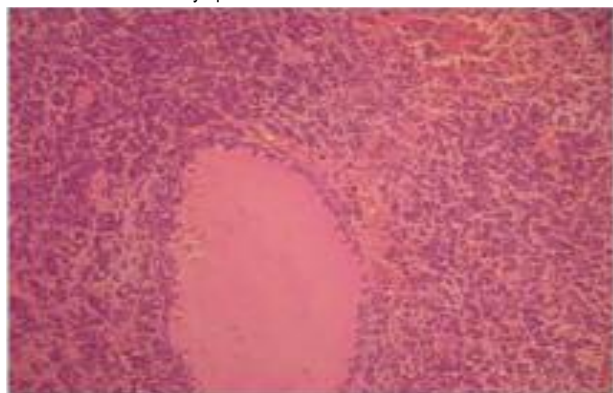


Figure 2 : Ovarian small cell carcinoma, hypercalcemic type. Prominent follicle-like spaces filled with eosinophilic fluid are present. Tumor cells are round and have scant cytoplasm.



Conclusion

The combination of hypercalcemia and an ovarian mass in premenarchial girls should awaken the suspicion of SCCOHT. SCCOHT had a malignant potential tumor with poor prognosis and complete surgical resection is strongly recommended, even in case of unsuspected diagnosis before surgery. Aggressive chemotherapy after surgery seems to be mandatory.

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Nephrogenic adenoma of the bladder associated with urinary tuberculosis

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The nephrogenic adenoma (NA) constitutes an uncommon benign metaplasia of the urothelial mucosa (1). It is probably underestimated in literature. NA can occur anywhere in the urinary tract, but the most frequent localization was the bladder (3). Our clinical case represents the 9th (1,2,4) report of a NA within an urinary bladder with history of urinary tuberculosis.

The aetiology of NA remains unclear; however, it has been linked to chronic irritating factors, such as trauma, chronic infection, urological surgery, urinary stones, irradiation, urinary catheterization or repeated instrumentation for diagnostic or therapeutic purposes and chemical

agents, such as Bacille Calmette-Guerin (3-5). The clinical and the endoscopic appearance of NA are not specific. It can be clinically as well as morphologically mistaken for malignancy of the bladder (5).

Thus, the definite diagnosis is anatomopathological. It is characterized by the presence of ducts lined with epithelium combined with the absence of atypia and mitotic activity. Immunohistochemical staining for nuclear transcription factor for renal development (PAX2) is useful to rule out others diagnosis such as prostatic adenocarcinoma, benign urothelium and urothelial carcinoma (3).

There have been no reports of NA malignant transformation or metastatic lesion (4,5).

NA is mainly treated by transurethral electroresection and administration of antibiotics in case of urinary tract infections (5). In spite of the benign nature of this condition, patients must be closely monitored (urine cytology, ultrasound and cystoscopy) because the rate of recurrence of NA is high (4,5).

Herein, we report a new case of NA in the bladder with history of urinary tuberculosis.

This case will be used to discuss diagnostic criteria of NA as well as its morphologic mimics.

Case report

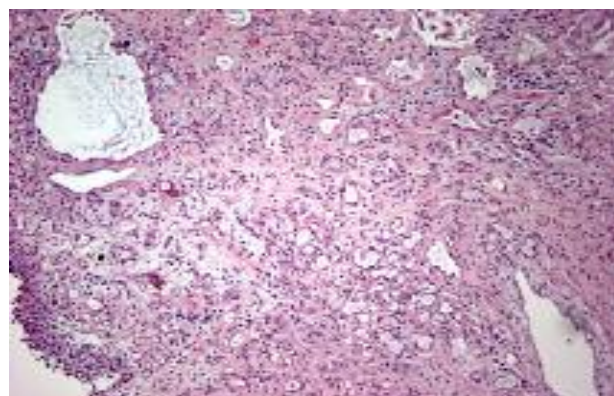
A 46-year-old female was seen for a consultation for intermittent painless gross hematuria for more than 1 month. She had a history of nephrectomy (11 years ago) for staghorn stone with non functioning left kidney, the pathological diagnosis concluded to renal tuberculosis. She was treated with antituberculosis drugs for 8 months.

Physical examination was normal. So were biological routine tests and urine analysis.

An ultrasound revealed a small lesion on the right side of the bladder. Cystourethroscopy disclosed diffuse, papillary, exophytic lesions over the trigone and all urinary bladder walls. A complete transurethral resection of the bladder tumors was performed.

