LETTERS TO THE EDITOR

Plasmacytoid urothelial carcinoma of the bladder with peritoneal spread. Cytological diagnosis in ascitic fluid

Carcinoma urotelial plasmocitoide de la vejiga con extensión peritoneal. Diagnóstico citológico en líquido ascitico

Dear Editor,

Plasmacytoid carcinoma (PUC) is a distinct entity of urinary bladder cancer with a high propensity for invasion and poor prognosis. There have been few reports about the cytologic interpretation of PUC in effusions. In such specimens, this neoplasm causes a wide range of potential pitfalls.

A major one is the positive staining with CD138. While CD138 is a marker for plasma cell differentiation, it is also positive in several epithelial tumors and in PUC. In addition to recognizing the cytomorphologic details, a full immunocytochemical panel is helpful in properly characterizing this entity.

A 72-year-old male patient presented with ascites, abdominal pain, and weight loss. Abdominal CT scan and ultrasound examination revealed a pelvic mass that involved large intestine and peritoneum. Evacuative paracentesis was performed to mitigate the patient's symptoms and to provide specimens for cytological diagnosis. Cytology showed abundant plasmacytoid cells (Fig. 1A), and immunocytochemistry revealed strong positivity for CD138 (plasma cell antigen) so the diagnosis of multiple myeloma (MM) was rendered. Further work-up did not demonstrate other signs of MM. Features of additional immunocytochemical analysis of the ascitic effusion with epithelial marker BerEp4 (positive expression) and cytokeratin subtypes (AE1/AE3, CK7, CK8/18) (positive expression), along with lymphocytic marker leukocyte common antigen (LCA) (negative expression), strongly supported the cytological diagnosis of a carcinoma of urothelial origin.

Biopsy specimens were obtained by exploratory laparotomy, from the large intestine and peritoneum. Histological and immunohistological findings were the same as those found in ascitic fluid. Following our cytologic diagnosis, and going back to the patient's previous history, we found out that he had been diagnosed and treated in another hospital of infiltrating urothelial carcinoma of plasmacytoid type.

Figure 1 (A) Ascitic fluid, direct smear: Plasmacytoid cells; Papanicolaou stain ×100. (B) Tissue section: Infiltrating urothelial carcinoma of plasmacytoid type; CD138 immunostain ×100.


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(CD138 positive) (Fig. 1B), a year ago. The presence of end stage disease did not allow for any efficacious treatment.

Plasmacytoid urothelial carcinoma (PUC) is a very rare histological variant of invasive urothelial carcinoma (IUC) first described by Sahin et al.1 PUC has been recognized in the current World Health Organization (WHO) (2004) classification of urothelial neoplasms2 and may pose a significant differential diagnostic problem; particularly if it is the predominant or exclusive pattern in a limited biopsy sample. Since the original publication, many cases of plasmacytoid urothelial carcinoma have been described. A small number of cytologic descriptions have been published, including cases involving cerebrospinal fluid cytology, bladder washings, urine cytology, and fine needle aspiration.3

Plasmacytoid morphology of tumor cells causes diagnostic dilemma and potential misdiagnosis as multiple myeloma (MM) mostly, but other epithelial tumors such as lobular carcinoma of the breast, neuroendocrine tumors, or melanoma should be considered as well. Early recognition of this type of tumor is important because of its aggressive behavior that demands a different therapeutic approach.

In our settings, we show that by combining morphological and immunocytochemical studies on centrifugation slide preparations, the cytologic diagnosis of PUC can be both accurate and efficient.

References

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Tonsil metastasis as initial presentation of clear cell renal carcinoma

Metástasis amigdalina como presentación inicial de un carcinoma renal de células claras

Dear Editor,

We present the case of a 49-year-old man who came to the emergency department because of suffering for a month from unilateral tonsillitis which had not been solved with antibiotics, also referring slight left sacroiliac pain. Upon physical examination, enlargement of the volume of the left tonsil by tumor appearance was confirmed. We obtained a biopsy that reported: clear cell carcinoma and probable kidney metastasis (Fig. 1). Abdominal ultrasound was performed demonstrating echogenic tumor imaging in the upper pole of the left kidney, with poorly defined outlines, and with hypoechoic areas within suggestive of necrosis, reaching 80 mm × 75 mm at their maximum diameters, associated with the existence of a lesion in the contralateral adrenal gland of metastatic appearance. We subsequently conducted a scan of the cranium, thorax, and abdomen, and intravascular of the latter body segment, confirming the ultrasound findings as well as the existence of retroperi-

toneal lymph node mass and metastases of the lung, brain, and bone, proving the presence of extensive left iliac osteolysis. The patient evolved torpidly and died in less than 2 months.

Renal cell carcinoma accounts for 3% of all adult malignancies and 85–90% of kidney cancers in the same stage of life, clear cell being the most frequent (70–80%). About 30% of these neoplasms have metastasis when they were examined for the first time.1,2

For now, there have been only 2 cases published of tonsillar metastases due to renal cancer in the last 5 years, both with known history of renal cell carcinoma. However, we found in the literature reviewed no cases published with a tonsillar metastasis as the initial manifestation of a renal carcinoma.2

Furthermore, tonsillar metastases, regardless of their origin, are extremely rare. Similarly, primary tumor lesions of this anatomical region are also unusual, representing only 5% of epidermoid carcinomas of the oral cavity.3

Figure 1 Tumor tonsil biopsy showing stroma with metastatic clear cell tumor with abundant blood vessels and inflammatory infiltrate.

References

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