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A unique presentation of a renal clear cell carcinoma with atypical metastases



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ABSTRACT

INTRODUCTION: Renal cancer is a relatively common neoplasia with renal clear cell carcinoma being the most frequent histological type. This tumor has a strong tendency to metastasize virtually to all organs. Today, new diagnostic tools allow physicians to distinguish between those patients with “incidental findings” and those with advanced metastatic disease.

PRESENTATION OF CASE: A 70-year-old male with multiple indolent subcutaneous masses underwent colonoscopy after a positive fecal screening test for colorectal carcinoma. A rectal lesion was discovered but biopsy was negative. CT scan revealed advanced renal cancer involving the peritoneal cavity, retroperitoneum and lung. Biopsy of subcutaneous masses confirmed the suspected metastases. The patient underwent surgery (an open left nephrectomy with rectosigmoid resection and metastases debulking) because of a high risk of bowel obstruction and increasing anemia. After three years of multi-targeted therapy and follow-up, the patient is still asymptomatic and in good general condition.

DISCUSSION: Treatment of metastatic renal cancer is still controversial even if more than 30% of patients have metastasis at the time of diagnosis. Recently introduced targeted therapies are encouraging but still present problems with side effects and an unlimited period of efficacy. Although there is no consensus, several studies and guidelines consider metastasectomy to be a valid option.

CONCLUSION: Recent series highlight surgery as a key-point in the management of advanced renal clear cell carcinoma. Our case demonstrates the validity of a surgical strategy supported by a multidisciplinary approach.

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1. Introduction

Renal cancer is a relatively common neoplasia, with approximately 11,800 cases per year in Italy, amounting to 3% of all adult malignancies [1]. Renal clear cell carcinoma (RCC) is the most frequent histological type, representing 60% of cases with the highest incidence occurring in individuals between 50 and 70 years of age. Renal cancer is the urological tumor with the highest mortality rate. Its aggressive behavior, due to a strong tendency to metastasize (30% of cases are metastatic at time of diagnosis or during follow-up) is associated with 14,000 estimated deaths in 2015 in the USA [2].

While in the past, RCC typically presented as hematuria, flank pain or palpable mass in the abdomen, most cases today are asymptomatic at time of discovery, due to the availability of more accurate diagnostic tools. This trend has resulted in a greater separation between cases presenting as “incidental findings” and those with advanced metastatic disease.

RCC's strong tendency to metastasize is mainly due to complex and rich vascularization and its lymphatic drainage. The major sites of metastasis are lung [75%], bone [20%], lymph nodes [11%], liver [18%], and brain [8%] but virtually all organs can be affected [3].

2. Presentation of case

The patient, a 70-year-old man with a history of hypertension, diabetes and multiple indolent subcutaneous masses, after a positive screening fecal test for colorectal carcinoma, underwent colonoscopy. The patient was asymptomatic, with neither rectal bleeding nor hematuria.

The endoscopist described a smooth flat lesion occupying one-third of the colonic lumen extending for 5 cm, characterized by rich superficial vascularization with no mucosal ulceration, 20 cm from the anal verge. Biopsy samples showed non-specific lymphocytic inflammation with edema of the colonic mucosal wall. The main tumor markers were normal: CEA 1 ng/mL, Ca19-9 3.1 U/mL, PSA 0.39 ng/mL, CA-72.4 1.1 U/mL. Renal function was conserved. The patient underwent whole body CT scan which revealed multiple nodular masses occupying the entire peritoneal cavity, pelvis and retroperitoneum, ranging from a few millimeters up to 4 cm in the retroperitoneum and 8 cm in the pelvis (Fig. 1). Specifically,

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Fig. 1. Abdominal CT scan.

the posterior aspect of the left kidney was occupied by an expansive process penetrating the para- and perirenal space with a maximum transverse diameter of 11 cm. The lungs were involved with lesions of secondary aspect with intense contrast enhancement and subcutaneous tissue was characterized by multiple lumps ranging from 1 to 10 cm. Surprisingly, the liver, pancreas, spleen and bladder were free of pathologic findings.