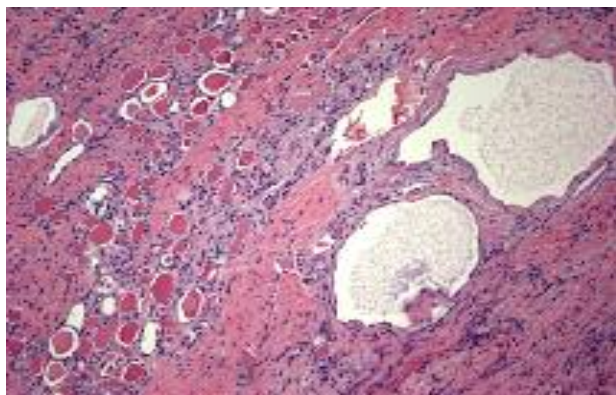
The histological study revealed a tubular proliferation with rare edematous polyps. The tubules are small round structures lined by cuboidal epithelium (Fig. 1).

Figure 1 : Microscopic findings of nephrogenic adenoma show tubular structures lined with hobnail cells (H. & E. stain, × 100).



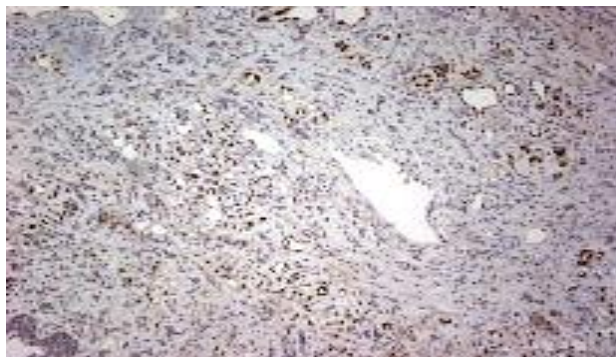
Cystic dilatation of the tubules is observed. Tubules and cysts contain focally eosinophilic secretions "colloid like" (Fig. 2).

Figure 2 : Tubules and cysts contain focally eosinophilic secretions "colloid like". (H. & E. stain, x 250)



Most tubules and cysts with have flattened cuboidal cells without atypia. But some tubules are lined with hobnail cells. Mitotic figures are absent. Tumor cells were positive with PAX2 (Fig. 3).

Figure 3 : Nuclear positivity of tumoral cells for PAX2 (IHCx100)



We followed up the patient 24 months after the initial diagnosis of NA. During this time, he didn't relapse. On imaging, there was no evidence of masses involving the bladder wall. Currently, the patient is asymptomatic, undergoes regular check-ups for the bladder tumor and urinary tuberculosis.

Conclusion

Nephrogenic adenomas of the bladder are rare benign lesions that should not be viewed as a premalignancy. Treatment consisted in endoscopic resection and regular follow-up.

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Colo-colonic intussusception secondary to a colonic lipoma : Report of two cases

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Intussusception is well recognized in children but only 5% of reported cases are in adults (1, 2, 3). In two-third of adult cases, intussusception is caused by a malignant tumour, with benign tumours accounting for only a few (1). We present two rare cases of symptomatic submucosal lipoma of the ascending colon causing intestinal obstruction that were surgically resected.

Case reports

Patient HZ, a 49-year-old man was seen because of painful umbilical hernia. There was history of abdominal distension and constipation a few months ago. On physical examination; distended abdomen and protruding and deformed umbilicus were detected. The swelling was tender and irreducible. Bowel sounds were normal. Urgent surgery was performed.

An incarcerated omentum in the umbilical defect was found, the bowel was viable. The non viable omentum was resected, and herniorrhaphy was performed for the fascial defect. Immediate postoperative outcome was uneventful.

Ten days later he complained of colicky abdominal pain, distension, and increasing constipation. An urgent CT scan outlined a soft tissue mass in relation to hepatic flexure with ring-like appearance of contrast around it indicating intussusception. On laparotomy, colo-colic intussusception was found. The intussuscepted bowel was not reduced. Right hemicolectomy according to oncologic principles followed. Histological examination revealed submucosal tumor lesion composed of lobulated mature adipose tissue. After the surgery and 4 years of follow up, no complications were observed.

Patient KN, a 59-year-old woman was admitted because of progressive colicky pains since two weeks. The right upper abdomen was tender without palpable lesions or signs of peritonitis. Laboratory results were normal.

An abdominal CT scan was obtained, revealing a 6-cm low attenuation mass at the hepatic flexure. The fat density and radiographic appearance suggested a colonic lipoma, which appeared to be functioning as a lead point (Figure 1). At laparotomy, colo-colonic intussusception at the ascending colon was found. Right hemicolectomy was performed because it was not possible to reduce the intussusception. The intussusception was caused by a 6 x 5 cm polypoid mass arising from the ascending colon (Figure 2). Pathological examination showed polypoid mass arising from submucosa of the colon with stroma containing mostly fatty tissue consistent with submucosal colonic lipoma, with no evidence of malignancy. The postoperative course was uneventful.