THE PROGNOSTIC VALUE OF A PRIMARY INVERTED PAPILLOMA OF THE URINARY TRACT

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ABSTRACT

Purpose: Ever since the recognition of the inverted papilloma as a distinct lesion of the urinary tract, there has been discussion about the possible (pre)malignant potential of this rare tumor, with subsequent uncertainty about followup. Hampering the discussion are the low frequency, the unknown etiology, the difficult histopathological diagnosis and the reported association with transitional cell carcinoma. We reviewed the literature and studied our patients, resulting in the largest series reported in the literature to date.

Materials and Methods: We selected 51 patients with an inverted papilloma without a history of or a concordant transitional cell carcinoma of the urinary tract. Histology of all patients was reviewed.

Results: After review, as many as 14 patients appeared to be misdiagnosed (transitional cell carcinoma in 11). In 37 patients, we could confirm the diagnosis of inverted papilloma, with characteristics that were highly comparable to those described in the literature. Only 1 patient had a superficial bladder tumor after 49 months.

Conclusions: Reviewing these data and our own results, we conclude that an inverted papilloma does not seem to be a risk factor for transitional cell carcinoma, although inverted papillomas and transitional cell carcinoma appear to be related to some extent. Therefore, frequent and long-term followup does not seem to be necessary provided that there is no doubt about the difficult histological diagnosis.

Key Words: urinary tract, papilloma

Since the inverted papilloma of the urinary tract was reported as a distinct lesion, there has been discussion about the relation between the inverted papilloma and transitional cell carcinoma of the urinary tract. This question, however, has not been answered for several reasons. First, inverted papillomas are rare, with around 280 cases reported in the literature. Most of these cases have been described in single or small case reports, and only 5 reports have been published with 10 or more patients. The largest dealing with 35 patients. A second problem is the difficulty of obtaining a correct histopathological diagnosis, with emphasis on the differential diagnosis with several kinds of cystitis, Brunn's cell nests and transitional cell carcinoma.

Because of these problems, the unknown etiology and recent reports about the association with malignancy, a proper followup policy remains difficult to define. In an attempt to contribute to this problem, we reviewed the literature and compared these results with our own series of 37 patients in whom the diagnosis of inverted papilloma was confirmed after pathological review.

PATIENTS AND METHODS

With the aid of the National Pathological Data Administration, all Dutch patients with the diagnosis of "inverted papilloma of the urinary tract" were selected. The National Pathological Data Administration started in 1979, and patients were selected until 1994, to allow for sufficient followup. For this study, 7 pathology departments were selected in the southeastern part of The Netherlands. Patients with an inverted papilloma of the urinary tract but with a previous or simultaneous transitional cell carcinoma were excluded from this analysis. The medical files of the selected patients were reviewed. Items investigated were symptoms, cytotology, radiological features, localization, macroscopic appearance and size, method of treatment and followup results.

In all patients selected for this study, histological slides (hematoxylin and eosin staining) were reviewed by 1 uropathologist (C. A. vdK.) based on criteria defined by Henderson et al (table 1). In cases of papillary structures or frequent mitoses, the diagnosis of inverted papilloma was not confirmed. While reviewing the histological slides, the uropathologist was unaware of the followup data.

RESULTS

Diagnosis. From the 7 pathology departments, 73 patients were selected. Sixteen patients appeared to have a concomitant or previous transitional cell carcinoma and were excluded from further analysis. Of the remaining 57 patients, 51 histological slides were available for review. Of these 51 cases originally diagnosed as inverted papilloma of the urinary tract, only 37 proved to be true inverted papillomas (see figure). Misdiagnoses, seen at all 7 pathology departments, were pTaG1-2A transitional cell carcinoma (9), pT1G2A transitional cell carcinoma (2), Brunn's cell nests (2) and polyploid cystitis (1).

Of the 37 patients having a true inverted papilloma of the urinary tract, 6 were women (16.2%), resulting in a male-to-female ratio of 5.2:1. The mean age at presentation was 55.5 years.

