectomy. She was given Triphasil medication between 2003 and 2004 and she never had a definite endometriosis syndrome.

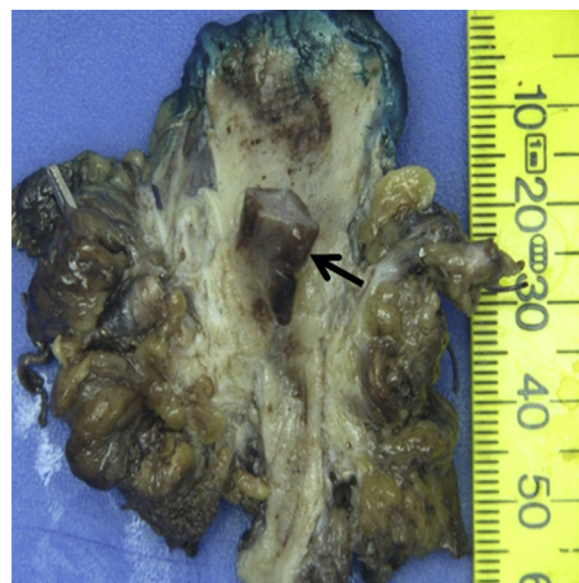


Fig. 1 A haemorrhagic polypoid lesion is present on the ureteric mucosa.

Macroscopic examination revealed a haemorrhagic polypoid lesion on the ureteric mucosa measuring $15 \times 10 \times 5$ mm (Fig. 1). The wall of the bladder was scarred with numerous small spaces on the cut surface. There were lymph nodes identified in the surrounding soft tissue.

Microscopically, the polyp protruding into the lumen of the ureter was composed of endometriotic glands and stroma and covered by urothelium (Fig. 2A). The wall of the ureter,

periueteric tissue and muscularis propria of the bladder were extensively involved by endometriotic glands and stroma. There was no hyperplasia and dysplasia of glandular cells, or cytological atypia of stromal cells. The diagnosis was polypoid endometriosis. Within the surrounded fibromuscular and adipose tissue, the endometriosis grew along neurovascular bundles (Fig. 2B) with an extension into nerve ganglia. Focal vascular involvement was seen (Fig. 2C). The

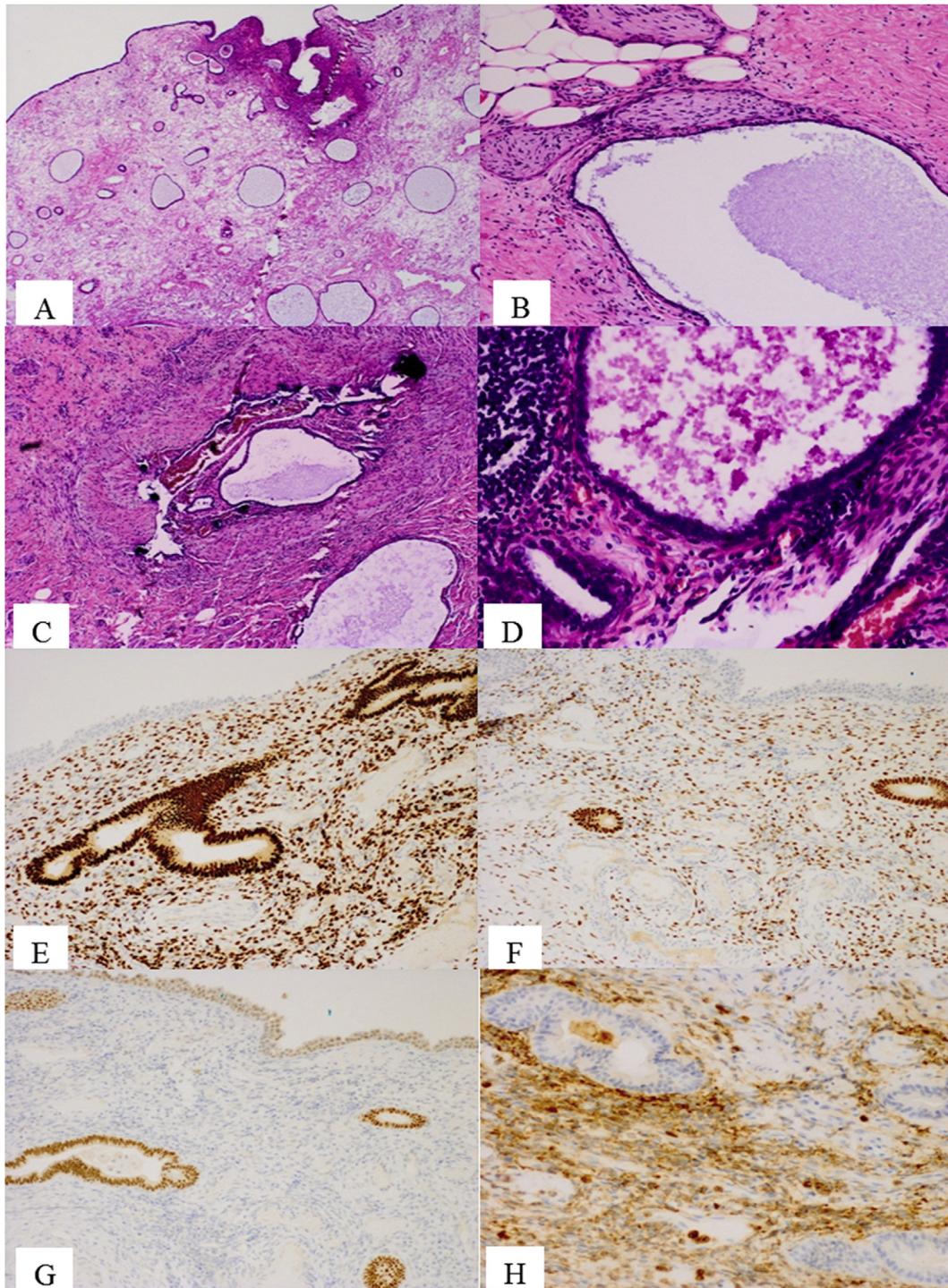


Fig. 2 (A) Ureteric endometrial polyp composed of endometrial glands and stroma. (B) The endometriosis grew along neurovascular bundles. (C) Vascular involvement. (D) Endometrial glands and stroma in lymph node. (E) Positivity of oestrogen receptor (ER) in epithelial cells of glands and stromal cells. (F) Positivity of progesterone receptor (PR) in epithelial cells and stromal cells. (G) Positivity of PAX8 in epithelial cells of endometriotic glands and urothelial cells. (H) Positivity of CD10 in the stroma.

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