Despite the unusual site, the symptoms and signs were classified for a glomus tumour. Although rare, it should be considered a part of the differential diagnosis for these symptoms.

J D McIntyre
J Lucas
M A Smith
H McKee[1]

Departments of Trauma and Orthopaedic Surgery and [1]*Histopathology, St. Thomas' Hospital, London, UK*

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Subepithelial haematoma of the renal pelvis (Antopol–Goldman lesion)

Sir: Subepithelial haematoma of renal pelvis is an extremely rare lesion, which was first described by Antopol and Goldman in 1948.[1] This is the 16th case reported in the literature.[2–4]

A 60-year-old man presented with right flank pain and microscopic haematuria. Physical examination was unremarkable. Retrograde pyelogram demonstrated filling defects in the right renal pelvis simulating a neoplasm. The renal pelvic wash and catheterized urine specimens were negative for malignant cells. Computerized tomography revealed a soft (30 HU), hypodense lesion 12×30 mm compressing the proximal ureter and renal pelvis (Figure 1). Right nephrectomy was performed. There was a yellow-grey lesion in the upper pole immediately adjacent to the pelvicaliceal system measuring 20 mm in diameter. Additionally, there were irregular vascular channels in the pelvic tissue of ureteropelvic region and the pelvic mucosa was hyperaemic. Microscopic examination showed a small area of submucosal haemorrhage with an organizing haematoma characterized by fibrinoid material containing fibroblasts and extravasated erythrocytes (Figure 2). Transitional epithelium was focally ulcerated with mild acute inflammatory reaction and the prominent capillary blood vessels were seen especially in lamina propria. There were no sclerosis, thrombosis or inflammatory reaction in and around the vessels. The renal cortex did not reveal any histopathological abnormalities.

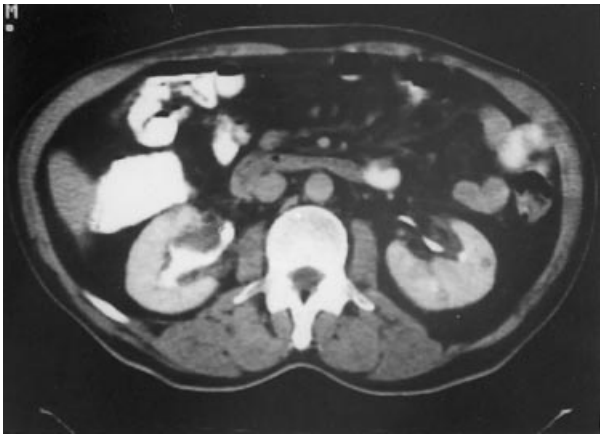

Figure 1. Computerized tomography revealing a soft hypodense lesion compressing the proximal ureter and renal pelvis.

This is clinically a typical case of Antopol–Goldman lesion. Histopathologically, instead of a focal or diffuse submucosal haematoma, we observed a small area of recent submucosal haemorrhage associated with an organizing haematoma. Because of the misleading view of this organizing haematoma at computerized tomography, the lesion was diagnosed as renal pelvic tumour, although cytological examination was negative for

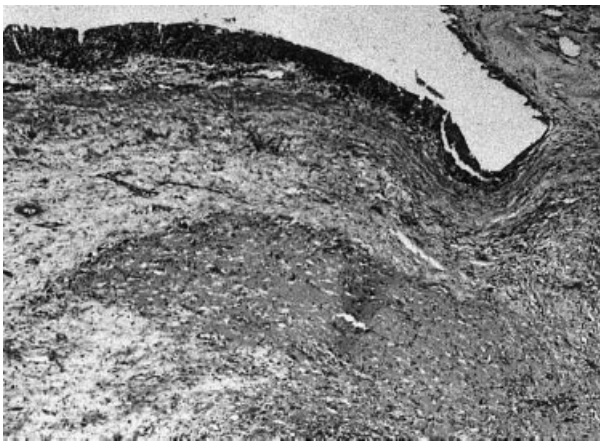

Figure 2. A small area of submucosal haemorrhage with an organizing haematoma.

malignant cells. As would be expected, there are no key radiological factors for the diagnosis of this lesion pre-operatively. Also, fine needle aspiration (FNA) is not an effective diagnostic tool in such a lesion, which consists of fibrinoid material, fibroblasts and erythrocytes without any epithelial component, and it is not possible to specify this lesion by FNA without histopathological correlation.

