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Case Report

Laparoscopic Bilateral Nephroureterectomy and Bladder Cuff Excision for Native Renal Pelvic and Ureteral Transitional Cell Carcinoma after Renal Transplantation

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Abstract:
A 37-years-old female who was suffering from end-stage renal disease for about 6 years received allograft renal transplantation 4 years ago. She has been receiving 50mg Cyclosporin A orally daily for immuno-suppression since then. Gross haematuria was noted and computerised tomography showed native left renal pelvic and ureteral multi-focal transitional cell carcinoma with severe hydronephrosis. Laparoscopic bilateral nephroureterectomy and bladder cuff excision were performed. In the past, history of previous operation was considered a relative contraindication for laparoscopic surgery. To our knowledge, we present the first case of laparoscopic treatment for native renal pelvic and ureteral transitional cell carcinoma after renal allograft transplantation without a hand-assisted device. This case shows the feasibility of laparoscopic bilateral nephroureterectomy in patients with transplanted kidneys. (J Postgrad Med 2003;49:148-150)

Key Words: Carcinoma, transitional cell, kidney transplantation, laparoscopy

Renal transplant recipients need long-term immunosuppressive therapy and it is, thus theorised that they are prone to develop malignant diseases. As much as 10% of allograft recipients are estimated to develop malignant tumours.1 However, transitional cell carcinoma arising from the native renal pelvis after a renal transplantation is still very rare. To our knowledge, we present the first case of laparoscopic treatment for native renal pelvic and ureteral transitional cell carcinoma after renal allograft transplantation without a hand-assisted device.

Case History
A 37-years-old female suffering from end-stage renal disease the past 6 years had received allograft renal transplantation 4 years ago. She was on 50mg Cyclosporin A orally daily for immuno-suppression since then. Gross haematuria was noted since 2 months. Cystoscopy revealed left ureteral transitional cell carcinoma protruding into the urinary bladder through the left ureteral orifice. Computerised tomography showed native left renal pelvic and ureteral multi-focal transitional cell carcinoma with hydronephrosis. Open nephroureterectomy and bladder cuff excision was suggested. Due to her strong desire to minimize the second operative scar, she was referred to our hospital for laparoscopic surgery.

Magnetic resonance imaging (Figure 1) was performed to delineate the tumour progression. Atrophy of right kidney was noted. Bilateral laparoscopic nephroureterectomy was successfully performed through transperitoneal approach by a 4-trocar technique. The left kidney and ureter were pulled out through a 6 cm. incision over her previous left lower abdominal scar for renal transplantation and left bladder cuff excision was done through this wound by open method. Right kidney and ureter were removed from the same wound after laparoscopic excision.

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Because recipients of renal transplant need long-term immunosuppressive therapy, as much as 10% of allograft recipients are estimated to develop malignant tumours.

Figure 1: MRI showing advanced renal pelvic and ureteral transitional cell carcinoma over native renal pelvis and ureter
of right bladder cuff.

The pathologic examination revealed multiple transitional cell carcinoma extending from left side renal pelvis to the whole ureter with grade III/IV (stage T2N0M0). Atrophy of right kidney with in-situ transitional cell carcinoma extending from right renal pelvis to the upper part of ureter was also noted (Figures 2 & 3). Surgical margins of the specimen were free of tumour. The total operation time was 5 hours and 15 minutes. The intraoperative bleeding was about 500 ml. Patient was discharged 6 days after operation. However, a small recurrent bladder tumour was noted 6 weeks later by cystoscopy. Transurethral resection of the recurrent tumour in the bladder was done and it was found to be transitional cell carcinoma (grade II/IV, stage T1). After 6 months of followup with cystoscopy and computerised tomography, there was no evidence of tumour recurrence. Her creatinine was 1.1 mg./dl. Chemotherapy was suggested but the patient refused.

**Discussion**

The incidence of malignancy following organ transplantation has been reported to be three times the excepted incidence for the general population.\(^2\) It was reported that the incidence of transitional cell carcinoma in a renal transplant population is about 0.8%.\(^3\) However, in our case, it is difficult to determine whether the tumour occurred before or after the renal transplantation.

In the past, history of a previous operation was considered a relative contraindication for laparoscopic surgery because of the possibility of tissue adhesions that would obscure surgical landmarks. In our case, there were severe adhesions in the retroperitoneal space near the middle third and lower third of left ureter due to previous renal transplantation. Chueh et al. reported their experience of hand-assisted laparoscopic bilateral nephroureterectomy on four patients with normal graft function after renal transplantation.\(^4\) They made a 7.5 cm long infraumbilical midline incision for a hand-assisted device instead of using the previous incision for renal transplantation. Our case proves that laparoscopic bilateral nephroureterectomy in patients with transplanted kidneys is possible without a hand-assisted device. Actually, the magnification of laparoscopy makes dissection between adhesive tissues easier and it is possible to safely dissect out the native ureter without damaging the transplanted kidney.

Complete native genitourinary exenteration with ileal conduit has been reported for synchronous multi-focal transitional cell carcinoma after renal transplantation.\(^5\) However, this technique reduced the quality of life and patient’s intention to undergo surgery. In this case, we decided to preserve her urinary bladder. The best therapy for transitional cell carcinoma after renal transplantation still remains controversial.

**References**


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**Announcement**

**Participate in the peer review process**

Peer review is an essential part of the scholarly communications process and an honourable and time-tested way of ensuring high-quality scholarship in the sciences. This tradition of volunteering and collegiality continues in JPGM. Referees read manuscripts submitted for publication, evaluate them and recommend to the editors whether or under what conditions they should be published. The process is anonymous; only the editors know the identity of the authors and referees.

The Journal of Postgraduate Medicine and its editors invite members of the scientific community to contribute to the process of improving the quality of scientific communication in particular and science, in general. Please return the attached application to help us understand your areas of expertise. This can be sent via email to editor@jpgmonline.com or via post to the Editorial Office in Mumbai.

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