Association of a renal papillary carcinoma with a low grade tumour of the collecting ducts

L Daniel, H Zattara-Cannoni, E Lechevallier, J F Pellissier

Abstract
This case report describes a 75 year old man who had a renal papillary carcinoma associated with a low grade tumour of the collecting ducts. These tumours showed different immunohistochemical patterns for epithelial membrane antigen, cytokeratin 19, and *Ulex europaeus* lectin expression. In addition, cytogenetic findings were 47, XY, +7<7> and 45, XY, −8, add(12)(q−ter)<10> for the papillary renal carcinoma and the low grade tumour of the collecting ducts, respectively. This is the first report where these two types of tumour are associated and cytogenetically distinguished.

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Dysplasia of the renal tubules is well described but only for the collecting duct subtype of renal cell carcinoma. Despite this fact, low grade tumours of collecting ducts have rarely been reported. Conversely, large series demonstrate that patients with collecting duct tumours usually have a poor prognosis, with a mean survival of less than two years. We report for the first time the association of a renal papillary carcinoma with a low grade tumour of the collecting ducts.

Figure 1  Computerised tomography with intravenous contrast showing two hypointense renal tumours.

Figure 2  Macroscopic examination: the two tumours show a grey heterogeneous cut surface (arrow) and a white homogeneous cut surface (asterisk).
The Alcian blue stain was slightly positive within the stroma. The cells were immunoreactive for CK7, CK19, and UEA-1 (fig 3F). No immunoreactivity was seen for vimentin and EMA. Mib-1 immunoreactivity was low, equivalent to that of normal neighbouring tubules. Cytogenetic analysis showed two different abnormalities, which were 47, XY, +7 <7> and 45, XY, −8, add(12)(q–ter)<10> (fig 4) for the renal papillary carcinoma and the low grade tumour of the collecting ducts, respectively. The patient was followed up for two years without the occurrence of metastasis. He died from cerebral stroke.

**Discussion**

Distinction of collecting duct carcinomas from renal papillary carcinomas can be difficult because both tumours often show a predominant tubulopapillary pattern; this differential diagnosis occurred in this case. For the 1.5 cm diameter right tumour, the location near the medulla, the features of dilated tubules with hobnail cells, and the lack of papillae account for the origin from the collecting ducts. Furthermore, the tumour cells expressed UEA-1 and CK19, which are markers for collecting duct carcinomas and not for renal papillary tumours. In addition, collecting duct carcinomas show variable staining, which is generally more intense for high molecular weight keratins than is seen in other subtypes of renal carcinoma, including papillary renal tumours. We also excluded the diagnosis of cystic nephroma because of the lack of both flattened cuboidal cells and sharp septa within the tumour.

In our case, the well defined borders, the lack of desmoplasia and infiltration into renal parenchyma, and finally the low index of proliferation supported the hypothesis of a low grade tumour. Conversely, the cytogenetic characteristics of low grade tumour of the collecting ducts are not well established, but by using polymorphic microsatellite markers Polascik et al found frequent loss of heterozygosity in chromosome arm 8p. Our case supports the involvement of chromosome 8 in such tumours. Ectopic
pancreas was probably an incidental finding, although anecdotal congenital syndromes associate ectopic pancreas and renal cysts.

Low grade carcinomas of the collecting ducts have already been reported in association with benign tumours, such as the metanephric adenofibroma. Nevertheless, our present case is of particular interest, showing the previously undescribed association between a renal papillary carcinoma and a low grade tumour of the collecting ducts with cytogenetic findings. This association is a new finding and accounts for the existence of low grade collecting duct carcinomas.


Figure 4  Karyotype of the low grade tumour of the collecting ducts showing monosomy 8 and supplementary material on the long arm of chromosome 12: add(12)(q–ter). Other chromosomal losses are random.
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