Following the CT scan, the patient was sent to our department for surgical evaluation. Physical inspection confirmed the presence of palpable masses in the left abdomen and multiple subcutaneous lesions of parenchymatous consistency in the patient's arms, back and chest that he reported as having had for years and that were always considered as benign lipomas. We decided to biopsy one subcutaneous lesion, located in the left chest wall, and histology identified it as clear cell carcinoma of possible renal origin (AE1/AE3+, CDK7–/+, Vimentin+, CD10+, TTF1–).

Although there is no sure evidence of major clinical benefit of surgery in metastatic renal cancer [4] after consulting with the pathologist and the oncologist, we decided to proceed to surgery mainly because of a high risk of bowel obstruction and increasing anemia due to recurrent rectal bleeding. Another purpose was to permit subsequent chemotherapy after massive cytoreduction of the neoplasia with possibly better efficacy [5,6].

The operation performed was an open left nephrectomy with rectosigmoid resection, because of two hypervascularized soft masses of 5 and 7 cm involved in the rectosigmoid junction. We also proceeded with debulking of three omental macrometastases of about 5 cm each (Fig. 2). Peritoneal multiple metastasectomy

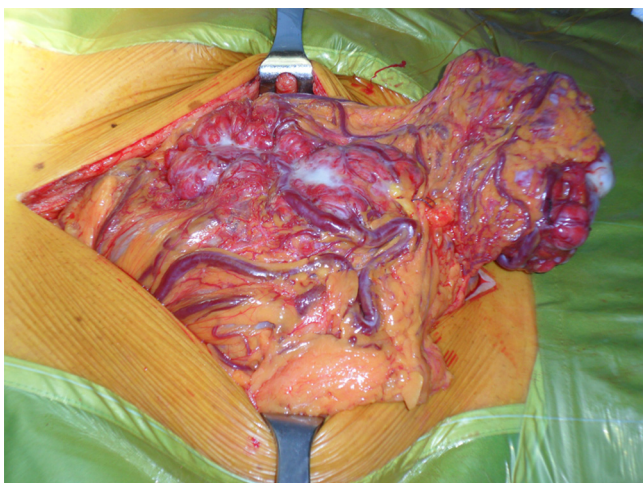


Fig. 2. Omental metastases.

completed the procedure (Fig. 3). No macroscopic radicality (R0) was achieved.

Surgical specimen examination revealed that the posterior of the kidney was completely substituted by a smooth hypervascularized 10 cm mass involving perirenal fat and retroperitoneal space (Fig. 4). Definitive histology confirmed a 10 cm renal clear cell carcinoma infiltrating perirenal fat, the left adrenal gland, omentum, sigmoid colon (Fig. 5), subdiaphragmatic stomas and subcutaneous tissues. The renal pedicle was free of metastatic infiltration as were surgical margins of the excised recto-sigmoid tract; pT4, pNx, pM1 (AJCC, TNM-2010).

The patient was referred to the oncologists for adjuvant chemotherapy. After 6 months of selective multi-target receptor tyrosine kinase inhibitor therapy (Pazopanib), the whole body CT scan demonstrated a diffuse reduction of thoraco-abdominal residual disease. After another 6 months of the same therapy, a new CT scan revealed no dimensional variation in the lesions. Almost 3 years after surgery, the patient is still asymptomatic, receiving home chemotherapy (Sunitinib) and is in good general condition. His most recent CT scan confirmed the stability of his neoplasia.

3. Discussion

Metastatic renal cancer is a relatively common event with more than 30% of patients presenting with a metastasis at the time of diagnosis, even with non-palpable and asymptomatic renal mass. As explained by Krumerman and Garret [7], the pattern of spread is almost always unpredictable, mainly due to deep angioinvasion



Fig. 3. Mesenteric metastases.

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