# A case of adenocarcinoma with clear cell carcinoma of the bladder

**Author(s)**
ITO, Kazuto; YAMANAKA, Hidetoshi; ICHINOSE, Yoshio; KURIHARA, Jun

**Citation**
泌尿器科紀要 (1999), 45(9): 637-640

**URL**
http://hdl.handle.net/2433/114116

**Type**
Departmental Bulletin Paper

**Textversion**
publisher

**Department**
Kyoto University
A CASE OF ADENOCARCINOMA WITH CLEAR CELL CARCINOMA OF THE BLADDER

Kazuto ITO and Hidetoshi YAMANAKA
From the Department of Urology, Gunma University School of Medicine

Yoshio ICHINOSE and Jun KURIHARA
From the Department of Urology, Haramachi Red Cross Hospital, Agatuma, Gunma

A case of adenocarcinoma with clear cell carcinoma of the bladder in a 65-year-old male is reported. Our patient had a walnut-sized nodular tumor located on the anterior wall of the bladder. The patient underwent radical cystoprostatectomy with urethral hemi-Koch pouch. Histopathological examination revealed a lesion composed of poorly differentiated adenocarcinoma and clear cell carcinoma with diffuse sheet patterns of cells with abundant, clear cytoplasm. The patient died of general metastasis 18 months after operation. To our knowledge this is the first case of adenocarcinoma with clear cell carcinoma arising from the anterior wall of the bladder in a male.


Key words: Clear cell carcinoma, Adenocarcinoma, Bladder

INTRODUCTION

Primary adenocarcinoma of the bladder is the third most frequent histologic type of all bladder carcinomas, and comprises only 0.5 to 2.0%1). Clear cell carcinoma, so-called mesonephric adenocarcinoma by Schiller2), is an uncommon histologic variant of adenocarcinoma typically found in the female genital tract, and is rarely found in the urinary bladder. There have been only 14 reported cases of pure forms of clear cell carcinoma of the bladder4-13). This case was a combination of clear cell carcinoma and adenocarcinoma of the bladder. Only one such case, in a woman, has been reported previously14). We report the first case of adenocarcinoma with clear cell carcinoma of the male, and review the literature.

CASE REPORT

A 65-year-old Japanese male with no prior urological problems was referred for evaluation of urinary frequency and gross hematuria. He had been treated for type 2 diabetes mellitus with dietary food and had been taking prazosin for treatment of hypertension. Physical examination revealed no unusual findings. Blood count and serum findings were normal. CA19-9, CEA and AFP were normal. Urinalysis showed 30 to 40 red blood cells and 10 to 15 white blood cells per high power field. Urinary cytology was unremarkable. An excretory urogram suggested a left renal cyst, which was confirmed by ultrasound and computed tomography, and showed an irregular space-occupying lesion of the bladder dome. An outpatient cystoscopic examination in May 1993 revealed a yellowish, non-papillary, nodular, pedunculated tumor on the anterior wall of the bladder. Computed tomography showed a nodular, pedunculated tumor (5×4 cm) with calcification on the anterior wall of the bladder.

Fig. 1. Computed tomography showed a nodular, pedunculated tumor (5×4 cm) with calcification on the anterior wall of the bladder.

Fig. 2. Clear cell carcinoma with diffuse sheet patterns of clear cells containing abundant, clear, glycogen-rich cytoplasm surrounding the nucleus (H & E, original magnification ×400).
Urology, Japan, vol. 45, no. 9, 1999


