

Letters to the Editor

Subtotal distal pancreatectomy for metachronous metastatic renal clear cell carcinoma

Key words: Renal cell carcinoma. Pancreas metastasis.

Dear Editor,

A 61-year-old man with a history of hypertension and diabetes mellitus had undergone left radical nephrectomy for renal clear cell carcinoma 10 years previously. The pathological staging was T3 N0 M0. He was monitored by oncology service and he maintained good health until he developed fatigue and had a significant weight loss. Evaluation with the computed tomography (CT) of abdomen revealed two lesions in the tail and body of the pancreas (Fig. 1A). No other lesions were detected in the PET-CT. The endoscopy ultrasound-guide biopsy did not contribute to further findings.

The suspected diagnosis was multifocal metastatic renal cell carcinoma (RCC) in the tail and body of pancreas.

Thus, he underwent an exploratory subcostal laparotomy and a subtotal distal pancreatectomy and splenectomy were performed (Fig. 1B). Histology was reported as a metastatic renal clear cell carcinoma. The margins of the resected pancreas and lymph nodes were clear of tumor.

In the postoperative course, the patient developed a low debit pancreatic fistula, it resolved with octreotide ambulatory treatment.

Discussion

The hypernephroma or renal clear cell renal carcinoma (CCRC) is the most common renal tumor in adults. Up to 30% of cases,

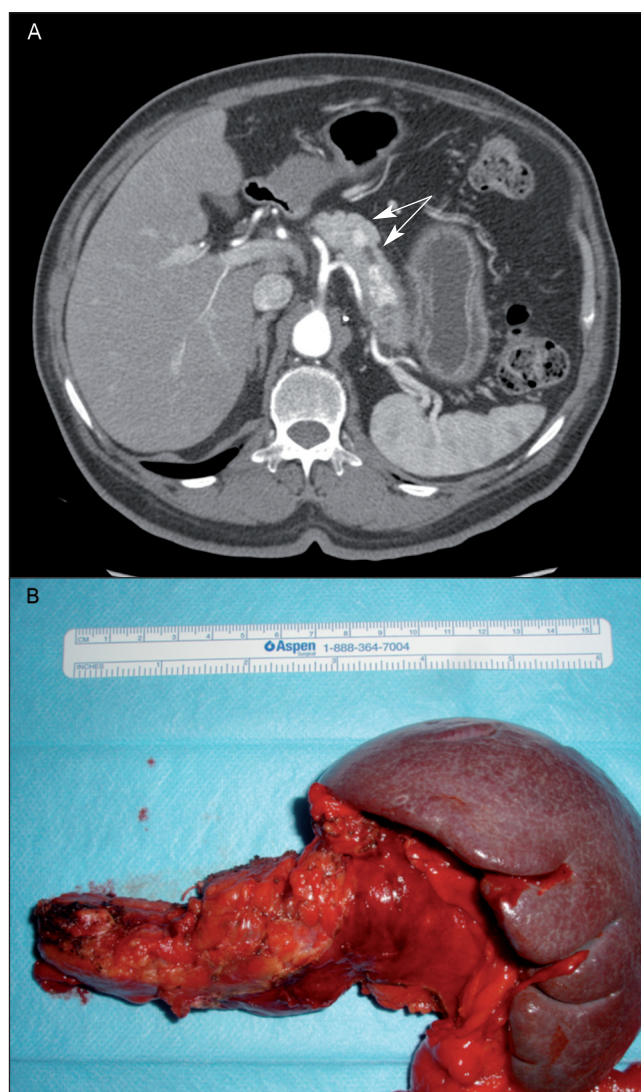


Fig. 1. A. Abdominal computed tomography (CT): Two lesions in the tail and body of the pancreas (white arrows). B. Subtotal distal pancreatectomy and splenectomy specimen.

metastases often present at the time of diagnosing, resulting principally affects the lungs and the liver, bones and brain and rarely the pancreas (3%) and it usually is metachronous (1-3).

Metastases cancer to the pancreas from another primary site is rare, representing 1-3% of the total pancreatic tumors. The way of spread of renal cell carcinoma to the pancreas is controversial and can either be hematogenous or via lymphatics. There is an indolent affinity of pancreatic parenchyma by clear cell (1).

Renal cell carcinoma metastasis to the pancreas typically occur long after nephrectomy and, thus, should be looked for during the follow-up or in patients with upper abdominal symptoms. The median duration of presentation was 10 years following a nephrectomy. The CT scan usually reveals the presence of mass or masses (in one third of cases are multifocal metastases). CT or endoscopic ultrasonography-assisted fine needle aspiration cytology could confirm the presumptive diagnosis preoperatively. The PET- CT is used to detect the neoplastic dissemination in other place and so it is possible to name the case as "isolated pancreatic metastases CRCC" (1,4).

A high resectability rate (80%) is characteristic of metastasis from renal cell carcinoma as compared to primary pancreatic cancer. When possible, complete surgical resection offers the best chance of cure (1).

It is necessary an individual surgical approach with optimal resection strategy which achieves adequate disease-free resection margins and maximal tissue preservation of the pancreas (1,2,5,6).

In inoperable or unresectable cases, there are biological therapies may be effective. Thus, the immunomodulators interferon-alpha (INF α) and IL-2, antiangiogenetic agents, such as bevacizumab, and the tyrosine kinase inhibitor erlotinib have been in use for some time, and the current standard in the treatment of metastatic disease (1,6).

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