<table>
<thead>
<tr>
<th>Table 1. Diagnostic criteria for inverted papilloma</th>
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<tr>
<td>Inverted configuration</td>
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<tr>
<td>Covering layer of urothelium</td>
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<tr>
<td>Uniformity of the epithelial cells</td>
</tr>
<tr>
<td>Absence or rarity of mitoses</td>
</tr>
<tr>
<td>Formation of microcysts (crypts)</td>
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<tr>
<td>Presence of squamous metaplasia</td>
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In 1927, Paschakis described 4 cases of adenoma-like polyps in the bladder.\textsuperscript{74} Histopathologically, these tumors were identical to the lesion that Potts and Hirst described as an inverted papilloma of the urinary tract in 1963.\textsuperscript{75} This tumor, with a histological appearance similar to that of the inverted papilloma of the sinonasal tract,\textsuperscript{75,76} is a rather infrequent tumor: in a series of 1,829 tumors of the urothelial tract, only 2.2\% were inverted papillomas.\textsuperscript{77} Until now, 277 cases of this rare tumor have been reported in the literature, usually as case reports with 1 or only a few patients. Only 5 series of 10 or more cases have been reported.\textsuperscript{1-5}

Apart from the fact that this tumor is infrequent, the differential diagnosis with transitional cell carcinoma is difficult. Also, the etiology is an unsolved problem. In this large series of patients with histologically confirmed inverted papillomas, several aspects of this distinct lesion have been documented and can be compared with data from the literature.

**Epidemiology.** As in the literature, we found a male predominance. In our series, the male-to-female ratio was 5.2:1 (31 versus 6). In different series, the male-to-female ratio ranges from 3:1\textsuperscript{14} to 7:1\textsuperscript{15}. Review of 277 cases reported in the literature reveals a ratio of 5.0:1 (231 versus 46).

An inverted papilloma of the urinary tract is usually found in patients in the 6th or 7th decade of life,\textsuperscript{1,9-11,77} but it may occur at any age, and even some cases in children have been reported.\textsuperscript{12-14} In 241 of 277 patients reviewed, age at presentation was specified. Mean age at presentation is 60.3 years (range 9 to 94 years), which is comparable to our results (mean 58.5 years, range 20 to 83 years). Also in the literature, the majority of patients (73\%, versus 81\% in our series) are between 50 and 79 years of age.

**Symptoms.** Hematuria and obstruction are the main presenting symptoms of patients with inverted papillomas, especially for lesions originating from the trigone, bladder neck and prostatic urethra.\textsuperscript{9,15} In many cases, the obstruction is probably the result of a simultaneous prostate enlargement rather than the inverted papilloma.\textsuperscript{5,16} In 219 of 277 patients reviewed, symptoms (271) were specified. It is of interest that in 21 of 25 patients with pain complaints, the lesion was found in the upper urinary tract. Together with our own results (51 symptoms in 37 patients), the symptoms are presented in table 2.

**Radiological aspects.** There are no specific radiological characteristics to support the diagnosis of inverted papilloma. Usually, a filling defect or signs of obstruction are seen on contrast films. In other cases, these investigations are normal or show unrelated changes such as concrements.\textsuperscript{1,19} Also in our series, the most frequent abnormality on an IVP is a filling defect (39.3\%, versus 54.9\% in the literature). All but 1 of the patients showing mild dilatation,\textsuperscript{17-19} obstruction,\textsuperscript{17,19-23} or hydronephrosis\textsuperscript{20,23-28} on contrast film had the inverted papilloma located in the lower half of the ureter or very near the ureteral orifice.\textsuperscript{4} Some have reported the diagnosis of the lesion by ultrasound.\textsuperscript{14,29,30}

**Endoscopy.** As for all bladder tumors, endoscopy is the diagnostic procedure of choice to detect an inverted papilloma.

<table>
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<th>Table 2. Presenting symptoms</th>
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<tr>
<td><strong>No. Current Series (%)</strong></td>
</tr>
<tr>
<td>Hematuria</td>
</tr>
<tr>
<td>Obstruction/anuria</td>
</tr>
<tr>
<td>Infection, penile soreness</td>
</tr>
<tr>
<td>Flank pain/low back pain, others such as nocturia, dysuria, urge and incontinence</td>
</tr>
<tr>
<td>None</td>
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</table>
PRIMARY INVERTED PAPILLOMA OF URINARY TRACT

The macroscopic aspect can be a gray to white solid or polypoid, generally pedunculated lesion with color. The size varies from a few millimeters to many centimeters, but rarely exceeds 3 cm. Inverted papillomas are predominantly seen in the bladder, especially in the trigone and bladder neck region. Inverted papillomas of the upper urinary tract are rare. Only 1 case has been reported in the penile urethra.

