

Letters to the Editor

Gastric metastasis from renal cell carcinoma

Key words: *Gastrointestinal metastasis. Renal cell carcinoma. Gastrointestinal bleeding. Gastric neoplasms.*

Dear Editor,

Metastatic tumours of the stomach are uncommon finding, usually discovered at autopsy (1). In the same way, gastric metastasis from renal cell carcinoma is uncommon. Brain, spinal cord, and lung are prevalent sites of metastasis from primary renal cell carcinoma (2). The occurrence of gastric metastasis might serve as an indicator of advanced disease and commonly shows concomitant tumour spread to other organs (3).

Case report

We present the case of a 87-years-old woman with arterial hypertension, atrial fibrillation treated with low molecular weight heparin, dyslipidaemia, hysterectomy and double oophorectomy due to myomas, appendectomy; breast cancer with right mastectomy with periodic checks finished years ago; in 2007, renal clear cell carcinoma with radical right nephrectomy (T3N0M0, stage III). In 2010, lung and pancreatic metastasis from renal cell were diagnosed. In the same year, the patient suffered an event of lower gastrointestinal bleeding, performing a colonoscopy with the finding of a nonspecific ulcerated lesion. In august 2011, the patient developed an episode of upper gastrointestinal bleeding with severe anaemia and melena. She underwent an upper gastrointestinal endoscopy, finding several erythematous polypoid lesions in the body of the stomach, around 2 to 6 mm of diameter, with cerebroid features, without active bleed-



Fig. 1. Gastric metastasis from renal cell carcinoma.

ing at the moment of the exploration. Endoscopic biopsy revealed renal cell carcinoma. Because of the age and comorbidity of the patient, palliative treatment was performed.

Discussion

Usually, gastric metastasis seems to be a late event in patients with renal cell carcinoma (mean of 7 years). The mean age of presentation was 65 years for males and 68 years for females (3). Gastric metastasis from renal cell carcinoma often starts as a submucosal lesion, which encroaches onto the mucosa and becomes ulcerated. The lesion may be single or multiple and is grossly polypoid or plaque-like (4). The vast majority of patients with renal cell carcinoma developing gastric metastases showed symptoms as microcytic anaemia or upper gastrointestinal haemorrhage, dyspepsia or abdominal pain, similar to those patients with primary gastric tumours. The median survival for patients with metastatic disease from renal cell carcinoma is 13 months, but, in patients with gastric metastasis, the clinical course appears to be unpredictable, and they could die within a few weeks because of the high frequency of concomitant tumour

involvement of other organs (5). Late colonic metastasis from renal cell carcinoma are uncommon too, but has been described presenting as a lower gastrointestinal haemorrhage or, less frequent, as an intra-abdominal bleed (6). Pathology did not confirm this fact in our patient, although the colonic lesion could be from renal origin. Several therapeutic approaches can be considered: surgical, local endoscopic and systemic therapy. It will depend on number and site of lesions, and status of the patient. The use of targeted drugs might offer a new perspective for affected patients (3).

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