Bilateral Simultaneous Ureteral Tumours

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The aetiology, pathology, clinical aspects and treatment of bilateral ureteral tumours, the role of carcinogenic substances, the pathology of Brunn's cell nests and chronic irritation are discussed. A case of bilateral synchronous ureteral adenocarcinoma is described, unique as far as the site of the tumours, simultaneity and morphological features are concerned. Its clinical manifestations were uraemia and urosepsis.

According to Senger and Furey [24], 86.5 per cent of the epithelial tumours of the urinary organs are seated in the bladder and only 8.4 per cent in the ureter and renal pelvis, although common ureteral tumours are less significant clinically, as suggested by the increasing number of publications dealing with them.

Among Hungarian authors two cases of primary unilateral ureteral carcinoma have been described by Dózza [8], seven by Noszkay [17], one by Palócz [18], one by Szendrői [25], one by Huth, two by Palócz and Lempert, one by Gyarmathy [13], one by Böszörmenyi and Szalay [5] and four by Kondás [15]. There was no adenocarcinoma among these cases and few of this kind could be found in the literature.

Two forms of bilateral ureteral tumours are known: those which appear simultaneously and those appearing with a certain time interval. Asynchronous bilateral tumours were described (one, each) by Utz et al. [28], Felber [9] and Gaca [10]. Barber [4] collected 6 cases of bilateral synchronous ureteral tumour from the literature and added one case of his own.

Having found no report on bilateral ureteral adenocarcinoma we feel justified in describing a case of this kind in the following.

Case history

L. N., male, 44, car-body sprayer. He underwent Billroth II operation for gastric ulcer at the age of 24. He was admitted in 1966 to a country hospital because of left-side colics and fever. Intravenous urography showed at that time no excretion on either side. Laboratory examinations revealed reduced renal activity (clearance 22 and 17 ml/min; NPN 66 and 60 mg%; urine: albumin slightly
opalescent, presence of pus). Fever subsided and colics stopped on antibiotic and spasmolytic treatment. The patient refused urological examination and left the hospital on his own responsibility. Diagnosis in discharge report: acute pyelonephritis; left-side nephrolithiasis (?).

The patient was admitted to our hospital on Oct. 30, 1967, with oliguria and fever. He had felt weak during the last year, taken in more than the usual amount of fluid but had no other complaints. Episodes of haematuria had not occurred. Urination had been frequent during the years preceding admission, but only a few ml of urine were passed on the day of admission. The bladder contained 15 ml of turbid urine.

The first renal colics occurred a year before admission; a strong colic on the left side and vomiting developed 5 days prior to admission. Temperature was 38 °C during the last couple of days. On admission he was dehydrated, pale, anaemic and lean. There was tenderness in the left renal region. Physical examination revealed no other anomaly of the urinary organs. NPN 66 mg%. Urine: albumin slightly opalescent; pus ++; sediment coated with leucocytes and bacteria; 30–40 red blood corpuscles per field, and many crystals. ESR 30–60, later 110–120 mm/hr. Blood pressure 120/70 mm Hg.

Fig. 1. Bilateral ureterectasis