ABSTRACT

The case of a 50-year-old male presenting with a perivesical tumor is presented. The patient had experienced pain and urinary symptomatology over a period of 3 years. Symptoms were vague and initially manifested as discomfort in the inferior abdomen and perineum. Computerized tomography showed minimal changes in the prostate gland classified as cystic degeneration. Three months earlier the patient had experienced significant progressive pain in the hypogastrium and left iliac fossa that did not let him move the left pelvis along with urinary frequency and urgency. Upon examination, an approximately 15 cm mass was palpated in the hypogastrium. Computerized tomography confirmed the presence of a perivesical mass displacing the bladder and whose periphery was reinforced by the contrast material. A central hypodense image was also visible. Because of uncertainty as to the origin of the mass, complementary transrectal ultrasound was done and showed heterogeneous echogenicity with both cystic and solid areas. Urethrocystoscopy showed obstruction with significant bladder displacement toward the bladder neck. The mass was removed via the abdomen without complications. Postoperative progression was satisfactory and the patient was released after three days. The histopathological study of the specimen reported solitary fibrous tumor. Immunohistochemical study was done later and was positive for vimentin and CD34.

RESUMEN

Se presenta el caso de una tumoración paravesical en un varón de 50 años de edad que producía dolor y sintomatología urinaria. El paciente refería padecimiento de tres años de evolución con sintomatología vaga, inicialmente manifestada por malestar en abdomen inferior y periné. Fue estudiado practicándose tomografía computada que mostró cambios mínimos en la glándula prostática que fueron calificados como degeneración quística. Tres meses previos a consultarnos, cursaba con dolor importante localizado a hipogastrio y fosa ilíaca izquierda, progresivo y que le impedía movilizar el miembro pélvico izquierdo, además de polaquiuria y urgencia miccional. Al explorarlo se palpó masa en hipogastrio de aproximadamente 15 cm. Se practicó tomografía computada que confirmó la presencia de masa paravesical que desplazaba a vejiga y que reforzaba con el contraste en la periferia, además de una imagen hipodensa central. Con la duda del origen de la masa se practicó ultrasonido transrectal complementario descubriendo masa con ecogenicidad heterogénea, con áreas quísticas y otras sólidas. Le realizamos uretrocistoscopia encontrando obstrucción con desplazamiento importante de vejiga y hacia el cuello, procediéndose a extirparla por vía abdominal, la cual se extirpó sin complicaciones. El postoperatorio evolucionó en forma satisfactoria y se egresó a los tres días. La pieza fue referida a estudio histopatológico que reportó tumor...
**Key words:** Solitary fibrous tumor, Perivesical tumor

**INTRODUCTION**

Solitary fibrous tumor was first described in the pulmonary pleura by Klemperer and Rabin in 1931 (1). Other names initially used to describe it were benign fibrous tumor of the pleura or fibrous mesothelioma. Its true mesothelial origin was later proposed by Murria and Scout (2). More recently a large number of cases of histologically similar tumors in different locations have been described and published, including tumors involving the urogenital tract (3-5), the ocular orbit, meninges and breast. This tumor has been reported more frequently in patients between the fourth and seventh decades of life with a slight predominance in women. In relation to urogenital tract lesions, cases have been reported of kidney tumors, paratesticular tumors, seminal vesicle tumors and periprostatic tumors (5-9). They may be asymptomatic and manifested by compression of neighboring organs although paraneoplastic syndromes with degenerative osteoarthropathy and hypoglycemia have also been described (10).

**CLINICAL CASE**

In March of 2006 a 50-year-old male patient sought medical attention complaining of inferior abdomen discomfort of a 3-year progression and slight intermittent pain in the hypogastrium. He had been studied and treated by several physicians. Computerized tomography had reported multi-nodular hypertrophy with degeneration zones in the prostate (Image 1) that was managed conservatively. Symptomatology had exacerbated in the last 3 months presenting with intense and constant stabbing pain localized in the hypogastrium and left iliac fossa that was progressive and ultimately extended to the left pelvic member and increased with walking. Urinary frequency and urgency also presented. The patient had had 5 previous surgeries, the first 12 years earlier for complicated diverticular disease of the colon, requiring temporary colostomy. Later the colostomy was closed and the patient underwent laparotomy for occlusive symptoms from adhesions and two more for abdominal wall plasty. During the physical examination along with the scarring from the previous surgeries a tumor in the inferior hemi-abdomen was palpated of approximately 15 cm in diameter. It was fixed to deep planes and painful when palpated. Rectal examination revealed a small and normal prostate. Laboratory work-up included complete blood count and full blood chemistry, electrolytes, prothrombin time and partial thromboplastin time, all of which were normal. Prostate-specific antigen was reported at 1.02 ng/mL.

