

CLINICAL VIGNETTE

Unusual Kidney Cancer Presentation, Case Report and Review

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A 73-year-old male with heartburn, nausea and weight loss was evaluated by gastroenterology. He underwent colonoscopy and removal of benign polyps. Upper endoscopy showed mild inflammation in stomach and esophagus as well as a small area of nodularity, which was biopsied. *H. pylori* was tested negative. The gastric biopsy was read as consistent with metastatic renal cell Cancer. It was positive for CAM 5.2, RCC and CD 10 and negative for mucicarmine. The patient had a history of moderate chronic renal disease, hypertension and myasthenia gravis. He also reported some chronic lower back pain. Ultrasound and non-contrast CT scans were performed and showed multiple cysts in both kidneys causing deformity and lobulation of both kidneys but no renal mass. MRI without contrast of Right kidney showed 4 cm and 2 cm cysts and other smaller cysts causing lobulation of kidney and possibly an area in between, which had slightly different texture and slight deformity on careful evaluation. Left kidney also had lobulation with cysts measuring 2- 2.5 cm in size. PET/CT showed Right kidney area of concern to be slightly less metabolic and no hypermetabolic areas. No adenopathy was seen and there was no evidence of metastatic disease. Incidental findings of diverticulosis, small liver cysts and abdominal aortic aneurysm and gall stones were noted. Patient underwent repeat EGD in 12/12/2011 again showing some mucosal nodularity of stomach which was biopsied and again returned as metastatic renal cell carcinoma. Pathology from stomach biopsies were reviewed and confirmed at UCLA pathology. He then underwent Ultrasound guided biopsy of right kidney area of slight irregularity of texture and shape and biopsy confirmed it to be primary renal cell cancer.

This patient presented with stomach mucosal metastatic nodules as the only area of metastatic disease and rest of workup for metastatic disease including PET / CT, bone scan and brain MRI were negative. Small ill-defined kidney cancer primary found with careful evaluation was asymptomatic. No hematuria was present. Clinical stage therefore was T1 N0 M1¹.

Kidney cancer most often spreads to lung, bone or liver, as well as local invasion in tumor bed or

adjacent organs like adrenal gland, blood vessels and regional nodal spread. Brain metastatic disease is seen less often but occasionally metastatic disease with lympho vascular spread to unusual locations are seen. Some renal cell cancers may present with elevated hemoglobin or anemia, and other paraneoplastic syndromes. Cachexia, hypercalcemia, thrombocytosis, AA amyloidosis and polymyalgia rheumatica has been described, as well as fever and liver dysfunction without metastatic disease to liver².

Incidental finding of renal tumor when scans are done for other purposes has been noted³. These incidentally diagnosed cancers carry usually better prognosis as they may be diagnosed at earlier stage before symptoms develop⁴. However 25 % of these patients may still have distant metastatic diseases.

Role of PET scan for routine staging has not been established, but renal insufficiency in this patient did not allow for contrast for CT or MRI scan and therefore decreased their sensitivity significantly^{5,6}.

Patients with chronic renal disease can frequently develop simple cysts without causing enlarged kidneys. Increased incidence of renal cancer has been described in these patients with acquired renal cystic diseases. Patients with tumors localized to kidney may present with hematuria, pain, or abdominal mass⁷.

Even with radiologically enlarged lymph nodes up to 2 cm only 50% actually will show pathological involvement⁸.

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Submitted on November 17, 2013