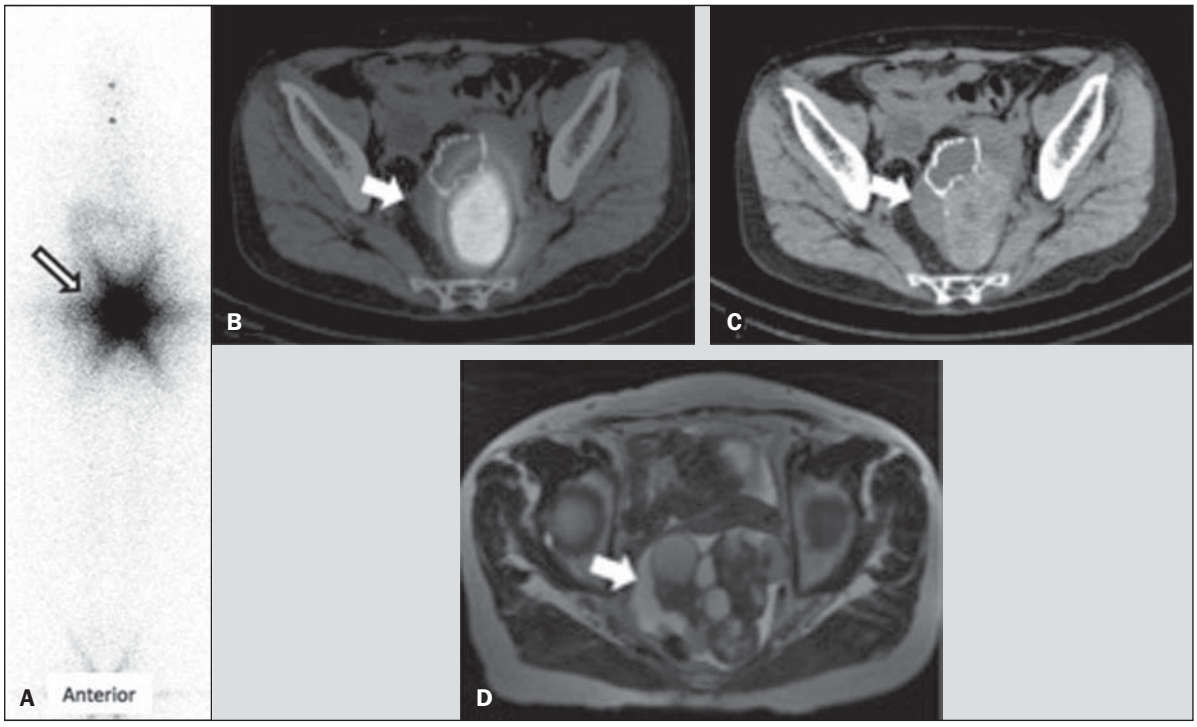

Figure 1. A: Anterior view of pre-treatment radioiodine whole-body scan showing an area of intense pelvic uptake (arrow). **B:** Fused SPECT/CT images. **C:** CT image. The arrows indicate a heterogeneous pelvic mass located posterior to the uterus. **D:** Axial T2-weighted magnetic resonance imaging scan. The arrow indicates a lobulated multicystic pelvic mass with a solid component.

tored through sequential thyroglobulin measurements, along with radioiodine WBS if recurrence is suspected, during follow-up. For malignant struma ovarii, a longer follow-up period is recommended, usually more than 10 years. Adjuvant I-131 therapy (after total thyroidectomy) might be considered in some patients[6]. In our case, post-treatment radioiodine WBS evinced a focal area of radioiodine uptake in the proximal left femur, probably due to benign and nonspecific etiology rather than metastatic disease, given that there were no matching anatomic alterations or symptoms. Subsequent follow-up will be needed in order to confirm that impression. In conclusion, fused SPECT/CT images played an important role in the differential diagnosis of a benign pelvic mass incidentally detected in a pre-treatment radioiodine WBS in a patient with papillary thyroid carcinoma.

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Pancake kidney with cysts and a single ureter

Dear Editor,

We report the case of a 56-year-old male patient who had undergone cholecystectomy with biliary-enteric anastomosis for the treatment of choledocholithiasis and was referred by a general surgeon for computed tomography (CT) at the University Hospital – Universidade Federal do Piauí, Brazil, because of the intraoperative finding of a pulsatile mass in the abdomen. The patient had no other comorbidities and was taking no medications at the time of referral.

A contrast-enhanced abdominal CT scan identified a pancake kidney with cysts (Figure 1A), and three-dimensional CT reconstruction with contrast (excretory phase) revealed that there was a single ureter (Figure 1B). The axial CT images and coronal CT reconstruction (portal phase) images of the abdomen showed a single, flat, medial, non-reniform mass in the region of the aortoiliac bifurcation, characteristic of the anomaly known as pancake kidney (Figures 1C and 1D).

