中文題目：疑似腎膿瘍之類肉瘤腎細胞癌案例報告
英文題目：Sarcomatoid Renal Cell Carcinoma Mimicking Renal Abscess: A Case Report
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Introduction

Sarcomatoid renal cell carcinoma (SRCC) was first reported by Farrow et al in 1968[1] to described tumors contained spindle-like cells, cellular atypia and high cellularity which are features found in sarcomas. Sarcomatoid renal cell carcinoma (sRCC) is rare, with an incidence of 4–32% based on contemporary studies, and is an aggressive cancer that is associated with a poor prognosis.[2] Here we reported a female patient of SRCC with initial presentation of spike fever and right flank pain.

Case Presentation

A 59-year-old Taiwanese woman with history of gastroesophageal reflux disease presented with spike fever, right flank pain, and dysuria for two weeks. On physical exam, it was noted that the patient appeared spike fever(39.0C) with right costo-vertebral angle tenderness elicited on percussion. Pertinent laboratory investigations revealed leukocytosis (white blood cell count: 16000/uL) and high CRP level (8.02 mg/dL). The urinary dipstick was positive for leukocyte esterase. On microscopic examination of the urine, pyuria was minimal (10 white blood cells per high-power field) and no bacteriuria was noted. She was admitted to the internal medicine ward with a preliminary diagnosis of acute pyelonephritis, and she was started on intravenous ceftriaxone. A contrast-enhanced computed tomography was performed on 7th day due to sustained fever which showed an ill-defined inhomogeneous density mass lesion, 8.4x7.3x4.8 cm over upper pole and medial aspect of right kidney with low density change and small amount of fluid after contrast medium administration (figure 1). She had received echo-guided percutaneous nephrostomy under the impression of renal abscess. The drainage samples were culture negative and no bacterial organisms. After 14-day antibiotic therapy, her fever persisted. Poor response to antibiotic therapy, negative bacteria culture, and only minimal mass shrinkage on follow-up computed tomography raised the suspicion of malignancy and the patient received radical nephroureterectomy. On gross examination, the tumor in upper pole of right renal parenchyma, with

cauliflower in shape, with 4 cm in diameter, was brown to gray-white in color. On histologic examination, the tumor was characterized by invasive, mixed giant trabecular and solid tumor nests composed of the tumor cells with large and bizarre nuclei, occasional mitotic figures, and mixed acute and chronic inflammation with necrosis. Immunohistochemical studies indicated that the sarcomatoid components were positive for cytokeratin (CK and CK7) and vimentin. The final pathological diagnosis was sarcomatoid renal cell carcinoma stage I(T1bN0M0) of AJCC stage groupings. The patient did not receive systemic chemotherapy and radiotherapy due to the organ-confined nature of the tumor. The postoperative recovery of the patient was good. Regular clinical follow-up was conducted for 12 months, and the patient had no evidence of local recurrence or distant metastasis.

Discussion

A variety of mass lesion may mimic drainable abscesses. This can lead to misdiagnosis of these entities, unnecessary percutaneous placement of a drainage catheter, and delay in appropriate treatment of the patient. In a retrospective analysis of 180 patients operated for renal cell carcinoma in 1997–2001. In 11 (6.1%) patients (8 men and 3 women, age 40–76 years, mean age 60 years) SRCC was present. Two of these 11 patients presented with atypical clinical picture imitated abscess of the kidney and calculous pyonephrosis.[3] Our case reinforced that in spite of the clinical signs of inflammatory disease of the kidneys, a tumorous origin should be excluded. Appropriate recognition of these entities is essential for optimal patient care.

References

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Figure 1