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CLINICAL CASE

Pancreatic metastasis from renal cell carcinoma: A different cause for recurrent duodenal bleeding

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KEYWORDS
Renal cell carcinoma;
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Abstract A 64-year-old man with a renal cell carcinoma (RCC) underwent right nephrectomy. There was no identifiable recurrence during follow-up. Six years after surgery he presented with melena and ferropenic anaemia. Endoscopic evaluation demonstrated a vascular lesion in duodenum and haemostasis was performed. However, the bleeding recurred and further endoscopies revealed an enlarged multilobulated infiltrative and ulcerative lesion over the duodenum bulb. Histological and imagiological investigations were, even so, suggestive of a vascular lesion adjacent to the duodenal wall. Given the uncertain diagnosis and recurrent bleeding a surgical resection was deemed unavoidable. A cephalic duodenopancreatectomy was performed and histologic evaluation revealed an intrapancreatic RCC metastasis with duodenal infiltration. No evidence of recurrence after 12 months was observed.

In conclusion, RCC metastasis should be considered in patients with a pancreatic mass as it gives the past history of RCC. Awareness of this entity and a high index of suspicion would help in proper diagnosis and treatment.

PALAVRAS-CHAVE
Carcinoma de células renais Metástase intrapancreática Hemorragia duodenal

Metástase intrapancreática de tumor de células renais: causa rara de hemorragia digestiva alta recorrente

Resumo Doente do sexo masculino de 64 anos de idade, submetido a nefrectomia direita há 6 anos, sem recidiva identificável durante o follow-up, apresentou-se com melena e anemia ferropriva. A avaliação endoscópica mostrou lesão vascular no duodeno tendo sido submetido a hemóstase com sucesso. No entanto, após 3 meses, ocorreu recidiva hemorrágica, observando-se lesão infiltrativa e ulcerada multilobulada no bulbo duodenal. O estudo histológico

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e imagiológico eram sugestivos de uma lesão vascular adjacente à parede do duodenal. Dado o diagnóstico incerto e hemorragia recorrente, optou-se por realização de ressecção cirúrgica. A gastroduodenopancreatectomia cefálica revelou a presença de metástase de carcinoma de células renais intrapancreática com infiltração duodenal. Não foi observada evidência de recidiva após 12 meses.

Em conclusão, as metástases do carcinoma de células renais devem ser consideradas em pacientes com massa pancreática e história de RCC. A consciência desta entidade e um alto índice de suspeita é necessário para o diagnóstico e tratamento adequado.

Background

Renal cell carcinoma (RCC) has the potential to metastasize to almost any site. Metastatic disease may be present in up to 25% of patients at the time of diagnosis while another 50% develop metastasis during follow-up.[1,2] Its tendency to vascular spreading as well as expansible ostetolytic skeletal metastization is well known. However, it is less expected that RCC presents as an unpredictable tumour which can manifest with very late metastases at unexpected sites, even a long period after successful resection of early stage lesion.[3,4] Common metastatic sites for RCC are lungs, bone, liver, adrenal glands and brain, being rarely detected in thyroid gland, gallbladder, pancreas and orbit.[5]

In this paper, we report a case of a 64-years-old man with solitary pancreatic metastasis with duodenal infiltration manifested as recurrent upper gastrointestinal bleeding 6 years after nephrectomy.

Case report

A 64-year-old man presented in the emergency room with melena. He also referred fatigue and generalized weakness for the previous 3 days. He had no associated symptoms and denied hematemesis, fresh rectal bleeding, abdominal pain or weight loss. There was no history of recent use of non-steroidal, anti-inflammatory, anticoagulant and antiagregant drugs. His past medical history was significant for hypertension and radical right nephrectomy, 6 years before, for pseudocapsulated renal cell carcinoma involving the central part of the kidney. Microscopically, the tumour was classified as clear-cell with eosinophilic and granular cells, grade II/III in the Furhman's nuclear grading system, with no calyx, capsular or vascular involvement and the ureter and hilar lymph nodes were also free of tumour. Abdominal contrast enhanced computed tomography (CT) revealed no metastization and the patient was staged as T1N0M0. No adjuvant chemotherapy was administered in view of a favourable tumour histopathology. He was placed on regular oncology follow-up and had been disease free up to his last visit.

On clinical examination he was hemodynamically stable and appeared pale. Abdominal examination was unremarkable (except for a surgical scar of right nephrectomy). Laboratory investigation on admission was significant for normocytic anaemia with haemoglobin 8.1 g/dl and leucocytosis (14.6×10^9/l). The upper gastrointestinal endoscopy (UGIE) showed an oozing haemorrhage from a solitary vascular lesion, without ulceration, in the duodenum bulb. It was injected with diluted (1:10,000) epinephrine and three endoclips (EZ clip, HX-610-090 l, Olympus, Pennsylvania, EUA) were applied, with proper haemostasis at the end of the procedure. After endoscopic review he was discharged on day 4, with proton-pump inhibitor (pantoprazole 40 mg id). As an outcome patient, he did the *Helicobacter pylori* urea breath test, which was negative.

Three months later, the patient suffered from another episode of melena, without haemodynamic repercussion, but with mild anaemia (10.5 g/dl). Upper GI endoscopy revealed an active oozing bleeding originating from an irregular, polypoid, eroded mass (1 cm) in the first portion of the duodenum (Fig. 1a). The lesion showed violet prominent structures, consistent with vascular nature. We chose to inject n-butyl-2-cyanoacrylate glue (Histoacryl®) and Lipiodol® (0.5 ml + 0.5 ml) in the central region of the lesion, with haemostatic success (Fig. 1b). The patient was discharged on the 5th day of hospitalization after endoscopic revision, which identified different characteristics of the lesion, that was now very irregular, with central ulcerated pigmented prominences (Fig. 2a). Biopsies were taken and histological examination revealed morphological findings compatible with an angiomatous lesion.

He was referred for detailed imaging and laboratory investigation, including abdominal angio-computerized tomography (CT) and endoscopic ultrasonography (EUS). The CT scan revealed a lesion between the pancreas and the duodenum with 42 mm × 30 mm, but ill defined, with no obvious mass effect, with multiple millimetric calcifications. This lesion was associated with slight regular thickening of the wall of the duodenal bulb, which could correspond to angiomatous lesion (Fig. 3a and b). No other alterations were identified, including tumour recurrence at the nephrectomy site. In the duodenal bulb, EUS revealed a multilobulated ulcerated lesion, occupying two thirds of the circumference, violaceous, easily bleeding on contact (Fig. 2b), which was reflected in ultrasound as heterogeneous wall thickness (12 mm). Hemogram (including MCV) and biochemical tumour markers (CEA and CA 19.9) were normal.