

Letter to the Editor

Sarcomatoid Chromophobe Renal Cell Carcinoma

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Dear Editor,

We read with great interest and attention the recent paper by De La Parra and co-authors on the sarcomatoid transformation of chromophobe renal cell carcinoma.^[1] In the review of the literature, these authors incorporate 10 cases of this uncommon condition including two own cases (their Table 1). However, the article of Akhtar et al.^[2] and the work of our group^[3] on this kind of tumor are missing.

The first case of sarcomatoid chromophobe renal cell carcinoma was published by Akhtar et al. in 1996.^[2] The patient, a 64-year-old woman, was admitted because of a six-month history of right upper quadrant pain and a mass in the right flank. Ultrasound and CT scan of the abdomen showed a large mass invading the anterior portion of the kidney. A chest radiograph revealed a questionable metastatic lesion in the right lung. A radical nephrectomy was performed. The nephrectomy specimen weighed 1050 g. The kidney was extensively replaced by a multinodular, firm, well delimited, 7x5x4 cm mass. Pathologic diagnosis was sarcomatoid chromophobe renal cell carcinoma showing presence of equal proportions of carcinoma and sarcomatoid component. The carcinoma component was positive for colloidal iron acid stain, cytokeratins (CKs) 8,18,19, and epithelial membrane antigen (EMA). One year later, she was readmitted. Ultrasound examination of the abdomen revealed enlargement of para-aortic and mesenteric

lymph nodes and massive recurrence of the tumor in the right renal bed. Besides, a metastatic nodule in the right lung and a supraclavicular mass were also present. She was given palliative radiotherapy to the renal bed and then discharged. She did not return for her follow-up visit and was considered dead.

In 1997, we described one case of this aforementioned neoplasm.^[3] A 61-year-old man presented with a six-month history of hematuria. A CT scan revealed an 11 cm hypodense mass with a central scar in the lower pole of the right kidney, suggesting the diagnosis of renal oncocytoma. The patient underwent a right radical nephrectomy. The right nephrectomy specimen weighed 667 g and measured 17x11x7.5 cm. The kidney presented an 11.2 cm light brown mass in the lower pole with hemorrhagic and necrotic foci that infiltrated the renal capsule and the perinephric adipose tissue (pT3aN0M0, stage III UICC). The microscopic study revealed a neoplasm composed of sheets of voluminous polygonal epithelial cells, with a narrow zone of condensation along the cell boundaries and translucent finely reticulated cytoplasm. The nuclei were central and vesicular with some areas where small nucleoli could be identified. 40% of the tumor displayed spindle-shaped and pleomorphic cells with large nuclei and prominent nucleoli and a significant number of mitotic figures (5/10 HPF; where 1HPF = 0.1924 mm²). Epithelial cells showed an intense diffuse reaction of the cytoplasm with Hale's

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acid iron colloid stain. The carcinomatous areas showed positivity for CKs 8,18,19 and EMA. The sarcomatoid areas reacted diffusely for vimentin, alpha-smooth muscle actin, and focally for EMA. A lectin study revealed positivity in the carcinomatous area for *Ulex europaeus*, *Glycine maximum*, *Dolichos biflorus*, and *Bandeiraea simplicifolia*.

The patient was alive and well seven years after diagnosis.

In the present case, the follow-up of seven years is an exceptional observation in a sarcomatoid carcinoma.^[4]

To the best of our knowledge, the case we have presented is the second report of the literature on this kind of tumor.

The authors did not take into account our study with a comparable title. We would like our report to receive appropriate recognition.

Disclosures

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