

中文題目：原發性膀胱腺癌之案例討論

英文題目：Primary urinary bladder mucinous adenocarcinoma

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## **Introduction**

Bladder cancer is still the fourth most common cancer in men with an estimated 79,030 new cases and 16,870 deaths in the United States predicted for the year 2017. Most of the bladder cancer are transitional cell in origin and other cell types are rare.

Adenocarcinoma is an uncommon histologic variant and accounts for only 0.5-2% of bladder cancers in the United States. Primary bladder adenocarcinoma often presents at an advanced stage and has a poor prognosis. We report the case of a 53-year-old patient with a stage III primary bladder adenocarcinoma. No surgical intervention was performed and he just received chemotherapy and radiotherapy. Progression disease was presented. We analyze clinical and therapeutic features of this disease in a literature review.

## **Case Presentation**

A 53-year-old male had hypertension and benign prostate hyperplasia with regular medicine control. He presented frequency, dysuria and weak stream for days. He came to Urology out-patient department for help and sonography revealed a bladder tumor with suspect right ureterovesicle junction (UVJ) invasion. Abdomen computed tomography scan and MRI were done and both showed urinary bladder cancer in the posterior wall with involvement of bilateral UVJ, distal ureter and prostate gland (cT4aN0M0). Transurethral resection of bladder tumor (TUR-BT) was performed and the pathological results revealed mucinous bladder adenocarcinoma.

Then, he received extensive work-up, including colonoscopy and positron emission tomography (PET) scan, to rule out other sites of primary tumor and the possibility of metastasis. However, no other possible lesion was noted so the diagnosis of primary urinary bladder adenocarcinoma was confirmed. Bone scan was also performed and showed low probability of bone metastasis from bladder cancer. Radical cystectomy was suggested but patient refused. Therefore, after discussion, patient started chemotherapy with regimen (Paclitaxel (75mg/BSA) + Carboplatin (AUC=5) + Gemzar (800mg/BSA)). Total 3 course of chemotherapy was performed

initially. Unfortunately, residual tumor was still noticed at follow-up pelvic MRI and PET scan. Surgical intervention was suggested again but still refused. Therefore, due to poor response to chemotherapy alone, radiotherapy (total dose 6600cGy/33fx) was added concurrently with further chemotherapy. Now, this patient is under progression disease status and further self-paid immunotherapy may be considered.

## **Discussion**

After bladder adenocarcinoma is diagnosed, it is necessary to investigate another source of cancer, since secondarily from a number of other organs, such as colorectum, prostate, endometrium, cervix and so on, are much more common.

Primary bladder adenocarcinoma exhibits several different growth patterns, including enteric, mucinous, signet-ring cell, not otherwise specified, and mixed patterns. The signet-ring cell type has a poorer prognosis compared with that of the other types of adenocarcinoma. What's more, there is another bladder adenocarcinoma variant, the urachal adenocarcinoma, which has different histologic features and better prognosis than primary bladder adenocarcinoma.

Primary bladder adenocarcinoma was usually found in the sixth and seventh decade of life with male predominance. Hematuria is the most common symptom, but some patients may present with bladder irritation symptoms. Once diagnosis, the tumor stage, grade and cell subtype were all important due to high association with prognosis. According to a previous study, when the tumor is confined to the bladder, the survival rate could be more than 75% but, unfortunately, less than 30% of patients are diagnosed at an early stage.

Bladder adenocarcinoma is resistant to chemotherapy and radiation, and surgery is currently considered the most effective treatment option. NCCN guideline also states the first choice treatment of primary bladder adenocarcinoma is local control with surgery, either radical or partial cystectomy.

Even no data support the use of neoadjuvant/adjuvant chemotherapy for pure adenocarcinoma of the bladder including urachal carcinoma, individualized adjuvant chemotherapy and radiotherapy was still favored due to high relapse risk. For advanced patient, systemic chemotherapy with 5-FU-based regimen (FOLFOX or GemFLP (5FU, Leucovorin, gemcitabine and cisplatin)) was suggested. Other regimen, such as ITP (paclitaxel, ifosfamide and cisplatin) and combination paclitaxel with platinum, may also be considered. Except for traditional radio-chemotherapy,

immunotherapy could be therapeutic. In recent animal model study, PD-1, PD-L1 and PD-L2 expression in mouse prostate cancer have been confirmed.

In conclusion, when bladder adenocarcinoma is diagnosed, surgical intervention should always be the best treatment due to poor response to chemotherapy or radiotherapy. Other treatment, such as immunotherapy, could be helpful but still under study.