fication on the anterior wall of the bladder (Fig. 1). The bladder wall was not thickened. Neither lymph node metastasis nor distant metastasis was noted. A chest radiograph showed no evidence of metastasis. On June 7, transurethral resection of the tumor was performed. Microscopically, transurethral resection of the tumor revealed a combination of two components. One component was clear cell carcinoma with diffuse sheet patterns of clear cells containing abundant clear glycogen-rich cytoplasm surrounding the nucleus (Fig. 2). The other component was adenocarcinoma with a poorly-differentiated, nonspecific glandular pattern lined by tumor cells with hyperchromatic nuclei (Fig. 3). Cellular pleomorphism was minimal in both components. Invasion into the muscularis propria was seen. Random bladder biopsies were unremarkable. Because of a suspected underlying malignancy, the patient underwent radical cystoprostatectomy, and pelvic lymphadenectomy with urethral hemi-Koch pouch. No macroscopic metastasis was noted. At cystectomy, a 4 × 5 cm tumor was present in the area of the anterior wall. The tumor showed poorly-differentiated adenocarcinoma. The tumor was found in the muscularis propria, but not outside of the bladder. Eleven pelvic lymph nodes were not invaded by the tumor. Immediate postoperative progress was satisfactory. The patient was discharged from the hospital on August 2. Maximal urinary flow rate was 24 ml per second, average urinary flow rate was 12 ml per second, and volume was 250 ml at 6 months postoperatively. CA19-9 increased at 8 months postoperatively. Computed tomography revealed cervical, and abdominal lymph

Fig. 3. Adenocarcinoma with a poorly-differentiated nonspecific glandular pattern lined by tumor cells with hyperchromatic nuclei (H & E, original magnification ×100).

<table>
<thead>
<tr>
<th>No.</th>
<th>Case</th>
<th>Age</th>
<th>Sex</th>
<th>Symptom</th>
<th>Location</th>
<th>Treatment</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dow et al. 1968</td>
<td>43</td>
<td>M</td>
<td>Frequency, Hematuria</td>
<td>Bladder neck, Lateral wall</td>
<td>TUR; EBRT; Radical cystectomy</td>
<td>DWD at 1y.</td>
</tr>
<tr>
<td>2</td>
<td>Misaki et al. 1976</td>
<td>64</td>
<td>F</td>
<td>Urinary retention</td>
<td>Bladder neck</td>
<td>TUR; EBRT</td>
<td>unknown</td>
</tr>
<tr>
<td>3</td>
<td>Skor et al. 1977</td>
<td>54</td>
<td>F</td>
<td>Frequency</td>
<td>Bladder neck</td>
<td>Radical cystectomy</td>
<td>NED at 2y.</td>
</tr>
<tr>
<td>6</td>
<td>Anderstrom et al. 1983</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>Radical cystectomy</td>
<td>DWD at 1y.</td>
</tr>
<tr>
<td>7</td>
<td>Pegoraro et al. 1983</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>EBRT</td>
<td>NED at 2y.</td>
</tr>
<tr>
<td>8</td>
<td>Schultz et al. 1984</td>
<td>70</td>
<td>F</td>
<td>Frequency</td>
<td>Bladder neck</td>
<td>Pelvic exenteration</td>
<td>NED at 10m.</td>
</tr>
<tr>
<td>10</td>
<td>Yamashita et al. 1986</td>
<td>62</td>
<td>F</td>
<td>Gross hematuria</td>
<td>lt. Ureteral orifice</td>
<td>TUR</td>
<td>unknown</td>
</tr>
<tr>
<td>11</td>
<td>Ikemoto et al. 1986</td>
<td>61</td>
<td>F</td>
<td>Gross hematuria</td>
<td>Posterior wall, Trigone</td>
<td>Partial cystectomy</td>
<td>NED at 5m.</td>
</tr>
<tr>
<td>12</td>
<td>Al-lzzi et al. 1989</td>
<td>62</td>
<td>F</td>
<td>Gross hematuria</td>
<td>Posterior wall</td>
<td>Radical cystectomy</td>
<td>NED at 2y.</td>
</tr>
<tr>
<td>13</td>
<td>Funabashi et al. 1990</td>
<td>73</td>
<td>F</td>
<td>Urinary retention</td>
<td>Bladder neck, Anterior, posterior wall</td>
<td>Pelvic exenteration</td>
<td>unknown</td>
</tr>
<tr>
<td>14</td>
<td>Butterworth et al. 1990</td>
<td>53</td>
<td>M</td>
<td>Gross hematuria</td>
<td>Anterior, Lateral wall</td>
<td>Radical cystectomy</td>
<td>NED at 14m.</td>
</tr>
<tr>
<td>15</td>
<td>Kuwabara et al. 1993</td>
<td>67</td>
<td>M</td>
<td>Gross hematuria</td>
<td>Trigone, Lateral, posterior wall</td>
<td>Radical cystectomy</td>
<td>DWD at 18m.</td>
</tr>
<tr>
<td>16</td>
<td>Present case 1999</td>
<td>65</td>
<td>M</td>
<td>Frequency, Gross hematuria</td>
<td>Anterior wall</td>
<td>Radical cystectomy, Chemotherapy</td>
<td>DWD at 18m.</td>
</tr>
</tbody>
</table>

