Bifocal metanephric adenoma

Abstract
Metanephric adenoma (MA) is a rare benign renal tumor. Diagnostic imagings do not elucidate this diagnosis versus renal carcinoma. We report the case of a woman with history of non-Hodgkin lymphoma. CT scan showed nodules in one kidney, and radical nephrectomy was performed under the appearance of hypernephroma. Two lesions were identified, and the histopathological diagnosis was MA. No other MA has been reported in patients with non-Hodgkin lymphoma. The correct diagnosis of this tumor prevents radical nephrectomy. In the current report we describe two foci of tumor, and being MA usually solitary, its benign characteristics might be more challenging.

Keywords: metanephric adenoma, kidney, bifocal, bifocal renal neoplasm

Introduction
Metanephric adenoma (MA) is a rare benign tumor of renal origin.1-3 First described by Mostofi in 1988, it represents 1% of renal neoplasms.3,4 The mean age of patients with MA is 41 years old, most commonly in the 5th decade.5 Most of the MA-like tumors are detected incidentally by diagnostic imaging, without showing clinical findings. CT scans, ultrasound and MRI imaging do not usually further elucidate a specific image diagnosis of MA versus renal cell carcinoma.1 This concept is relevant, given that initially the malignancy of MA was uncertain, although it almost always has a benign clinical course.6 However, two cases have been reported showing malignant behavior with metastasis.6,7 MA ranges in size, being around 30-60 mm in diameter with the largest being 200 mm.6 This tumor is usually unifocal and unilateral, with few exceptions reported.1,6

Case presentation
A 72-year-old woman with medical history of non-Hodgkin lymphoma in complete remission after chemotherapy underwent routine follow-up. Ultrasound and CT scan identified two echogenic masses in the right kidney. One solid, measuring 3.5 cm; and the other cystic-like 3 cm in diameter. The solid lesion displayed an expansive pattern and hypernephroma appearance. A right radical nephrectomy was performed, under the prior clinical diagnosis of malignant neoplasm. The specimen revealed a 3.5 cm whitish circumscribed mass in the cortex in the lower pole. The cut surface made evident that the mass was separated by fibrous septae.

During the specimen sampling another solid nodular well-defined lesion was observed, located in the upper pole; a 0.8 cm diameter tumor with similar macroscopic features to those described in the former nodule. Furthermore, two renal retention cysts were found (measuring 3 and 1 cm diameter). Histologically, both solid tumors were composed of a highly cellular neoplasm (Figure 1) with basophilic proliferation of small rounded and extremely uniform cells with smooth nuclear contours, scant pale cytoplasm, dark-staining nuclei, and inconspicuous nucleoli. These tumoral cells were arranged into compact ductal and acinic fashion, with glomeruloid and papillary structures. Several psammoma bodies were also identified (Figure 1). Mitotic figures were absent throughout the lesion. The tumor expressed CK AE1AE3, CK18 and Vimentin (Figure 2). Besides, it was EMA, CK7 and WT-1 negative. The final diagnosis was MA.

Figure 1 Well-defined and highly cellular neoplasm (left, HEX100). Several psammoma bodies and papillary structures were identified (right, HEX200).
MA is a rare benign tumor which has not been always well identified. The clinical and morphological features of this lesion should lead to accurate diagnosis, with the aim to deal better with the right treatment. In the current case report we found two tumoral foci, and being MA usually solitary, its benign characteristics might be more challenging, and may need some more clinical and radiological follow-up.

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Conflict of interest

The author declares no conflict of interest.

References