Images – Ureteral fibroepithelial polyps: A modern approach to management

Dylan Hoare, MD; Michael Hobart, MD, FRCSC

Division of Urology, Misericordia Community Hospital, University of Alberta, Edmonton, AB, Canada

Cite as: *Can Urol Assoc J* 2018;12(7):E360-1. http://dx.doi.org/10.5489/cuaj.5001

In November 2016, a 45-year-old male presented to his family physician with undifferentiated left flank pain. There was no evidence of urosepsis or renal dysfunction. He had a remote history of isolated gross hematuria and a negative ultrasound from 2006, but otherwise no appreciable risk factors for urinary pathology.

Initial assessment with ultrasound was once again inconclusive. The abdomen was further evaluated with a triphasic renal computed tomography (CT) scan, confirming the presence of a 7 x 25 mm central filling defect within the proximal right ureter (Figs. 1, 2). Based on the tubular, elongated nature of the filling defect, the presumptive diagnosis of a ureteral fibroepithelial polyp (UFP) was made.

Both semi-rigid and flexible ureteroscopy were performed. A single stalk was identified at the level of the UPJ from which the polyp extended (Fig. 3). Holmium laser was used to incise and photocoagulate the stalk, after which it was excised using rigid biopsy forceps and delivered through the semi-rigid ureteroscope (Fig. 4).

After excision, the base was fulgurated with a laser frequency of 40 Hz. The specimen was delivered for permanent section and histopathological analysis. Pathology was read consistent with a benign fibroepithelial polyp, demonstrating a loose, predominantly fibrovascular stroma covered by a benign urothelium.

With increasing comfort of endourological modalities, the ureteroscopic management of UFPs at the UPJ represents a mainstay of therapy in modern-day urology. In addition, it circumvents the unnecessary morbidity of open and laparoscopic procedures.

Competing interests: The authors report no competing personal or financial interests related to this work.

This paper has been peer-reviewed.

Correspondence: Dr. Dylan Hoare, Division of Urology, Misericordia Community Hospital, Edmonton, AB, Canada; dylanhoare24@gmail.com

Fig.1. Triphasic computerized tomography scan of a coronal image of central ureteric filling defect.

Fig. 2. Triphasic computerized tomography scan of an axial image of central ureteric filling defect.

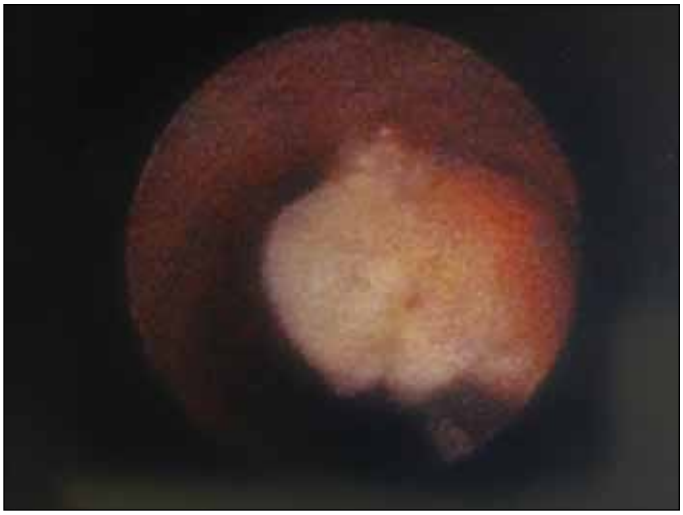

Fig. 3. Endoscopic visualization of ureteric lesion.

Fig. 4. Gross pathology of ureteric lesion.