ABSTRACT
Atrophic kidney-like lesion is a recently recognized entity, post 2016 World Health Organization Classification of tumors of the urinary system. The behavior of this tumor is not fully known as only a handful of cases with limited follow-up are available. This entity closely mimics thyroid-like follicular carcinoma of the kidney, which has different prognosis.

We report a case of incidentally detected atrophic kidney-like lesion in an elderly gentleman who had urothelial carcinoma of the urinary bladder with a brief review of literature.

Atrophic kidney-like lesion and urothelial carcinoma of the urinary bladder association has not been reported in the literature.

Keywords: Atrophic kidney-like lesion, Thyroid-like follicular carcinoma, Kidney

INTRODUCTION
Atrophic kidney-like lesion (AKLL) is a recent entity described post 2016 World Health Organization (WHO) classification of tumors of the urinary system. With the available limited follow-up data, this is considered as a benign renal neoplasm with indolent behavior. Owing to its follicular architecture, it closely resembles thyroid-like follicular carcinoma of the kidney (TFRCC) (1). The distinction between the two is essential as the latter has chromosomal alterations in the form of gains and losses and an aggressive behavior with metastatic potential (2,3).

CASE REPORT
A 71-year-old gentleman was a known case of recurrent low-grade urothelial carcinoma for 9 months for which he had undergone transurethral bladder tumor resection thrice. On routine surveillance, contrast enhanced computed tomography (CECT) abdomen showed a well-circumscribed tumour measuring 2.6x2.4cm in the mid-third region of the right kidney with focal extension into the upper pole. The kidney measured 5.5cm in length with indistinct corticomedullary junction (Figure 1A,B). The patient underwent simple nephrectomy for the lesion. On gross examination, the renal capsule was intact, and the cut surface showed a well-demarcated tan brown lesion measuring 3x2.8x2.5cm in the mid-third region. (Figure 1C). The renal sinus and ureter were unremarkable. On microscopy, the lesion was well demarcated from the renal parenchyma by a thin fibrous capsule (Figure 2A). The lesion was composed of compact tubules lined by flattened and atrophic epithelium interspersed by cyst-like follicles. Many of the follicles were filled with pale to dense eosinophilic material detached from the epithelium (Figure 2B,C). The stroma between the follicles showed collagen deposition, few atrophic tubules, and capillaries. Focal amorphous calcific areas were also noted (Figure 2D). No atypical features like mitosis, necrosis or high nuclear grade areas were noted.

The differential diagnoses considered were atrophic kidney-like lesion, thyroid follicle-like renal cell carcinoma, metastatic follicular carcinoma of the thyroid, and well-differentiated neuroendocrine tumour (carcinoid). A panel of immunohistochemistry was performed that included PAX8 (Cell Marque, RTU, clone MRQ-50), CK7 (Cell Marque, 1:300, clone OV-TL12/30), WT-1 (Dako, 1:50, clone 6F-H2), Synaptophysin (Cell Marque, 1: 200, Clone MRQ-40), CD117 (Dako, 1:500, clone A4502), and CD10 (Cell Marque, 1:30, clone 56C6). The cells were diffusely positive for PAX-8 (Figure 3A), and CK7 (Figure 3B), while negative for CD10 (Figure 3C), TTF-1 (Figure 3D), Synaptophysin, WT-1 and CD117. The renal sinus, pelvis and ureter were free. No extracapsular invasion was noted. Adjacent renal parenchyma showed preserved glomeruli and non-atrophic tubules. Based on morphology and immunophenotyping, an ‘Atrophic kidney-like lesion’ was diagnosed; Tumor stage – T1a; World Health Organization/
Figure 1: A, B) Contrast-enhanced CT abdomen showed a well-circumscribed tumour nodule in the upper pole in the background of a small kidney. C) Cut surface shows a well-demarcated tan brown colored tumour measuring 3x2.8x2.5cm in the mid-third region.

Figure 2: A) Tumour composed of multiple tightly packed varying sized follicles separated from native kidney by a thin capsule (arrow pointed) (H&E, 40x). B) The follicles are filled with dense eosinophilic colloid-like secretions (H&E, 100x). C) The lumen is filled with pink eosinophilic material and focal macrocystic degeneration (H&E, 40x). D) The follicles are lined by flattened to cuboidal epithelium with occasional amphophilic calcific deposits (H&E, 200x).
the tumors impart a follicular architecture. However, the distinguishing feature between AKLL and TFRCC can be appreciated on higher magnification. In TFRCC, the cells lining the follicles are cuboidal with abundant eosinophilic cytoplasm, high nuclear grade, and prominent nucleoli, resembling a proper follicular neoplasm of the thyroid whereas in AKLL the cells are flat/atrophic to low cuboidal (9,10).

Distinction of atrophic kidney-like lesion from the end stage renal disease induced by chronic pyelonephritis is important. Chronic pyelonephritis with thyroidization also shows atrophic tubules with hyaline casts mimicking the neoplasm. The important distinguishing point is the presence of a well-defined capsule, lack of inflammation, and absence of glomeruli in-between the lesion. In the present case, the background renal parenchyma did not show features of chronic pyelonephritis. The differential diagnosis of AKLL includes metastatic follicular carcinoma of the thyroid, metanephric adenoma, multilocular cystic renal neoplasm of low malignant potential, and

DISCUSSION

The nomenclature “Atrophic kidney-like lesion (AKLL)” has been used interchangeably in the literature with “atrophic kidney-like tumour” and “atrophic kidney-like renal cell carcinoma” (4,5). This was originally described by Hes et al in 2014 as a separate entity and its clonal nature was proven in a series of 3 cases (1). Atrophic kidney-like lesion was initially considered under Thyroid-like follicular carcinoma of the kidney (TFRCC) (5). Following the original description, many cases were reviewed and described as reports and case series, of which few were initially diagnosed as TFRCC (6,7). The pathogenesis of AKLL is compared with that of glomerulocystic disease as the cells lining the cysts expressed WT-1, which is a marker of podocyte differentiation (8). At low power, both

Figure 3: A) The tumour (follicular) cells are positive for PAX-8; B) CK7 Positive; C) CD10 Negative D) TTF-1 Negative (Immunoperoxidase, 200x)
Conflict of Interest
The authors declare no conflict of interest.

Authorship Contributions
All the authors were involved in conception and design of the work. BM and SS were involved in data collection and writing. AB and APS were involved in analysis of data and approval.

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