Ureteritis cystica and ureteral polyp—case report

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Abstract: Ureteritis cystica associated with ureteral polyp is a rare urology condition and may be related to ureteral obstruction, therefore needs to be treated accordingly. It may be accompanied by other ureteral pathologies and definitive diagnosis requires biopsy or resection of the lesions. Few similar cases have been described in the literature. We report a case of a patient with simultaneous ureteritis cystica and a benign ureteral polyp that had a satisfactory surgical approach.

Keywords: Ureteritis cystica (UC); ureteral polyp; endourology

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Introduction

Ureteritis cystica (UC), also known as cystic pyeloureteritis, is a rare benign condition due to chronic upper renal tract inflammation (1,2). It is asymptomatic and was initially described in 1761 by the Italian anatomist Giovanni Battista Morggani (2,3). Another rare condition is benign ureteral lesions, as most ureteral tumors are malignant and derived from the urothelium (4,5). The aim of this study is to report the case of a patient with simultaneous UC and a benign ureteral tumor.

Case report

The patient is a 47-year-old female, who complained of a right iliac mild colic pain, with no irradiation, not associated to bladder filling and not related to voiding. Her physical examination did not reveal anything abnormal and ultrasound revealed a hypoechogenic lesion at her right lateral bladder wall. The lesion was 14-mm wide and not vascularized using color Doppler. Urine analysis was normal and urine culture was negative.

Cystoscopy revealed a 14-mm right ureteral lesion that protruded into the bladder during ureteral peristalsis (*Figure 1*). Bladder mucosa was normal. A complete resection of the tumor was done and during rigid ureteroscopy, and several ureteral lesions were identified and interpreted as benign by the attending urologist. Patient recovery was uneventful. Pathology revealed a fibroepithelial benign polyp and interstitial ureteritis with transitional type epithelium-coated glands (*Figure 2*). Urine cytology was negative.

Thirty days after the procedure the patient had a complete recovery of the pain and no urinary symptoms. She was again referred for a control flexible ureteroscopy, which revealed a normal urothelium and no ureteral lesions (*Figure 3*). She is now asymptomatic and is being followed every six months.

Discussion

UC occurs predominantly in women, and is usually localized in the upper renal tract (1,4). The presentation of cystic urethritis associated to a ureteral polyp is very uncommon and usually more than a few ureteral cysts are present (4,6). In this particular case, the patient had a very rare association between cystic ureteritis to a ureteral benign tumor.

UC as initially described by Morgani as a chronic ureteral inflammation. von Brunn soon described submucosal epithelial bodies with descendent proliferation (4). Etiology is uncertain, there are no specific symptoms related to

Figure 1 Ureteral lesion protruding from right meatus.

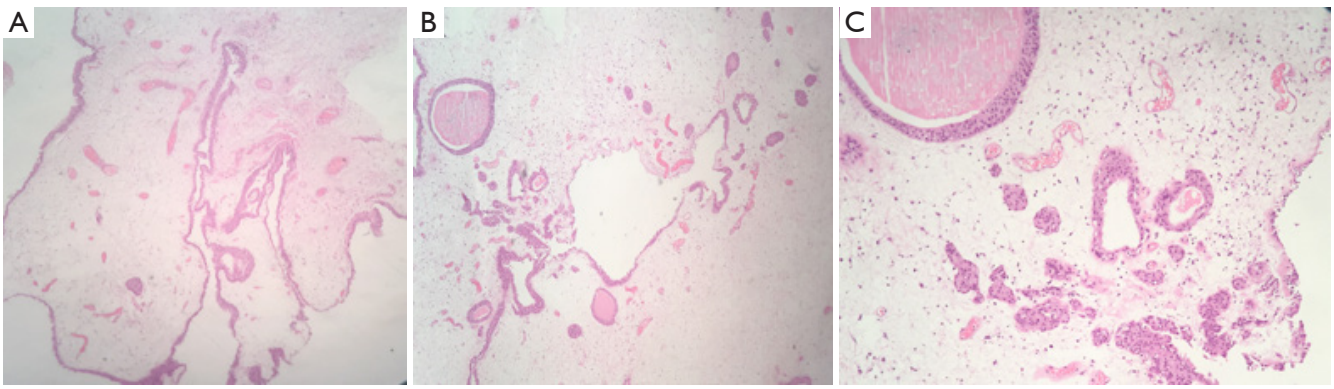

Figure 2 Pathology (H&E staining). (A) Polypoid lesion with epithelial (transitional) lining slightly thickened and dilated and congested vessels, delimited by lymphoplasmacytic infiltrate (magnification: ×100); (B,C) transitional type epithelium-coated glands (magnifications: B, ×100; C, ×200).

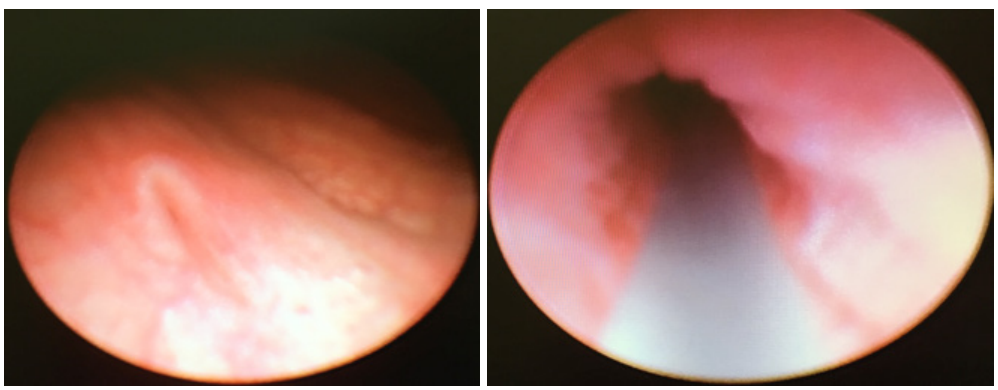

Figure 3 Control ureteroscopy.

the disease and it is usually detected accidentally using screening imaging techniques due to urinary infection, lithiasis and haematuria (1,2,3,7-9).

It can be characterized by a polypoid submucosal growth that may lead to ureteral obstruction. In most cases multiple small cysts are present, usually not big enough to induce ureteral obstruction (9).

Currently, CT scan is the preferred imaging choice,

which allows differentiation of epithelial polyps from other ureteral filling defects. Definitive diagnosis usually requires cystoscopy, ureteroscopy and biopsy or complete resection of the lesions (3,4,6,10).

Several treatments were described, from instillation of antibiotics and other substances, to ureteral dilation, mechanic rupture of the cysts and resection of the polyps. Recently, a more conservative protocol has been proposed, when the patient is asymptomatic and lesions do not induce infection or obstruction (4).

Our patient had both rare ureteral conditions, which may be from the same pathological origin. Of note, our patient was treated for the ureteral lesion and no specific treatment was done for ureteral cystitis. We were surprised to see how well she recovered and how her ureter was endoscopically normal during control ureteroscopy. One could argue that removing the fibroepithelial lesion treated obstruction, which was the trigger for ureteral cystitis (1,10).

Acknowledgements

None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

Informed Consent: Written informed consent was obtained from the patient for publication of this manuscript and any accompanying images.

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