Abstract:
Upper urinary tract urothelial tumors involving the renal pelvis or ureter are relatively uncommon, accounting for only 5 to 7 percent of all renal tumors and about 5 percent of all urothelial tumors. Here, a case of urothelial tumor involving the entire kidney, ureter and bladder is presented on account of its rarity and remarkable response to neo adjuvant chemotherapy.

Keyword: upper urinary tract urothelial tumor.

HISTORY:
42 year old male, presented with H/o hematuria, on and off, total, painless with clots, H/o left loin pain, dull aching, H/o dysuria for 4 months, H/o Loss of weight, loss of appetite. The patient is a chronic smoker smokes 1 pack/day for past 20 years.

CLINICAL EXAMINATION:
- Patient was anaemic, vital signs were stable.
- Abdominal examination: hard irregular ill defined 14 X 10 cm renal mass in left lumbar region,
  - No ascites,
  - No hepatomegaly,

INVESTIGATIONS:
- Hemoglobin- 9 gms%,
- Renal function tests- Serum creatinine-1.1mg/dl, Blood urea-23mg/dl,
- Liver function tests - within normal limits,
- Urine routine: few RBCs/high power field,
- Urine cytology: No malignant cells.
- Plain x ray KUB - normal
- X ray chest PA view - normal.
X ray chest PA view - normal. Ultrasound abdomen: ill defined heterogeneous mixed echoic occupying the entire left ureter and projecting as an irregular papillary growth into the bladder.

CONTRAST CT ABDOMEN:
Heterodense lesion - 18 * 10.5 cm arising from medial aspect of left kidney pushing it laterally with heterogeneous contrast enhancement

CONTRAST CT ABDOMEN:
Mass extending into the ureter up to vesico ureteric junction causing exophytic lesion into the bladder

MRI ABDOMEN:
Mass lesion in the collecting system of left kidney causing hydronephrosis infiltrating into left renal cortex and extension into left pararenal space and laattismus dorsi muscle. Mass extending inferiorly into the ureter upto vesicoureteric junction causing an intravesical exophytic lesion.

ULTRASOUND: mixed echoic left renal mass with perinephric fluid collection
Contrast enhanced CT scan and MRI of the abdomen done showed a mass lesion in the collecting system of left kidney with infiltration into left renal cortex and perinephric extension. The mass was occupying the entire left ureter and seen protruding into bladder. Periureteric soft tissue extension and Perinephric urinoma were noted.
**CYSTOSCOPY** done with 20 F/30 degree scope showed: An irregular papillary growth in the region of left ureteric orifice sized 5 X 4 cms. Rest of bladder was normal. TURBT (TRANS URETHRAL RESECTION) biopsy done. Biopsy reported as Transitional cell carcinoma - High Grade (GRADE -3)

**TNM STAGING OF THE TUMOR**: Transitional cell carcinoma of renal pelvis and ureter with perinephric/periureteric spread, No lymphadenopathy, No metastasis, T4 N0 M0. Stage IV disease.

Patient was started on Neo adjuvant chemotherapy Gemcitabine 1000mg - Day 1 / Cisplatin 50 mg Day 1 & Day 3 -3 Cycles once in 21 days. Patient is symptomatically better. Clinically mass has regressed well. Radiologically mass has considerably reduced in size and tumour burden has decreased.

**POST CHEMOTHERAPY CONTRAST CT SCAN**: well enhancing mass lesion mid and lower pole of left kidney 8 * 7.2 cm with 12 * 5 * 7 cm perinephric urinoma (+ 10 HU).

Patient is to be planned for LEFT NEPHROURETERECTOMY WITH CUFF OF BLADDER & ADJUVANT CHEMOTHERAPY.

**DISCUSSION**: Upper urinary tract urothelial cell carcinomas account for only 5-10% of urothelial carcinomas. The main prognostic factors are age, grade and tumour stage. Natural history: 60% of upper urinary tract urothelial cell carcinomas are invasive at diagnosis compared with only 15% of bladder tumours. Synchronous bladder cancer occurs in 2%-4% of patients with upper tract tumors. 40% of patients with upper tract TCC will develop metachronous Transitional cell carcinomas of the lower urinary tract. Cytology is less sensitive for upper urinary tract urothelial cell carcinomas than for bladder tumours, even for high-grade lesions. It seems there is no longer a prognostic impact for tumour location (i.e. ureteral vs pyelocaliceal tumours) when adjusted for tumour stage.
Neo adjuvant chemotherapy has been used from stage T2-T4 tumors, with an intent to treat micrometastatic disease at diagnosis. It has got the advantages of being better tolerated before surgery and as a method of assessing in vivo drug sensitivity testing. Tumor downstaging offers the technical advantage of easier surgery.

REFERENCES:
