RENAL CELL CARCINOMAS METASTASES TO THE PANCREAS.
CLINICAL CASE REPORT

INKSTŲ LĄSTELIŲ KARCINOMOS METASTAZĖS KASOJE.
KLINIKINIO ATVEJO PRISTATYMAS

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ABSTRACT
Key words: renal cell carcinoma, metastases to pancreas, metastases.
Metastases of renal cell carcinoma to the pancreas are very rare and uncommon. Routine image follow – up play very important role in early detection of pancreatic metastases from renal cell carcinoma. We report the case of 75 years old man with Renal cell carcinoma metastasis to pancreas 13 years after nephrectomy. Successful surgical treatment, with pylorus-saving pancreatoduodenal resection and small bowel resection, was applied. We can state the fact, that long – term survival can be the result of surgical metastasectomy of pancreatic metastases from renal cell carcinoma.

SANTRAUKA

INTRODUCTION
Metastatic lesions in the pancreas are uncommon, accounting for only 5 % of all pancreatic malignancies. Renal cell carcinomas (RCCs) account for 2 % of all cancers and have a predilection to metastasize to rare locations, including the pancreas[1]. RCC metastases in pancreas is assigned to late metastasis and usually are found many years after primary tumor operation [2]. The appearance of metastatic disease many years after nephrectomy is a well-known feature of RCC and is associated with a more favorable outcome than early recurrences, which tend to have more rapid progression of disease. One study found that 11 % of patients who survived 10 years or more after ne-
phrectomy developed metastases, with an interval of up to 32 years in some reports. Usually it coexists with metastases of the lungs, brain, or bones. When it is solitary to the pancreas, it is distributed equally to all parts of it (head, body, and tail). The metastasis of the kidney occurs via blood or lymph vessels, although no infiltration of the peripancreatic lymph nodes exists. Patients may present with a variety of gastrointestinal symptoms, including abdominal pain, biliary obstruction, an abdominal mass, pancreatic exocrine/endocrine dysfunction, weight loss, and/or gastrointestinal bleeding secondary to hemosuccus pancreaticus. Since pancreatic metastasis from RCC may be asymptomatic in up to 50% of cases, long-term follow-up surveillance with routine imaging is indicated [3, 4].

**CASE REPORT**

F. J. 75 years old man presented to surgeon due to aches in the left side of abdomen in renal projection. 1996-12-18 abdominal ultrasound and abdominal computed tomography was performed and 3.6 cm formation was found in lateral margin of left kidney. Intravenous urography showed that both kidneys function as normal. Chest x-ray, abdominal CT and US did not show enlarged lymph nodes and metastasis in other organs. 1996-12-23 left kidney was removed and histopathology analysis result was *Carcinoma clarocellulare*, pT3, renal adipose capsule was impaired. Immunotherapy with Interferon-alfa was performed after the operation. 2002.06 when chest x-ray and chest CT was performed, 3.5 x 3 x 2.5 cm slightly wavy contour formation in the right lung L2 and increased lymph node of the lung root was found. Immunotherapy was performed again. After US of abdomen was performed spread of tumor into other organs was not found. Atypical segmentectomy S5 was performed on 2003-02-14 due to tumor growth, histopathology analysis result was renal cell carcinoma. Postoperative course was good.

Patient was observed every six months. 2009.05 patient started to complain of aches in the left infracostal region. 2009-05-15 US of abdomen was performed, and it showed...
wed 2.6 x 2.6 hypechoicogenic solid tumor in pancreas head projection, as well as hypechoicogenic 6 cm. formation with opening below the umbilicus. Tumor markers were: CA19-9 – 6.96 U/ml, CEA 0.7 U/ml. Metastasis in pancreas was suspected. Additional examination was performed – irrigoscopy did not show any pathology, upper GI x-ray with contrast did not show any pathology as well. 2009-05-27 needle biopsy under ultrasound of both formations in pancreas and below umbilicus was performed. Histopathology examination showed: formation in pancreas – renal cell carcinoma metastasis, formation below umbilicus – marginal zone B-cell lymphoma. 2009-06-16 pylorus-saving pancreatoduodenal resection and small bowel resection were performed (resectio pancreatoduodenalis cum preservatione pylori + resectio intestini tenue). Postoperative histopathological examination results showed renal cell carcinoma metastasis in pancreas, reactive lymphadenopathy in lymph nodes. B marginal zone lymphoma in lymph node and extranodal with spreading to small bowel mucosa. Postoperative course went well. Patient was sent to hematologist for consultation regarding additional examination and further treatment.

CT scan was performed 2 years after the surgery on 2011.05.26 and showed no focal changes in liver. Biliary tract not dilated, accumulation of air in biliary tree due to biliary-enteric anastomosis. Gall bladder was removed. Pancreas head was removed, pancreatic duct in body and tail diameter 3 mm, pancreas tissue structure – normal, parapancreatics formation was not observed. Spleen and adrenal gland without any changes. Left kidney removed. Right kidney also without changes, without dilatation of collecting tubules, any formations was visualized. Enlarged paraaortic lymph nodes were not observed. Metastasis in bones was not detected. Figures 1, 2, 3.

Progression of disease was not detected. As of 2014 08 01 the patient is alive.

DISCUSSION

Patients with nephrectomy for diagnosed renal cell carcinoma are always at risk of late metastasis. Out of patients who survived 10 years from the date of nephrectomy 11 per cent had late recurrence, even after radical treatment, when RCC was diagnosed early [2]. Metastases to the pancreas are rare and are about 2 % of all pancreatic neoplasms. The most common primaries that lead to pancreatic metastases are carcinomas of the kidney, lung, and colon/rectum. Breast cancer, melanoma, thyroid cancer, or sarcoma are less frequently origin of metastases to the pancreas [5, 6].

Metastatic tumors to the pancreas, excluding those involved with widespread disease or in direct continuity with the pancreas, are rare clinically and are exceedingly difficult to differentiate from a primary pancreatic neoplasm, usually they are found during routine image follow-up [6, 7, 8].

The main diagnostic methods, which are used for patient monitoring are: ultrasonography, Doppler ultrasonography, CT, magnetic resonance imaging and angiography. Performing radiological imaging characteristic hypervascular view of RCC metastasis are likely also hypervascular view is common in pancreatic neuroendocrine tumors. Hypovascular view is common in pancreatic exocrine tumors. Histopathological examination for those tumors are not necessary, because it has no influence on patients survival and relapse. Based on modern diagnostic technique and RCC in anamnesis, hypervascular tumors in pancreas can be considered as metastasis. In such cases tumor biopsy is not necessary and even dangerous [9].

Calvin H. L. Law et al. shows, that the estimated 5-year survival was 75 % after pancreatic resection for RCC metastasis [9]. These results are similar to other which shows 5 year survival at 68 % to 75 % [10].

These results are certainly superior to those of patients with widely metastatic, unresected RCC. These latter patients have a poor prognosis, with 1-year survival rates of < 50 % and 5-year survival rates in the range of 5 % to 30 %. Thus, surgical resection of RCC metastases to the pancreas should be considered in all patients where complete resection of disease is possible [9].

CONCLUSION

Routine and long term image follow–up for patients after radical surgery for primary Renal Cell Carcinoma tumor plays very important role in early detection of distant RCC metastasis in pancreas. RCC metastasis in pancreas should be treated surgically, because of good results in long term survival after pancreatic resection.

REFERENCES