TUR: transurethral resection of bladder tumor; EBRT: extrabeam radiation therapy, DWD: died with disease; NED: no evidence of disease.
node metastases. He received 3 courses of cisplatin and etoposide. CA19-9 decreased slightly after chemotherapy, but the patient died of generalized metastasis less than 18 months after the operation.

**DISCUSSION**

Clear cell adenocarcinoma, so-called mesonephric adenocarcinoma, is an extremely rare primary tumor of the bladder. The appellation “clear cell adenocarcinoma” is used for these cases because of their histopathologic similarity to clear cell adenocarcinoma of the female genital tract. The origin of clear cell adenocarcinoma is disputed. Many reported cases have been designated as “mesonephric adenocarcinoma” despite the lack of convincing evidence for a mesonephric origin. Some investigators have proposed that clear cell carcinoma is the malignant counterpart of the nephrogenic adenoma, but the arguments in support of this conception are not convincing.

There have been 15 cases reported in the literature. The clinical features are presented in Table 1. There was a 5-to-2 female predominance and the age of the patients ranged from 43 to 73 years, mean 61.2 years. The tumors were located in the posterior wall, ureteral orifices, trigone, and neck of the bladder, and were of mesodermal origin. Only 2 cases were located (except for those of mesodermal origin) on the anterior and lateral wall of the bladder. Transurethral resection appears to be an inadequate treatment in most cases, and 10 patients required radical cystectomy or pelvic exenteration.

It is known that clear cell carcinoma is an uncommon histologic variant of adenocarcinoma, and is typically found in the female genital tract and rarely found in the urinary bladder. Histologically, it is composed of tubules, papillary and solid patterns in which characteristic malignant clear and hobnail cells are found in varying proportions. The consensus reflected in the more recent literature is that it is a malignancy of Mullerian origin. Since the present case was located in the anterior wall of the bladder and had components of both adenocarcinoma and clear cell carcinoma, the origin of this case is unknown. Al-Izzi reported the only such case, in a woman, in 1989.

In the present case, CA19-9 was normal at preoperative evaluation, though it increased with the spread of the tumor, and decreased after chemotherapy with cisplatin and etoposide. CA19-9 was not useful for first line screening, but it is possible that a continuous follow-up of CA-19-9 may be important. A standard treatment method of clear cell carcinoma of the bladder has not yet been established. In the present case, delayed chemotherapy at metastasis could decrease CA19-9 slightly. Thus, it is possible that neoadjuvant and adjuvant chemotherapy would be necessary in such a case.

**REFERENCES**

2) Schiller W: Mesonephroma ovarii. Am J Cancer 35: 1, 1939
15) Sorensen FB, Jacobson F, Nielsen JB, et al.: Nephroid metaplasia of the urinary tract, a survey of the literature, with the contribution of new immunohistochemically studied cases, including one case examined by electron microscopy. APIMS [A] 95: 67-81, 1987

(Received on March 23, 1999       Accepted on June 11, 1999)
和文抄録

明細胞癌を伴った膀胱腺癌の1例

群馬大学医学部泌尿器科学教室（主任：山中美喜教授）

伊藤一人、山中英喜

原町赤十字病院泌尿器科（部長：栗原潤）

一ノ瀬義雄、栗原潤

65歳の男性に発生した膀胱の明細胞癌を伴った腺癌の1例を報告する。腫瘍はクルミ大で膀胱前壁に存在した。根治的膀胱全摘除術、尿道吻合セミコックバウチ造設術を行った。病理組織所見は明細胞癌の成分を伴った低分化腺癌であった。術後18ヶ月で全身転移をきたし死亡した。腫瘍が前壁に位置し、明細胞癌と腺癌の成分を伴う腫瘍は非常に珍しく本症例が最初の報告である。

（泌尿誌 45：637-640, 1999）