

Three Synchronous Atypical Metastases of Clear Cell Renal Carcinoma to the Maxillary Gingiva, Scalp and the Distal Phalanx of the Fifth Digit: A Case Report



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Oral cavity metastasis of malignant tumors is extremely rare and accounts for only 1% of all malignant oral tumors. Renal cell carcinoma (RCC) can metastasize to any part of the body, with a 15% risk of metastasis to the head and neck region when the disease is disseminated and a 1% risk when it is not. RCC also is the third most common infraclavicular neoplasm that metastasizes to the oral cavity, after lung carcinoma in men and breast carcinoma in women. In the maxillofacial region, the nasal cavity and paranasal sinuses are the most commonly affected sites, followed by the oral cavity. This report describes the case of a 51-year-old man with a history of clear RCC presenting with 3 synchronous atypical metastases of this tumor to the maxillary gingiva, scalp, and distal phalanx of the fifth digit. Clinical findings, diagnosis, pathology, and treatment of these lesions are discussed. Metastasis of RCC should always be included in the differential diagnosis when a new oral and maxillofacial lesion appears in a patient with a history of RCC because the metastatic lesions can often present in a broad spectrum of forms. The rapid growth of these lesions should alert clinicians to avoid any delays in biopsy examination and subsequent treatment, which is usually palliative, because prognosis is usually poor.

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Report of Case

A 51-year-old man was referred to the oral and maxillofacial surgery service by his oncologist for the evaluation of a rapidly progressive but painless intraoral exophytic lesion that was first noticed 2 weeks before initial presentation (Fig 1).

The patient's medical history was notable for obesity and renal cell carcinoma (RCC) clear cell type (T3N0M0) that was treated with left radical nephrectomy 3 years before presentation. One year after nephrectomy, he presented with a metastasis to the lung and underwent wedge resection of the right middle lobe. Two months before referral to the

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FIGURE 1. Initial presentation of the lesion between the right maxillary central and lateral teeth.

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authors' clinic, the patient began therapy on a clinical trial with immune-based therapy for his RCC and received 2 cycles of a human immunoglobulin G1 monoclonal antibody that is used to block programmed death-ligand 1 receptors. Soon after receiving these 2 doses, he developed the oral lesion, a left parietal scalp lesion (Fig 2), and a fast-growing distal phalanx lesion on his left hand (Fig 3A-C). His drug trial was discontinued and the patient was referred to the following clinics: oral and maxillofacial surgery for his intraoral lesion and surgical oncology for the parietal and distal phalanx lesions.

The patient was a lifelong nonsmoker, consumed 1 to 2 alcoholic beverages per week, and denied using any recreational drugs. He worked in management for an environmental consulting and engineering firm and denied any occupational exposures of concern.



FIGURE 2. Lesion on the left parietal area of the scalp (arrow).

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