Metachronous Pancreatic Metastases of a Bilateral Renal Cell Carcinoma: A Case Report

Soufiane Ennaciri1*, Toufik Michel Bitard2, Fadi Al Derzi2, Alban Zarzavadjian Le Bian2 and Moulay Hassan Farih1

1Department of Urology, Hassan II University Hospital, Morocco
2Department of Visceral and Urological Surgery, Simone Veil Hospital, France

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*Corresponding author: Soufiane Ennaciri, Department of Urology, Hassan II University Hospital, Fes, Morocco

Abstract

We report the case of a 57-year-old patient who developed two pancreatic metastases eight years after surgical treatment of a bilateral renal cell carcinoma. A subtotal pancreatectomy with splenectomy was performed. Three years later, the patient is in good general condition and free from any tumor recurrence. Pancreatic metastases of kidney cancers are rare and onset usually late. They are most often fortuitous discovery during the surveillance of the neoplastic disease. The curative treatment is most often surgical.

Keywords: Pancreatic metastases; Bilateral renal cell carcinoma; Nephrectomy; Pancreatectomy

Introduction

Adult kidney cancer represents 3% of all cancers and the third urological neoplasm [1]. Metastases of renal cancers are usually located in the lung, liver or bones. Secondary pancreatic localization are unusual [2].

Case Report

A 57 years-old man, with a history of smoking, presented to the emergency room for a lower back pain and hematuria with blood clots.

The uroscan by computed tomography showed a bilateral kidney tumor. The left one was very large measuring 12x8x9cm taking up the lower two-thirds of the kidney. There was also a lymphadenopathy and no left renal vein thrombosis. The right kidney was occupied by an heterogenous polar superior tumor, measuring 4.3x5.1x5cm. Screening for metastasis was normal.

The patient under went at first a left radical nephrectomy. The anatomopathological study revealed a clear cell renal cell carcinoma: Fuhrman grade 3, stage pT2N0. Two weeks later, a right partial nephrectomy was performed and histological analysis found a clear cell renal cell carcinoma: Fuhrman grade 2, stage pT1N0 (Figure 1).

The survey was by CT without injection and MRI as the patient developed renal failure. Two years after nephrectomy, the imaging revealed two suspicious pancreatic nodules, on the body and the tail measuring 3 and 1cm respectively (Figure 2).

Endoscopic ultrasound with biopsy confirmed the metastatic nature of the pancreatic lesions. So the treatment was a subtotal pancreatectomy with splenectomy. Besides the appearance of diabetes, there was no tumoral recurrence three years after the surgery.

Figure 1: CT scan showing the large tumor of the left kidney.

Figure 2: CT scan showing the right kidney tumor taking the superior part.
Discussion

Figure 3: Non-injected abdominal CT scan showing both pancreatic metastases at the body (A) and at the tail (B).

Clear cell renal cell carcinoma represents up to 90% of adult kidney cancers. Risk factors include mainly smoking and obesity [3]. The tumor is usually unilateral. In case of bilateral localization, a hereditary disease should be suspected and the surgical approach should be conservative [4] (Figure 3-5).

Figure 4: Abdominal MRI without injection in T2 séquence, showing the hyperintense signal of the nodule in the pancreatic body.

Pancreatic metastases of renal carcinoma are rare, representing 2 to 5% of pancreatic malignancies [5]. The average time between the nephrectomy and the metastasis diagnosis is 8 years [5] as it was the case for our patient.

Pancreatic metastasis are often asymptomatic. However, they can cause abdominal pain, jaundice, gastrointestinal bleeding, weight loss, exocrine or endocrine pancreatic insufficiency and even acute pancreatitis [5,6].

Figure 5: The surgical specimen of caudal pancreatectomy with splenectomy.

In most cases, there are discovered incidentally in imaging. Indeed, doppler ultrasound and abdominal CT are first-line examination, they allow us to see the heterogeneous and hypervascular character of the pancreatic lesion. MRI is of great help in case of renal failure. The result are similar to the CT scan but with better detection of the lesion before injection of contrast product which is hypointense on T1 and hyperintense on T2-weighted images [7].

The diagnosis can only be confirmed with the anatomopathological examination [8]. Which can be done after a guided CT, endoscopic ultrasound biopsy or after surgical excision [7].

Surgical excision is currently the best curative treatment. Depending on the lesions topography, a pancreateco-duodenectomy or a spleno-pancreatectomy can be performed [9,10].

Conclusion

Pancreatic metastases of clear cell renal cell carcinoma are rare and can occur many years after the nephrectomy, hence the interest of a careful surveillance. The accessibility of medical imaging leads to the early diagnosis at an asymptomatic stage, thus making them accessible for a surgical treatment, allowing a good survival rate in the long.

References


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