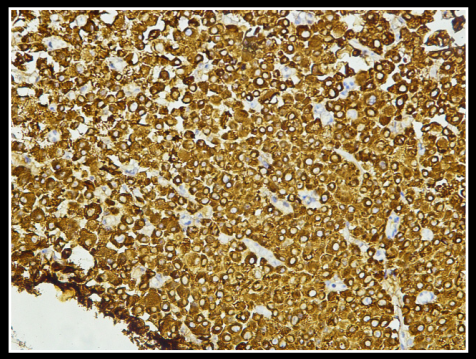

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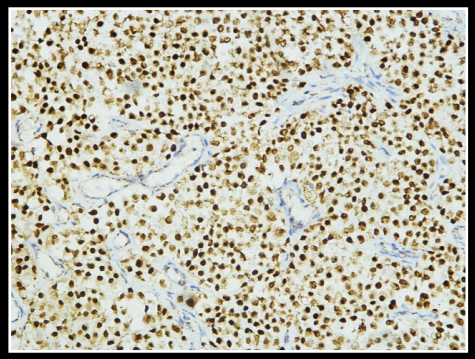

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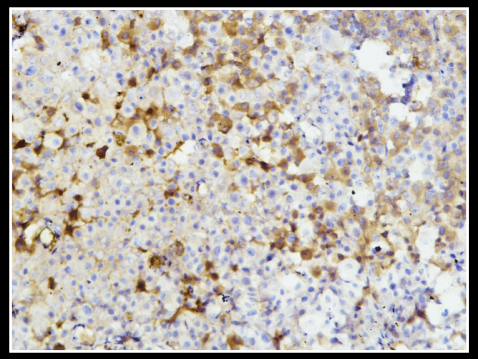

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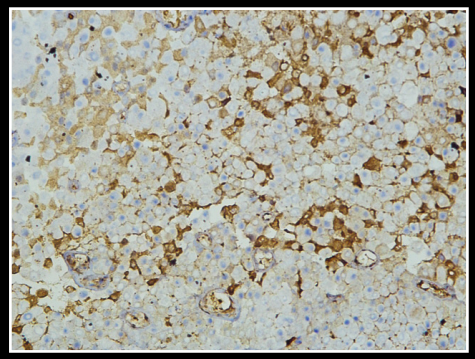

LAMBDA

DISCUSSION

Several morphological variants of Urothelial carcinomas have been described with a difference in prognosis, clinical behavior and management strategies. The Plasmacytoid variant of urothelial carcinoma (PUC) was first described by Sahin et al in 1991[1] and less than 100 cases have been described since then. This variant is more common in elderly patients with a mean age at diagnosis of 60 years, a male predominance and constitute around 3% of muscle invasive urothelial carcinomas.[2] Clinically these patients have a poor prognosis and present at an advanced stage with a higher incidence of metastatic and extravesical disease compared to non- PUC muscle invasive urothelial carcinomas.[3] Although hematuria is the most common presenting symptom, it may not be present until late stages of the disease.

Histomorphologically, PUC is characterized by sheets, cords or single files of discohesive cells with a plasmacytoid morphology and a relatively monomorphic appearance.[4] Individual cells are polygonal in outline with eccentrically placed vesicular to hyperchromatic nuclei and moderate to abundant eosinophilic cytoplasm. Focal intracytoplasmic mucin may be seen giving rise to a signet- ring like appearance. Surrounding stroma may show retraction artifact and myxoid change.[5] Nests and single cell infiltration of these tumor cells into the underlying bladder wall is commonly seen. Similar findings were seen in the present case. The differential diagnosis keeping in mind the plasmacytoid morphology include, benign conditions such as chronic cystitis with prominent plasma cell infiltrates to malignant conditions such as plasmacytoma and