In all 277 patients reviewed (285 inverted papillomas), localization was specified. As expected, most of the lesions were found in the bladder neck and trigone. This percentage is even higher in a subset of the larger series (105) and also in our own series (40 in 37 patients) (table 3). It is possible that less frequent localizations, such as those in the upper urinary tract, are reported more often in case reports. This is illustrated by the fact that all case reports written in 1986 and 1987 (8 articles reporting 12 cases) describe lesions of the upper urinary tract.

**Cytology.** Because an inverted papilloma is covered by a normal and intact mucosal layer, the cytopathological fall within the range of normal or degenerate transitional epithelium, as can be seen in patients with stones and a variety of inflammatory conditions. In the literature, cytology is specified in only 22 of 277 cases; of these cases, 3 showed mild atypia. One patient had malignant cells, but he appeared to have a concomitant transitional cell carcinoma. In our series, 4 patients with mild atypia were seen. In conclusion, cytology does not seem helpful for diagnosis.

**Treatment.** Simple transurethral resection of the tumor and/or electrocoagulation is generally accepted as the treatment of choice. However, because of initial diagnostic problems, many patients are treated with open (radical) surgery. Treatment is specified in 173 of 277 patients reviewed. Transurethral resection (58.4%), open local resection (18.5%) and (hemi-)nephroureterectomy (17.9%) are the most frequent procedures. Most of the open local excisions have been performed for lesions of the upper urinary tract (27 of 32). In our series, all patients were treated with transurethral resection.

**Histopathology.** The typical appearance of an inverted papilloma is that of a polypoid lesion covered by a flattened but otherwise normal-looking layer of transitional cell epithelium. Beneath this surface, there are numerous communicating crypts formation may occur, resulting in an adenomatous appearance of the tumor. This cyst may contain a high degree of nuclear atypia and pleomorphism and a rare cyst formation. Inverted papillomas, on the other hand, central cores of delicate vascular stroma in the epithelial strands or exophytic papillary components are absent. These difficulties in the diagnosis were also seen in our series at all 7 participating pathology departments.

Some attempts have been made to define a histopathological classification. Although these classifications are followed by some authors, none of them is widely used.

**Etiology.** In their first description of this lesion, Potts and Hirst suggested that an inverted papilloma is a neoplastic transformation of basal cells of subcervical Albarran's or subtrigonal Home's glands. Because inverted papillomas were later found outside the bladder, this idea seemed unlikely. Instead, Trites stated that this lesion was an invasive variant of the urothelial papilloma, a belief adopted by some others. A high frequency in the trigone and bladder neck and localization of the inverted papilloma in the pelvis and ureter may be explained by the mesodermal origin of the urothelium of these areas, whereas the remainder of the bladder epithelium is derived from endoderm.

In contrast to this view, Cummings and Matz et al postulated that this lesion was not neoplastic, but rather a kind of hyperplastic reaction, especially of Brunn's cell nests, to chronic inflammation or irritative agents. This could explain the predominance at areas of greatest irritative potential, the rare multicentricity and the very low recurrence rate of the inverted papilloma. In recent years, this theory has been supported by others. The development of the tumor can be caused by chronic inflammation and by carcinogenic agents, as was proved in rats by Kunze and Scharf. Today, most authors believe that the inverted papilloma of the urinary tract is a true neoplasm, although precise tissue of origin and causative agents or processes are still not known.

**Malignant potential.** The problem of benign or malignant potential has important clinical consequences. In favor of a benign character of an inverted papilloma are the histological appearance, rare recurrences and multiplicity and lack of invasion and metastasis. However, in recent years several authors reported multiple and recurrent lesions, the presence of a concomitant transitional cell carcinoma or malignant transformation of the inverted papilloma itself. This raised the question of whether the idea of the inverted papilloma as a benign tumor should not be reevaluated.

Multiple tumors were reported in 15 of 277 patients (5.4%) reviewed. In 9 patients, 2 lesions were found. In 3 patients, 3 lesions were found. In 1 patient, a total of 7 lesions in 1 ureter, and in 1 recent case, the number of tumors was not specified. If we review only the larger series to eliminate the bias of over publications of multiple cases, the percentage of multiplicity is 3.6% (4 in 110 patients). In our series, 3 patients had 2 tumors.

These percentages are much lower than those in primary superficial transitional cell carcinoma and do not suggest malignant potential.

