Aim of this work is to present cases of renal neoplasms where all available diagnostic modalities and control exams were applied, still explorative surgery was needed. Asymptomatic tissue mass with diagnostic findings of hypovascular renal cell carcinoma and renal pelvic carcinoma were inconclusive. While percutaneous CT guided biopsy is advisable in such cases, it was not performed due to central, hilar localization of the lesions and its small dimensions. In rare cases, such ours are diagnosis is achieved by surgery-histology examination.

Key words:

CASE PRESENTATION:

Case 1. Fifty eight years old, male patient three months ago underwent left hemicolectomy due to colon adenocarcinoma (Dukes II). On the control check up he complained on left flank pain with slight rise of body temperature. Ultrasound revealed solid, hetero-echoic, approx. 3.5 cm in diameter mass, in front of and without left kidney involvement. Biochemistry and white blood cells account excluded acute inflammation. Two successive CT (computed tomography) exams were done, monthly (Picture 1, 2). Left radical nephrectomy was done and patho-histology obtained.

Case 2. Female patient 55 years old, on routine gynecology exam left kidney tumor was suspected by ultrasonography. Hetero-echoic, 2 cm in diameter, situated around the kidney hilum, not sharply demarcated, slightly prominent on anterior kidney surface, tumor was detected without dilatation of pelvicaliceal system. Retrograde uretero-pyelography (Picture 3.) and CT exam (Picture 4.) was performed. Diagnostic dilemma concerning RCC (renal cell carcinoma) and RPC (renal pelvic carcinoma) still stood. Angiography of the left kidney (Picture 5) was done. Patient underwent left radical nephrectomy (Picture 6.).

DISCUSSION:

Talking about our first pt, first CT exam beside oval mass adjacent to left lateral abdominal wall, in the region of recent surgery, revealed also mass located at the left kidney hilum. Because clinical symptoms and signs as the CT findings were inconclusive, control CT was advised.

The second CT gave conclusive data: mass at the location of surgery was still present, hypodense with hyperdense rim surrounded by hypodense but hypovascular tracks, corresponded to percutaneous draining tube position and adhesions formations.

Another, with irregular margins especially from left psoas muscle, tumor mass was localized at the hilum level but involving renal parenchyma of the posterior segment. Tumor was isodense (40 HU) on native scans but hypodense in late parenchimal fase, on contrast scans. There was no evidence of vessels involvement or kidney collecting tract obstruction. Hypovascular RCC of left kidney was suggested.

After radical surgical intervention and pathohystological specimen examination, renal cell carcinoma was diagnosed, grade III, infiltrating striate muscle (psoas muscle), stage pT3a No Mo.

Incidental finding of tumor on ultrasound was confirmed on CT exam in our second case. Tumor lesion of the left kidney, 2.5 cm diameter, was isodense on native scans, with border line contrast enhancement (10-20HU) during arterial, parenchimal and excretory phases (8). It was centrally located, slightly bulging the lateral kidney border.

Chevassy revealed dislocation of medial calices with infiltration suspected. Percutaneous biopsy was not advisable because it was adjacent to renal hilum and spleen. Selective left renal angiography showed only dislocation of interlobar branches at the medio-renale level, without visible neo-vascularization signs.
Diagnostic doubt was still present at the surgery, between hypovascular RCC and RPC. Hystology confirmed RCC grade II, pT2bNoMo.

For diagnosis, staging and differentiation RCC from other, solid, cystic parenchimal as from renal canal tract malignances, CT is concerned "gold standard". Multi-helical CTs attributed great deal in vascular pattern evaluation, minimazing volume effects false results thus enabling more accurate tumor characterization.

Most of the RCC s are hypervascular, still more than one third are hypo or morphologically avascular tumors. In such cases especially when they are small ( cm) due to its localization inconvenient for percutaneous biopsy diagnostic doubts in many cases remains open.

Upon literature data and our own clinical experience, rate of false negative results of percutaneous cytology and biopsy is much higher in patients as ours. Diagnosis of hypovascular neoplasms sometimes is achieved by conventional angiography particulary if nephron sparing surgery is concerned.

Detection of malignant lesion in early stage emphasizes in renal neoplasm where surgery is, despite advances in gene and immunotherapy, still only curative method of therapy. When incidentally detected, small size lesion, suggesting low stage tumor, even if the grade is higher radical surgery gives better 5 years survival.

CONCLUSION:

Nowadays, many noninvasive highly informative diagnostic procedures are available. Still CT, especially multislice CT gives greatest tumor diagnostic value and stage evaluation.

In unspecific lesions control CT exams are advisable. Rarely conventional angiography and explorative surgery, for diagnostic differentiation are needed.
SUMMARY

Diferencijalno dijagnostički problem u slučajevima granične prezentacije malignom bubrenog parenhima i kanalnog trakta bubrega

Cilja rada je da se prikaže da pored brojnih, neinvazivnih, visoko senzitivnih i specifičnih dijagnostičkih procedura, u retkim slučajevima malignoma bubrega je neophodna eksplorativna operacija. Nalaz asimptomatske tkivne promene bubrega, preoperativno dijagnostički se nije mogao izdiferencirati hipovaskularizovan tumor bubrenog parenhima u odnosu na tumor kanalnog trakta bubrega. Perkutana biopsija koja se savetuje u sličnim slučajevima, nije radjena zbog hilarne lokalizacije i malih dimenzija tumorske promene. U retkim slučajevima dijagnoza se postavlja operativno odnosno patohistološkim pregledom odstranjencubrega.

Ključne reči:

BIBLIOGRAPHY


