Urology Case Reports 17 (2018) 12–14

Contents lists available at ScienceDirect

Urology Case Reports

journal homepage: www.elsevier.com/locate/eucr

Oncology

Renal tumor with pancreatic metastasis: About a case report

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ARTICLE INFO

Article history:
Received 22 October 2017
Received in revised form
6 December 2017
Accepted 14 December 2017
Available online 15 December 2017

Keywords:
Renal tumor
Pancreatic metastasis
Immunotherapy
Radical nephrectomy

1. Introduction

Renal adenocarcinoma is an epithelial malignant tumor. Usual localizations of metastases are pulmonary, osseous and hepatic. Pancreatic metastases are exceptional and may occur late.

2. Clinical observation

A 53-year-old patient, without urological or medical history, presented with epigastric pain lasting for 6 months. Physical examination was normal. Biology revealed a normal pancreatic and renal function. An abdominal scan showed a left renal lesion measuring 11 cm, isodense with heterogeneous enhancing after injection of contrast material, associated to a pancreatic tissular lesion with a cystic central component measuring 8 cm (Fig. 1). A CT guided pancreatic biopsy concluded to pancreatic metastasis of a probable renal cell carcinoma (Fig. 2). The patient underwent a left radical nephrectomy approached by lumbotomy. The final histological examination concluded to renal cell adenocarcinoma Führman grade 2 (Fig. 3). No other metastatic sites were found. The patient was then addressed for anti-angiogenic treatment as a surgical excision was not considered efficient. After two years of treatment, the pancreatic lesion's size decreased and there was no functional complaint or any sign of reccurence.

3. Discussion

Pancreatic metastases excluding contiguous lesions are rare estimated at 3% of all pancreatic neoplasia.[1] Pancreatic metastasis of renal cancers can reveal the disease, but is most commonly metachronous with an average delay of 12 years, reaching extremes of 25 years.[1] These pancreatic lesions are asymptomatic in 50% of cases or evolve in a polymetastatic context: hepatic (20%), pulmonary (20%) or renal (12%),[1] a finding confirmed by SAITOH's autopsy work shows that the rate of pancreatic metastases increases with the total number of secondary sites.[2] When pancreatic lesions are symptomatic, clinical signs are dominated by epigastric pain with frequent and important alteration of the general state.[1] The diagnosis is made by an abdominal and pelvic CT scan to certify the presence of a pancreatic lesion. Important vascularization of the lesion shows its renal origin that must be more suspected if the renal tumor is known.[1] In fact, only histological examination can confirm the diagnosis. It can be performed by guided biopsy which has a major risk of hemorrhage due to the hyper-vascularization of the lesion. Medical treatment of these metastatic lesions (hormonal, chemotherapy) is not effective but immunotherapy (Interferon, interleukin) seems to be the best therapeutic option.[3] Survival without recurrence at 2 years was 60%.[4] Overall survival at 2 years and 4 years is respectively 79% and 72%.[4] There is no significant difference between the overall survival of patients with multiple and unique pancreatic metastases.[4] The indications for surgical excision are based on data from the literature which show an acceptable survival after surgery. It therefore seems reasonable to limit the pancreatic surgery to

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https://doi.org/10.1016/j.eucr.2017.12.004

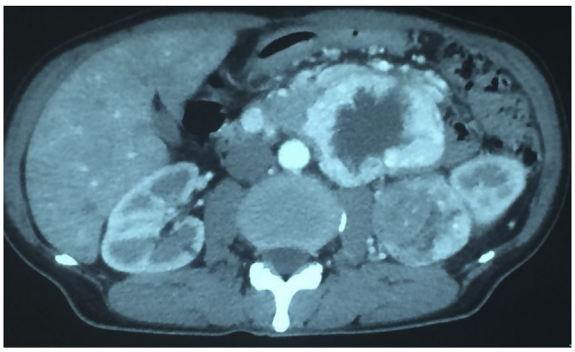

Fig. 1. Abdominal CT scan showing a left renal lesion of 11 cm, isodense with heterogeneous enhancing associated to a pancreatic tissular lesion with a cystic central component.

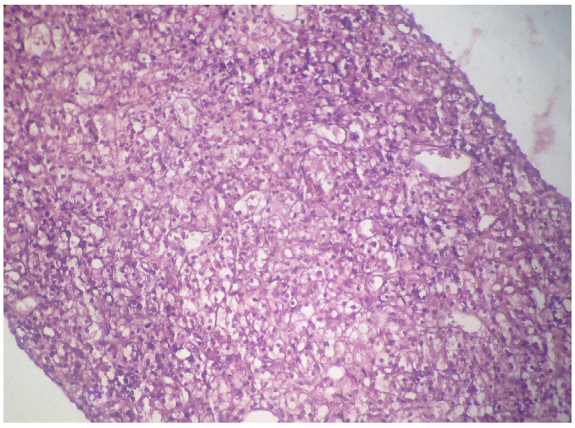

Fig. 2. Pancreatic biopsy showing a pancreatic parenchyma infiltrated with epithelial cells suspecting a pancreatic metastasis of a renal cell carcinoma.

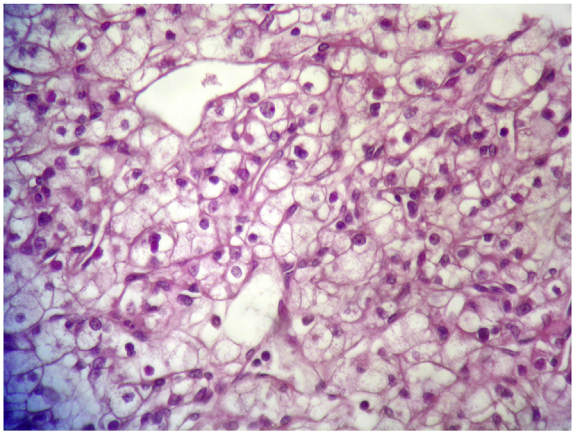

Fig. 3. Histological examination concluding to clear renal cell adenocarcinoma Führman grade 2 with maximum diameter of 9 cm, there was no invasion of the renal capsule. Pathological staging was T2a, Nx, M1.

patients with only a single synchronous or metachrone pancreatic location.[5]

4. Conclusion

Pancreatic metastasis of renal carcinoma remains rare. Literature data remains limited on this subject. Surgical treatment can be justified when the lesions, synchronous or metachronous, are limited to the pancreas in patients maintaining a good clinical condition.

Conflicts of interest

The authors declare that there are no conflicts of interest regarding the publication of this article.

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