Pancake kidney is a rare congenital urinary tract anomaly, the exact incidence of which is unknown[1]. Like other abnormalities involving renal fusion, pancake kidney is most commonly

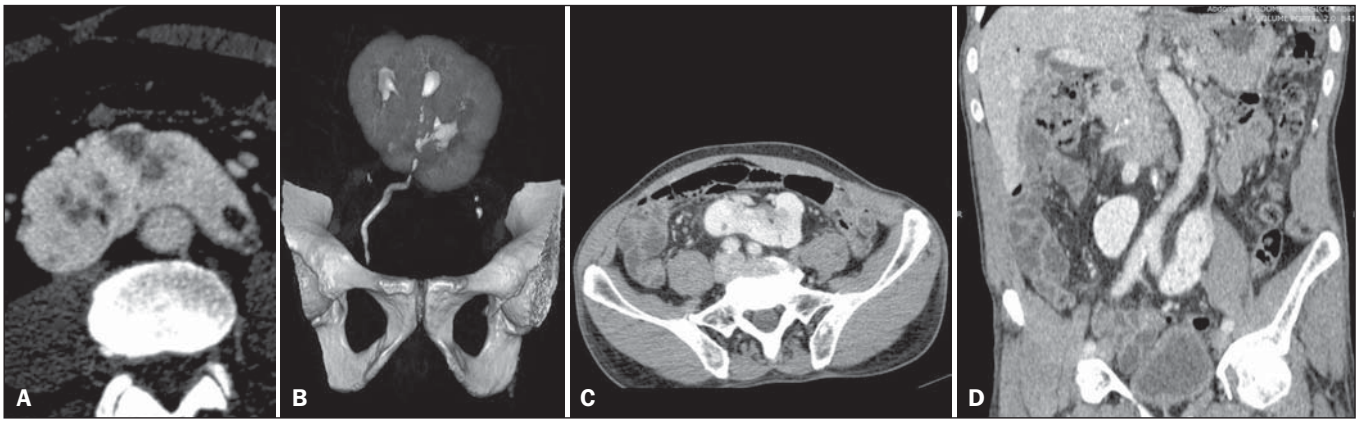

Figure 1. A: Axial CT image of the abdomen in the arterial phase showing pancake kidney with cysts. **B:** Three-dimensional CT reconstruction of the abdomen (excretory phase) showing a single ureter. **C,D:** Axial CT images and coronal CT reconstruction of the abdomen (portal phase), showing a single, flat, medial, non-reniform mass, at the level of the aortic bifurcation.

found in males, at a ratio of 2–3:1, and can be diagnosed at any age[2].

The pancake kidney malformation results from complete medial fusion of the metanephric blastema at an early stage of embryonic development and is characterized by a single, flat, non-reniform mass, in a medial position within the pelvic cavity or at the level of the aortic bifurcation. The renal collecting system is anterior and typically drains via two ureters or, less commonly, via a single ureter. The renal vasculature is also anomalous; blood flow can be supplied by multiple branches of the internal and external iliac arteries or of the abdominal aorta[3].

In most cases, pancake kidney is asymptomatic but can be accompanied by nephrolithiasis, hydronephrosis, and vesicoureteral reflux resulting in recurrent urinary infections, all of which are attributable to the anomalous rotation of the collecting system and the short ureters, which are prone to stasis and obstruction, as well as by renovascular hypertension, ureteropelvic junction stenosis, anomalous implantation of the renal pelvis, and polycystic kidney disease[1,4]. Among individuals with pancake kidney, the incidence of neoplasms, Wilms tumor in particular, is higher[5].

A little more than 20 cases of pancake kidney have been described in the literature, and a single ureter was reported in fewer than 10 of those cases[6,7]. Early identification of renal abnormalities is important to the investigation of associated conditions and for the differential diagnosis of pelvic masses, in order to preventing unnecessary injury or removal[3,6]. Here, we have reported another case of the rare anomaly pancake kidney, accompanied by cysts and with a single ureter, in a patient who was asymptomatic and was diagnosed after an incidental intraoperative finding.

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Thrombocytopenia-absent radius syndrome: prenatal diagnosis of a rare syndrome

Dear Editor,

A 32-year-old woman in her third pregnancy was referred for prenatal care because of fetal malformations found on a routine ultrasound. In the second trimester fetal morphology ultrasound scan (conducted at 21 weeks of gestation), the following were identified: mild right pericardial effusion, shortened ulnae, shortened humeri (< 1st percentile for gestational age), and no radii (2nd percentile for gestational age), as shown in Figure 1A; and internally rotated hands, as shown in Figure 1B. There were no alterations in the lower limbs. The fetal biometry was consistent with the gestational age, the estimated gestational weight was 463 g, and the amniotic fluid index was 10.4 cm.

Follow-up ultrasound scans were performed every four weeks. At 31 weeks, the mother went into preterm labor, evolving to normal delivery without complications. The newborn developed respiratory distress, requiring endotracheal intubation and mechanical ventilation. Physical examination revealed deformity of the upper limbs, without other anatomical changes (Figure 2). On the sixth day of life, the ventilation patterns worsened and the infant developed pneumothorax, subsequently evolving to death.

The advent of ultrasound imaging represented a major advance in the prenatal diagnosis of fetal malformations[1,2]. The diagnostic criteria for thrombocytopenia-absent radius (TAR) syndrome are bilateral radial agenesis, with preservation of the index finger, and thrombocytopenia. Thrombocytopenia can manifest at any age, from the prenatal period to adulthood[3]. It has been