of invasiveness. There was moderate but inhomogeneous enhancement, suggesting the diagnosis of malignancy. Based on the MDCT findings the preoperative histologic characterization of the neoplasm was extremely difficult. Renal malignancies, like RCC, lymphoma, and other uncommon tumors, e.g. sarcoma, were included in the differential diagnosis.

It is known that imaging cannot predict the histology of a renal mass, although the presence of heterogeneous and significant enhancement on CT should suggest the preoperative diagnosis of a conventional RCC [9, 10]. The major question to be answered with cross-sectional imaging modalities (either CT or MRI) is whether a renal mass represents a surgical or non-surgical lesion. The most important criterion used in this differentiation is mass enhancement, and any enhancing solid renal lesion should be considered a possible renal tumor, as in our patient.

Shirkhoda and Lewis [6] described the CT (on conventional CT scanners) and angiographic features in 4 cases of advanced-stage SRCCs, detected as soft-tissue density, hypervascular masses, originating from the renal parenchyma. The differentiation from RCC in these cases was not possible, as was also the case in our patient [6]. The same group of authors suggested the preoperative diagnosis of renal sarcoma in the presence of a tumor arising from the renal capsule or the renal sinus, appearing hypovascular or avascular on angiography [6]. Our case was neither capsular in origin, nor avascular. Based on our findings, the presence of heterogeneous enhancement on imaging should suggest an aggressive nature of renal malignancies preoperatively.

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Erratum

The name of one of the authors was misspelled in the article: Split technique in horseshoe kidney transplantation. Urol Int 2006;77:6–8.

The correct name is Ricardo Miyaoka, instead of 'Myiaoka'.