LETTERS TO EDITOR

CAPILLARY HEMANGIOMATOUS POLYP IN ANTERIOR URETHRA

Sir,

Urethral hemangioma is an unusual entity. Its exact incidence is not known; however, in a Russian study of 107 benign tumors of the male urethra, polyps constituted 22.4% and angioma, 10.4%. We report an unusual case of capillary hemangiomatous polyp in the anterior urethra.

A 60-year-old man presented with dysuria and obstructive urinary symptoms of 2 months’ duration. On examination, he had a polypoid lesion protruding from the urethral meatus [Figure 1]. Urine microscopy showed hematuria and leukocyturia. All other laboratory parameters were within normal limits. Urethroscopy revealed a 32-mm solitary pedunculated lesion arising from the ventral aspect of the glanular urethra. Rest of the urethra and the bladder was normal.

The lesion was excised after applying tourniquet to the proximal penis. Histology showed pure capillary hemangioma [Figure 2].

Urethral hemangioma is a benign disease, believed to be of congenital origin, arising from the embryonic rest of unipotent angioblastic cells that fail to develop into normal blood vessels. Mean age of presentation is 22 years (range 3-68 years). Young age at presentation is expected; however, it is reported even at the age of 68 years. The common presentation is of bloody urethral discharge. Frank hematuria and urinary retention are also noted, depending on the site and number of lesions. Urethral bleeding is common when hemangioma occurs in the distal urethra, while hematuria is common in the membranous or proximal urethra. Our patient presented with voiding symptoms. Urethral hemangioma can be localized in a small or extensive area and can occur as single or multiple lesions. Unlike in our patient, cavernous hemangioma is the commonest variety in the distal urethra. The extent of lesion is much more than what is seen, and

Figure 1: Preoperative appearance of urethral hemangioma

Figure 2: Microphotograph: stroma showing closely packed proliferative small vascular channels lined by bland-appearing endothelial cells, consistent with capillary polypoid hemangioma (H and E, x10).

S. V. KANDASAMI, M. ARUL, P. KATHAMUTHU, S. B. VISWAROOP, D. ANANDA KUMAR

Vedanayagam Hospital, Coimbatore, Tamil Nadu, India

E-mail: akendouro@gmail.com

REFERENCES

left-sided consolidation, along with central bronchiectasis [Figure 1]. On further evaluation, the patient also gave history of recurrent nasal discharge for 25 years, which persisted despite long-term medical treatment. Nasal examination demonstrated an edematous nasal mucosa, nasal polyp and thick mucus. CT scan of the sinuses revealed hyperdense lesion in the left ethmoid and maxillary sinus without any bony erosion, along with deviated nasal septum on right side [Figure 2]. Functional endoscopic sinus surgery was performed with a left-sided polypectomy and maxillary antrostomy. Microscopic examination of material from maxillary sinus showed allergic mucin with eosinophils, and culture grew *Aspergillus species*. Thus he was diagnosed as a case of ABPA with AFS and was started on a single daily dose of 40 mg prednisolone (0.5 mg/kg), along with topical nasal steroid by inhalation, montelukast sodium (10 mg/day) and inhaled salmeterol with fluticasone dipropionate 500 mcg two times per day from a metered dose inhaler. At the present time, the patient continues to do well.

All asthmatics with a positive skin-prick test to aspergillus antigens must be evaluated for ABPA.[3] AFS is a noninvasive form of fungal sinusitis that is seen in highly atopic individuals with *Aspergillus*-specific IgE, intractable sinusitis and nasal polyposis.[4] While the diagnosis of AFS is primarily based on histopathology, roentgenology is essential for the diagnosis. Haziness of one or more paranasal sinuses is almost always seen on plain roentgenograms. However, CT offers more reliable information with characteristic features that include heterogeneous densities and serpiginous areas of increased attenuation.[5] Since asthma and sinusitis are often seen by two different specialties, the occurrence of AFS in ABPA and ABPA in AFS may easily be overlooked. Therefore, a high index of suspicion is required for the diagnosis of AFS, and a patient with history of asthma and/or rhinitis should be investigated for ABPA and/or AFS.

REFERENCES


R. PRASAD, R. GARG, SANJAY, RUCHI DUA
Department of Pulmonary Medicine, King George's Medical University, Lucknow, India

Correspondence:
Dr. R. Prasad, Department of Pulmonary Medicine, King George's Medical University, Lucknow - 226 003, India. E-mail: rprasad2@sancharnet.in