The cause of the lesion is still unknown. Morphologically, we could find no congenital abnormality and a trauma history was denied. However, after a careful review of our patient's history we learnt that, a few years ago, he was taking analgesic regularly for headaches. Fourie *et al.* reported that experimental analgesic abuse results in prominent renal vascular proliferation and our histopathological finding of prominent capillary blood vessels in the lamina propria of the renal pelvis is consistent with this report.[5] Levitt *et al.* also stated that analgesic abuse may be the cause of pelvic haemorrhage.[6] We can also say that analgesic abuse may be a significant factor in our case, since the morphological features reflect an old lesion of organizing haematoma rather than a recent fresh haemorrhage except a minute area of extravasated erythrocytes.

None of the cases of subepithelial haematoma of the renal pelvis was diagnosed pre-operatively. Consequently, we recommend that subepithelial haematoma of the renal pelvis should be kept in mind by both radiologist and pathologist, if a localized lesion is suspected in a pole of the kidney especially with a history of analgesic abuse and computerized tomography is not very helpful for differential diagnosis.

N C Demirkan
L Tuncay[2]
E Düzcan[1]
Ö Atahan[2]
E Pakdemirli[3]

Pamukkale University, Faculty of Medicine, Departments of [1]*Pathology,* [2]*Urology and* [3]*Radiodiagnostics, Denizli, Turkey*

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Sclerosing mucoepidermoid carcinoma of minor salivary glands: a case report

Sir: Mucoepidermoid carcinomas most commonly arise from the parotid glands, but is not unusual in minor salivary glands. The most common site of origin in these cases is the palate, and rarely in the larynx and hypopharynx.[1] Mucoepidermoid carcinomas can usually be readily diagnosed, however, sometimes some unusual features may make the diagnosis difficult. In this case report, we describe an unusual sclerosing mucoepidermoid carcinoma arising from minor salivary glands in the parapharyngeal space.

A 65-year-old man presented with a 6-month history of pain and stiffness in the right tempero-mandibular area. Clinical examination demonstrated severe trismus and paraesthesia over the distribution of maxillary and mandibular divisions of the right trigeminal nerve. MRI scan of the neck demonstrated a large, $50 \times 40 \times 30$ mm, mass in the right parapharyngeal space. This was noted to be invading pterygoid muscle and the base of skull. At endoscopy, multiple biopsies were taken from the area, but failed to yield a tissue diagnosis. It was decided to proceed to a definitive surgical procedure. At surgery, a transpharyngeal approach was used to access the lesion. Frozen section confirmed carcinoma. The lesion was then dissected out from the surrounding tissues. Postoperative recovery was uneventful. The tumour bed was irradiated.

The specimen was a well demarcated, firm to hard, roughly spherical tissue measuring $60 \times 50 \times 40$ mm. Microscopically, the predominant pattern was dense areas of sclerosis with scattered, predominantly solid islands of pleomorphic tumour cells showing squamous, glandular and intermediate cell differentiation (Figures 1 and 2). Nests of tumour cells extended to the surgical margin of excision. The sclerotic centre consisted of thick bundles of collagen arranged haphazardly. There were few fibroblasts and the collagenous component was thus sclerotic, rather than being desmoplastic. Several foci of spotty calcification and necrosis were also noted. The histological features were those of a high-grade mucoepidermoid carcinoma. Mucin stains revealed both intracellular as well as pools of extracellular mucin within the stroma.

Mucoepidermoid carcinoma is the most common malignant neoplasm observed in the major and minor salivary glands[2] and may show a wide range of differentiation and behaviour. Classical cases of