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Case Report

Laparoscopic Nephrectomy with Adrenalectomy for Synchronous Adrenal Myelolipoma and Renal Cell Carcinoma

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Introduction. Adrenal myelolipomas are uncommon nonfunctioning tumors of the adrenal. Synchronous renal cell carcinomas with adrenal myelolipomas are very rare. We present the case report of adrenal myelolipoma with synchronous RCC managed laparoscopically. *Case Report*. A 60-year-old old gentleman presented with incidental right upper polar mass with right adrenal mass. Metastatic work-up was negative. Laparoscopic radical nephrectomy with adrenalectomy was done under general anesthesia. The biopsy report was right kidney clear cell adenocarcinoma (T1b) with right adrenal myelolipoma. *Conclusion*. This is the first case report of laparoscopic adrenalectomy with nephrectomy for ipsilateral synchronous renal cell carcinoma with adrenal myelolipoma.

1. Introduction

Adrenal myelolipomas are uncommon nonfunctioning tumours of the adrenal gland. They are usually found incidentally [1]. Myelolipoma was first described by Gierke in 1905 [2]. Adrenal adenomas with synchronous renal cell carcinomas are not uncommon [3].

However, synchronous adrenal myelolipoma associated with ipsilateral RCC is extremely rare with very few cases reported [4–6]. These were managed by open approach. We present the case report of adrenal myelolipoma with synchronous RCC managed laparoscopically.

2. Case Report

A 60-year-old gentleman presented with incidental right adrenal and renal tumor on ultrasound evaluation. General and systemic examinations were within normal limits. He was a hypertensive on treatment for 10 years. He had no other comorbidities. Blood and urine evaluations were normal. Contrast CT showed a 4 cm upper polar enhancing mass in the right kidney and a well-circumscribed 4 cm adrenal mass with fat components predominating (Figure 1).

Metastatic work-up was negative. Though adrenal tumors associated with RCCs are more commonly metastasis, the fat element in the adrenal mass suggested otherwise. He was planned for right nephrectomy with adrenalectomy. Under GA, with the patient in the right lateral position, laparoscopy was done transperitoneally.

Using 4 ports (Figures 2 and 3), the hepatic flexure of the colon was mobilized and the liver was retracted superiorly to visualize the mass.

The kidney was mobilized all around along with the adrenal mass. Renal artery and vein were identified, clipped, and divided. The ureter was clipped and divided. Right adrenal vein was clipped and divided. Adrenal gland was dissected superiorly and right kidney and adrenal were removed. Port sites were closed and a drain was placed. The patient had uneventful postoperative recovery.

The histopathology was right conventional clear cell renal cell carcinoma (Figure 4) confined to Gerota's fascia with no