Fibroepithelial polyp is a benign neoplasm of a mesodermal origin that arises in the wall of the ureter, renal pelvis, bladder or urethra\(^1\). Here we report a case of a fibroepithelial polyp of the ureter in a young adult.

**Case Report**

A 20-year-old girl was admitted to another institution with gross painless hematuria. Her physical examination was within normal limits. Abdominal ultrasound examination demonstrated an echogenic structure with polypoid projections extended into the bladder suggesting bladder tumor (Figure-1). The patient was then referred for cystoscopy to our institution. At cystoscopy a papillary tumor was seen protruding from the left ureteral orifice. An intravenous pyelogram confirmed the above finding and revealed a large obstructing filling defect located in the distal third of the left ureter. Rigid ureterorenoscopy was then undertaken to obtain tissue sample for pathological examination. Ureterorenoscopy of this lesion revealed a polypoid ureteral lesion starting from the distal third of the left ureter and protruding into the bladder, a biopsy of which was done and the remainder protruding part was excised. Pathologic examination of the tissue specimen confirmed a fibroepithelial polyp.

Then the patient lost follow-up. After admitted 5 months later, she underwent an uneventful left ureterotomy and an 8 cm fibroepithelial polyp that stemmed from a single stalk was excised (Figure-2) and a partial ureterectomy with an end-to-end anastomosis was performed. A double-J stent was placed at the end of the procedure and removed 2 months postoperatively. At follow-up, the patient was asymptomatic and had no

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Fibroepithelial Polyp of the Ureter in a Young Adult

Evidence of disease on cystoscopy and IVP for one year.

Discussion

Ureteral fibroepithelial polyps are rare neoplasms(1). These lesions can occur at any age and has been reported even in a neonate(2). Most patients present with hematuria and/or flank pain(1). Ureteral fibroepithelial polyps are usually located in the proximal third of the ureter(1). In our case the polyp was in the distal third of the ureter.

Radiologic appearance is variable according to the gross appearance of the tumor. Intravenous urography may show an intraluminal lesion that is smooth or polypoid and does not cause marked dilatation of the urinary tract. If identification cannot be made by intravenous urography, retrograde and/or antegrade pyelography should be made(3). Preoperative radiologic examination was important in this patient because it directed the proper mode of therapy. Ureteroscopy can differentiate clearly the smooth, regular surface of pedunculated fibroepithelial polyps from the irregular, friable appearance of urethelial carcinoma(4). Appropriate treatment of these tumors is by local excision with or without segmental resection(5).

In our case, the polyp was removed completely with its stalk so that an obstructing base would not be left. Recurrences have not been reported in spite of observations of up to 15 years(3). Although our follow-up is minimal (one year), no recurrence is noted.
REFERENCES


