Dear Editor:

With regard to the recent article by Husillos et al. on the scarcely prevalent collecting duct renal cancer and due to its histological peculiarity, we want to share our experience with another no less characteristic anatomopathological variant with the readers of Actas Urológicas.¹

It is a 65-year-old male who consulted in May 2007 for epigastric pain with mass at that location. He underwent a CT scan which showed large retroperitoneal tumor that depended on the left renal upper pole, as well as multiple pulmonary nodules compatible with metastasis in balloon release (Fig. 1). Given these findings, left radical nephrectomy was carried out. The anatomopathological analysis revealed a renal carcinoma with leiomyo-sarcomatoid differentiation in 90% of the sample, Fuhrman grade IV. It showed positivity immunohistochemically for cytokeratin (AE1/AE3), actin, desmin, and vimentin (Figs. 2 and 3).

He received a first-line treatment with interferon until June 2008, when he progressed with new lung lesions, so he started treatment with sorafenib.

He was evaluated quarterly by means of CT, the disease remaining stable until August 2010, which presented a progression at the level of surgical and retroperitoneal site, so the treatment was changed to everolimus, which continues today.

The peculiarity of this case lies in its scarcely prevalent histology. Renal cell cancer (RCC) with sarcomatoid differentiation is an aggressive variant that confers an ominous prognosis. Its frequency is 4–20% of renal cancers and cancer-specific survival at 5 years is 15–25%, compared with 80% in patients with clear cell renal cancer.² There is little experience in its treatment. They respond poorly to chemotherapy, although doxorubicin and gemcitabine regimens have shown a partial response rate in 40% of the cases, but with a median duration of response of 5 months.³ Escudier published a prospective multicenter phase II study in 2002 that analyzed the efficacy of doxorubicin and ifosfamide in 25 patients with sarcomatoid RCC. No objective responses were observed, the median time to progression and overall survival were 2.2 and 3.9 months, respectively.⁴ Due to the poor results obtained with chemotherapy in these patients, several VEGF therapies were attempted (sunitinib, sorafenib, bevacizumab).

In 2010, Staehler et al. treated 15 patients with sarcomatoid RCC with sorafenib after progression to doxorubicin-gemcitabine regimen. There were no responses to chemotherapy, but a patient who received antiangiogenic treatment showed a partial response for three months, and 4 others held a stabilization of their disease for 3–9 months.⁵

Our patient had a stabilization of his disease for three years of treatment with sorafenib. Maybe in the future VEGF therapies replace the classical chemotherapy schemes in the treatment of metastatic renal cancer with sarcomatoid differentiation. However, further prospective studies are needed to confirm these findings.

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Transurethral endoscopic removal of urinary foreign bodies in the child

La extracción endoscópica transuretral de cuerpos extraños urinarios en el niño

Dear Editor:

Self-insertion of foreign bodies through the urethra in children is a serious urologic problem. In children, this procedure is common and results from the child’s curiosity about his or her body, and it is more frequent among boys. The child introduces the foreign body through the urethra, and when they lose the tip of the object, they compress the glans and the foreign body migrates superiorly.

The presentation is variable. The child may present with urinary tract infections, dysuria, urinary frequency, lower abdomen pain, hematuria, or even signs of nephritis. Diagnosis is often delayed, after protracted urinary tract symptoms, and a high index of suspicion is required for the diagnosis. The delay in recognition of this condition may lead to the onset of complications such as formation of stones or even bladder rupture.

After diagnosed, the best treatment option is their removal. That is often a challenging condition, and we must then choose the technique that is most appropriate for the given situation. The foreign body can often be removed transurethrally. However, because of the small-caliber child’s urethra, there is always concern about iatrogenic urethral damage. We should choose between endoscopic or open techniques according to foreign body’s size and mobility. Endoscopic techniques should be preferred whenever possible, but some unusual or large foreign bodies may require individual treatment, and sometimes an ingenious method of extraction is required.

We have successfully treated two cases of self-introduction of foreign bodies through the urethra. The two boys, aged 7 and 9, presented with dysuria and hematuria. The first case was initially misdiagnosed as glomerulonephritis, but an abdominal ultrasonography suspected of a foreign body inside the bladder, and it seemed to be a steel pin (Fig. 1). The second case had a ball head pin palpable in the peno-scrotal urethra, which was confirmed in the abdominal X-ray. In both, the foreign body was removed via the transurethral route. The first one was removed endoscopically, with the aid of a grasping forceps. The second one was removed with a sailor’s knot placed with the aid of a grasper, under endoscopic guidance (Fig. 2). The postoperative courses were uneventful.

It is important to keep in mind the diagnosis of foreign body in the urinary tract whenever urinary symptoms are not fully understood. At examination, the objects distal to the urogenital diaphragm can typically be palpated directly. When they are not readily palpable, the diagnosis is usually performed by abdominal ultrasonography or radiography.

After diagnosis, the best management of these patients is the retrieval of the foreign body, in order to solve the symp-

Figure 1  Abdominal ultrasonography may suspect a foreign body inside the bladder.