**Conclusion.** The malignant potential of the inverted papilloma cannot be found in the number of recurrences, which has been estimated to be between less than 1% and about 7%. Of 199 patients for whom follow-up was presented in the literature, 10 (5.0%) were reported to have had probable recurrent lesions (only larger series 6.1%) after a follow-up of 9 to 12 months (table 4). In 2 patients, recurrence appeared twice, and in 4 patients, no histological confirmation of the recurrent papilloma was obtained.

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**Table 3. Localization of inverted papilloma**

<table>
<thead>
<tr>
<th>Localization</th>
<th>No. Current Series (%)</th>
<th>% All Cases</th>
<th>% Large Series</th>
</tr>
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<tbody>
<tr>
<td>Upper urinary tract</td>
<td>0 —</td>
<td>26.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Bladder:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td>18 (40.0)</td>
<td>26.0</td>
<td>30.5</td>
</tr>
<tr>
<td>Trigone</td>
<td>11 (27.5)</td>
<td>16.5</td>
<td>23.0</td>
</tr>
<tr>
<td>Lateral wall</td>
<td>5 (12.5)</td>
<td>6.0</td>
<td>16.2</td>
</tr>
<tr>
<td>Elsewhere</td>
<td>3 (7.5)</td>
<td>20.5</td>
<td>25.8</td>
</tr>
<tr>
<td>Prostatic urethra</td>
<td>5 (12.5)</td>
<td>4.2</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Table 4. Follow-up data

<table>
<thead>
<tr>
<th>All Cases</th>
<th>Large Series</th>
<th>Current Series</th>
</tr>
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<tbody>
<tr>
<td>Total No.</td>
<td>199</td>
<td>98</td>
</tr>
<tr>
<td>No. alive and well (%)</td>
<td>166 (83.5)</td>
<td>85 (86.7)</td>
</tr>
<tr>
<td>No. recurrence of inverted papilloma (%)</td>
<td>10 (5.0)</td>
<td>6 (6.1)</td>
</tr>
<tr>
<td>No. transitional cell Ca afterward (%)</td>
<td>10 (5.0)</td>
<td>3 (3.1)</td>
</tr>
<tr>
<td>Unrelated death (%)</td>
<td>13 (6.5)</td>
<td>4 (4.1)</td>
</tr>
<tr>
<td>Follow-up range (yrs.)</td>
<td>0-17</td>
<td>0-14</td>
</tr>
</tbody>
</table>

*In 8 of 10 patients (2 of 5 in large series), there was a previous transitional cell carcinoma. In our series, patients had only primary inverted papillomas.

The inverted papilloma of the urinary tract is a rare lesion. Most information comes from case reports, whereas few large series have been published. Comparison of characteristics of the inverted papilloma found by reviewing the literature on one side and our own results on the other side reveals no major differences. The lesion is particularly diagnosed in white men between the ages of 50 and 80 complaining of hematuria or outflow obstruction. Contrast film shows a filling defect, mild obstruction or nothing. Cytology and macroscopic appearance are nonspecific. The inverted papilloma, which is located mostly in the bladder neck or trigone, is treated by transurethral resection and finally diagnosed by the pathologist for its characteristic features.

Recently, transitional cell carcinoma in or malignant transformation of inverted papillomas has been described, raising questions about the malignant potential of this lesion. This question remains unsolved because the etiology is unknown and the incidence is very low. Another problem is the difficult histopathological differential diagnosis, especially with several kinds of cystitis, Brunn's cell nests and low grade transitional cell carcinoma. Misdiagnoses occur frequently, as was also seen in our series (14 of 51).

Because of the histological appearance, rare multiplicity, very low recurrence rate and absence of progression, the inverted papilloma itself does not seem to be a (pre)malignant lesion, in spite of the fact that some recent data suggest a higher proliferative activity of inverted papillomas compared with normal urothelium. On the other side, there is a limited but clear relation with transitional cell carcinoma, possibly because of a common cause, although in 8 of 10 patients in whom a transitional cell carcinoma developed after an inverted papilloma this could have been the result of a previous or concurrent transitional cell carcinoma. In our study, for which only patients with no previous or concurrent transitional cell carcinoma were selected, 1 patient (2.7%) had a pT1aG1 bladder tumor 49 months after transurethral resection of an inverted papilloma.

We conclude that an inverted papilloma does not seem to be a risk factor for transitional cell carcinoma, although inverted papillomas and transitional cell carcinoma appear to be related to some extent. Therefore, we do not advocate frequent and long-term followup provided that there is no doubt about the difficult histological diagnosis.

REFERENCES


