Renal Cell Carcinoma with Gastric and Paratracheal Metastases

Rodrigues AN*, Pranavan G and Gananadha S

Department of General Surgery, The Canberra Hospital, 77 Yamba Drive, Garran, Australia

*Corresponding author: Rodrigues AN, Department of General Surgery, The Canberra Hospital, 77 Yamba Drive, Garran, ACT 2605, Australia, Tel: +61402902282; E-mail: Nicole.rodrigues@act.gov.au

Rec date: May 05, 2017; Acc date: May 06, 2017; Pub date: May 08, 2017


Description

Renal cell carcinoma (RCC) has been known to metastasize to almost all organ systems [1], however gastric metastasis is rare, with 50 cases reported in the literature to date [2]. There are also few reports of Paratracheal RCC metastases. Here we describe a case of a 73-year-old patient with disseminated metastatic renal cell carcinoma (RCC) with gastric metastasis and a large Para-tracheal deposit resulting in tracheal invasion and compression.

The RCC was initially resected in 2009 with a right partial nephrectomy, followed by a complete right nephrectomy in 2014 after tumour recurrence. He had stable disease on Pazopanib, however presented in August 2016 with melena, and was found to have a large polypoid lesion at the gastric greater curvature on gastroscopy (Figure 1). This was revealed to be an ulcerated metastatic RCC deposit on histopathology. He underwent a distal gastrectomy in September 2016 and was commenced on Sunitinib. PET-CT also showed a suspicious large left Para-tracheal mass (Figures 2 and 3), and despite the chemotherapy, had grown on a subsequent CT in January 2017, with tracheal deviation and invasion causing haemoptysis and stridor. After multidisciplinary consultation, he decided for palliative treatment and died due to acute respiratory distress 5 days later.

Figure 1: Gastric RCC deposit on gastroscopy in August 2016.

Figure 2: CT axial slice of left paratracheal deposit causing tracheal deviation in January 2017.

Figure 3: PET/CT of left paratracheal deposit, again demonstrating tracheal deviation to the right, as well as the FDG avid gastric lesion.

References:
