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CLINICAL CASE

Diagnosis and treatment of isolated pancreatic metastases from renal clear cell carcinoma: Report of a case and review of literature☆

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KEYWORDS
Pancreatic metastases;
Kidney cancer;
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Abstract
Background: The development of pancreatic metastases in renal carcinoma is very uncommon.
The aim of the paper is to present a clinical case of this disease and review the clinical presentation, diagnosis, and treatment.
Clinical case: A case is presented of a 72-year-old female, with a history of renal carcinoma in the right kidney treated by total nephrectomy. At follow-up, in a radiological control, a suspicious metastatic pancreatic lesion was detected. A distal pancreatectomy with splenectomy was performed, and histopathology confirmed the origin as metastatic renal cancer.
Conclusions: Pancreatic metastases from renal cancer are very rare, and are usually diagnosed in the monitoring the primary cancer (because most of them are asymptomatic). The treatment for isolated resectable pancreatic metastases without extra-pancreatic extension is surgical resection.

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PALABRAS CLAVE
Metástasis pancreática;
Cáncer de riñón;
Pancreatectomía distal con esplenectomía

Diagnóstico y tratamiento de una metástasis pancreática única de un cáncer renal de células claras: a propósito de un caso y revisión de la literatura

Resumen
Antecedentes: El desarrollo de metástasis pancreáticas de un cáncer de células renales es muy infrecuente.

El objetivo del trabajo es presentar un caso clínico de esta enfermedad y realizar una revisión de la presentación clínica, del diagnóstico y tratamiento.
Caso clínico: Paciente mujer de 72 años, con antecedentes de carcinoma renal derecho, tratado mediante nefrectomía total. En el seguimiento se detectó en un control radiológico una lesión pancreática, sospechosa de metástasis. Se realizó una pancreatectomía distal con esplenectomía. A través del estudio histopatológico se confirmó el origen metastásico del cáncer renal.
Conclusiones: La metástasis pancreática de un cáncer de riñón es muy rara y suele diagnosticarse en el seguimiento de la neoplasia primaria (ya que la mayoría son asintomáticos). El tratamiento de elección de una metástasis pancreática solitaria, resecable sin extensión extrapancreática, es la resección quirúrgica.

Background

Isolated pancreatic metastasis is exceptional and may be caused by several primary tumours.[1–3]

The mechanism causing the production of isolated pancreatic metastases of renal carcinoma may be haematogenic or lymphatic.[4] Clinical signs will depend on the site and are similar to those produced by a primary pancreatic tumour (obstructive jaundice, intestinal bleeding, abdominal pain, weight loss, pancreatitis, diabetes mellitus, etc.).[2] They are asymptomatic in up to 50% of cases and are usually diagnosed in the follow-up of primary neoplasia.[1,5–10]

In computed tomography and magnetic resonance they present as highly vascularised lesions, usually very large in size, with well defined margins,[1,2] which may be confused with a primary neuroendocrine tumour of the pancreas,[1–3] and complementary tests are therefore undertaken to establish a differential diagnosis.

The treatment of choice for isolated resectable pancreatic metastases without extra-pancreatic extension is resection. Site conditions the technique to employ, with corresponding oncological criteria, to obtain a safety margin.[1,2,4]

There follows the clinical case of this rare entity and a review of the literature.

Clinical case

A case is presented of a 72-year-old female, with a history of high blood pressure and gynaeco-obstetric treatment for ovarian bleeding, 45 years ago, for which laparotomy was performed through appendectomy. She was operated on for clear cell renal cancer in the right kidney and was treated by total nephrectomy. Successive computed tomography controls were carried out, initially 6 months after surgery and subsequently each year. Three years after the right nephrectomy a hypervascular nodule was detected in the pancreatic body, which suggested the differential diagnosis between a metastasis and a primary pancreatic neuroendocrine tumour (Figs. 1 and 2).

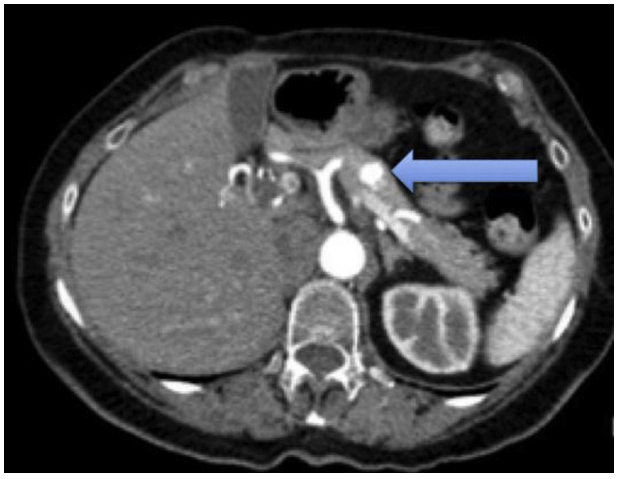

Figure 1 Axial slice of computed tomography of the abdomen without intravenous contrast in arterial phase. A hypervascular lesion of 11 mm diameter is observed in the body of the pancreas, which quickly presents contrast lavage.

As a result of these findings, a study with complete hormonal markers and a scan were performed to rule out the primary pancreatic neuroendocrine tumour. The study of the tumour and hormonal markers tested normal. No abnormal accumulations of activity showed up in the scan to indicate the existence of lesions which express somatostatin receptors. On suspicion of pancreatic metastases due to the previous surgical background of the patient, a first diagnostic possibility was indicated to be the performing of a corporocaudal pancreatectomy with open splenectomy. During the operation and with use of a scan, a tumour of