Simple contrasted computerized tomography revealed a large 128 x 111 x 101 mm heterogeneous mass that appeared to be dependent on the prostate gland (Image 2). The bladder was greatly displaced. The study was complemented with transrectal ultrasound of the prostate and seminal vesicles because of the uncertainty of the origin of the mass. The study showed a large, 636 cubic cm volume mass and areas of periprostatic infiltration.
of cystic degeneration apparently dependent on the prostate gland (Image 3).

Preoperative urethrocytoscopu revealed a large mass on the right side of the pelvic floor displacing the bladder and bladder neck with no alterations in the bladder mucosa. The prostate gland was partially obstructed. Surgical exploration through a Gibson incision was carried out and the mass was resected without incidence. It was well-defined with a smooth surface and adhered to the prostatic capsule and the posterolateral face of the bladder. The histological evaluation reported a 12 x 11 x 10 cm solid cystic tumor with a fibrous whitish-brown aspect (Image 4). Histological cuts showed a mesenchymatous tumor with the characteristic growth pattern of solitary fibrous tumor (patternless). Immunohistochemistry for CD34 was characteristically positive. Postoperative period for the patient was uneventful and the patient was released on day 3 with a bladder catheter which remained in place for 7 days. The patient has had significant clinical improvement and has been asymptomatic up to the present. He is being monitored as an out-patient. Control tomography was done at 12 months and there was no local recurrence of the tumor.

**DISCUSSION**

In recent years reports of extra-pleural localization of solitary fibrous tumor have appeared in the literature. These types of neoplasm are usually well-defined, frequently encapsulated benign tumors of indolent growth. They can be asymptomatic for long periods of time and can become very large and weigh up to 10 Kg before becoming symptomatic (10). Macroscopically these types of tumor have a smooth external surface of a hard or rubbery consistency and a fibrous aspect. They are yellowish-brown or whitish-grey and can have mixoid, necrotic, hemorrhagic or cystic aspects, as the one in the case presented here. Microscopically two basic growth patterns have been described: solid fusiform and diffuse sclerosant. Some authors have proposed dividing them into benign and malignant categories taking into consideration that the tumors with good prognosis would be the encapsulated and pediculated tumors that can be completely resected and that lack cellular pleomorphism and mitotic activity (11,12). Immunohistochemical studies have consistently demonstrated cytoplasmic positivity for vimentin and CD34. The patient in the present case presented with long-term vague symptoms which suddenly became worse, most certainly due to the considerable growth of the tumor. From a clinical and imaging point of view, this case was a diagnostic challenge due to the doubt about tumor origin. It was first thought to be dependent on the prostate or seminal vesicles especially because of the characteristics seen in the ultrasound and its topographic location.

A large series of 15 patients was published in the Mexican literature in which 13 presented with atypical localization, one of which was paratesticular (10). There have been many publications describing tumors located in the urogenital tract and all of them were a diagnostic challenge despite the ultrasonography, tomography and magnetic resonance studies carried out. The most common sites referred to within the urogenital tract include the seminal vesicles (5-7), prostate (6), kidney (8,12), epididymis (9) and bladder (13). In the clinical case presented here differential diagnosis should have been made with cystic tumors of the seminal vesicle and a magnetic resonance study would have provided greater certainty in tumor localization.

**CONCLUSIONS**

In conclusion it may be stated that solitary fibrous tumor is a rare entity and that its localization in the urogenital tract is exceptional, of difficult preoperative diagnosis...
and even though it is benign in nature it represents a diagnostic and therapeutic challenge. The progression of the case presented here was evaluated during 40 months and tumor growth was demonstrated in the tomographic studies carried out during that period of time. Histopathological and immunohistochemical studies were complementary studies for making the correct diagnosis and defining follow-up.

BIBLIOGRAPHY