Synchronous Vaginal Metastasis in Patient with Clear-Cell RCC. A Case Report and Review of the Literature

By Hevia Palacios M, Gómez Rivas J, Tueti Silva D, Aguilera Bazán A, Martínez-Piñeiro L & Gonzalez Peramato, P.

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Case presentation: 68 years old female patient that debuted with haematuria. In the extension study we can objectify a left renal mass treated by laparoscopic radical nephrectomy.

During admission the patient presented and episode of metrorragia. A lesion was found in the lower thrid of the vagina, which was biopsed, resulting a vaginal metastasis of clear cell carcinoma. The patient presented a favorable evolution being discharged four days after de surgical intervention. The subsequent extension study revealed progression of the underlying disease with mediastinal nodes and bone metastases.

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The patient died 9 months after surgery having received treatment with tyrosine-kinase inhibitors.

Conclusions: About 30% of patients diagnosed with renal carcinoma have metastases at the time of diagnosis. Vaginal location is extremely rare and usually occurs with episodes of metrorrhagia and mass effect. Treatment consists on removal of the lesion or local radiotherapy. The prognosis of these patients is conditioned by metastases in other organs.

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I. Background

Vaginal metastasis in patients with clear cell renal carcinoma are rare. There are fewer than 100 cases currently described as the revised literature. At the time of diagnosis, we observe metastasis by hematogenous or lymphatic spread in 20-30% of patients [1].

Vaginal metastases, despite being rare, are more common than primary tumors and as presentation of the disease is extremely rare.

We present the evolution and treatment of a patient with renal cell carcinoma and vaginal metastasis.

II. Case Presentation

We report the case of 68 years old caucasian female, with a history of hypertension, Sjögren's syndrome, vitamin D deficiency, mild mitral regurgitation and mild aortic regurgitation.

The patient has constitutional syndrome associated with macroscopic hematuria for 4 months evolution.

On physical examination we find a palpable mass in the left flank and evidenced gross hematuria. We performed a pelvic abdominal CT scan that evidence a heterogeneous mass of 10 x 16 x 9 cm dependent on the back side, the middle and lower third of the left kidney. Also striking, the presence of bilateral pulmonary parenchymal involvement with multiple nodular formations compatible with metastatic involvement (the greater than 4 cm) and apparent hilar and mediastinal infracarinal lymph nodes. The clinical stage was cT3 No M1. This case was discussed in the uro-oncology committee and despite being classified as intermediate risk according to MSKCC/Motzer's criteria [2], the patient was intervened because she had symptomatic disease.

The patient underwent a left laparoscopic radical nephrectomy.

The study of the specimen reveals a mass of 9x6x8 cm located in the middle third and lower pole, infiltrating the renal capsule, the renal sinus, perirenal fat, renal vein and numerous segmental renal veins. In addition, numerous tumor thrombosis in lymphatic vessels of renal sinus were observed (Figure 1).

Regarding lymph node staging, lymph node metastases were seen in one of the two extracted hilar lymph and in two of the three nodes obtained from the specimen of regional lymphadenectomy. On microscopic analysis we observed a renal clear cell carcinoma, grade 4 (ISUP 2014/WHO 2016) in 90% of the tumor, Fuhrman IV (90%), with 40% tumor necrosis with negative surgical margins. The pathological stage was pT3a N2.

In the first postoperative day, the patient has an important episode of metrorragia. On genital examination we found a solid mass of 2x2 cm in the left lateral surface of the vagina, on the lower third.
The patient underwent emergency surgery to suture the vaginal tear and excisional biopsy of the lesions. The pathology of both lesions revealed metastasis of clear cell renal cell carcinoma with high grade nuclear atypia and abundant lymphovascular tumor thrombosis (Figure 3 and 4). The patient had a favorable evolution getting discharged from hospital four days after nephrectomy.

One month after discharge the patient begins treatment with pazopanib (800 mg / day). A thoraco-abdomino-pelvic CT control done two months after surgery reveals an acute pulmonary embolism in lobar artery on right lower lobe as well as progression of the underlying disease with increased number and size of hilar lymphnodes and mediastinal conglomerates adenopathics as well as lytic lesion in the posterior arch of the 5th costal left rib with probable metastasic origin. The patient died 9 months after surgery.

III. Discussion and Conclusions

Since the 1970s the incidence of RCC has increased given the use of ultrasound and CT routinely for the diagnosis and evaluation of various abdominal disorders.

The classic triad of hematuria, flank pain and palpable mass is observed between 5% and 15% of patients and may also debut as different paraneoplastic syndromes like Cushing's syndrome, Staufer syndrome, deep vein thrombosis or amyloidosis among others.

At the time of diagnosis, we can observe metastasis by hematogenous or lymphatic spread in 20-30% of patients [1]. The most frequent locations are retroperitoneal nodes, lung, liver and bone. Vaginal adenocarcinomas are rare entities (5% vaginal cancers) and almost always metastatic (91%). In young women, they are often related with exposure to diethylstilbestrol. In older women, as in our case, they are almost always metastatic.

The appearance of the vaginal lesion usually precedes the diagnosis of the primary tumor, and the presenting symptoms, usually metrorrhagia, vaginal discharge and mass effect. Vaginal metastases are more common in tumors located in the left kidney and generally, these metastases occur ipsilateral to the primary kidney tumor. Less than 90 cases of vaginal metastasis of RCC were reported. In most of these cases, vaginal metastases were diagnosed as metachronous metastatic disease that discovered long term after radical nephrectomy. There are only four cases of synchronous vulvo-vaginal metastases from RCC in medical literature [3-6].

As for the way of disseminacion, JJ Mulcahy proposed the theory that even today remains the most plausible explanation for this phenomenon [7].
analysis of the specimen. All authors read and approved the final manuscript.

Acknowledgements: We don’t have acknowledgements.

References Références Referencias


Figure Legends

Figure 1: Numerous tumor thrombosis of clear cell renal cell carcinoma in lymphatic vessels of renal sinus.
Figure 3: Metastasis of clear cell renal cell carcinoma in vagina. Note the squamous epithelium of the vagina at the bottom right corner. The stroma is infiltrated by a tumor with hemorrhagic areas. Tumor thrombosis of lymphatic vessels is evident at lower part of the figure.

Figure 4: High power field of high-grade clear cell renal cell carcinoma metastatic in the vagina nested and alveolar
Table 1. Published case report of synchronous vaginal metastasis in patients with renal cell carcinoma.

<table>
<thead>
<tr>
<th>Literature</th>
<th>Age</th>
<th>Symptoms</th>
<th>Side tumor</th>
<th>Metastasis in other organs</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chibuzo et al. 2016</td>
<td>43</td>
<td>Flank pain</td>
<td>Right</td>
<td>-</td>
<td>Nephrectomy</td>
</tr>
<tr>
<td>Pisavadia et al. 2017</td>
<td>79</td>
<td>Vaginal bleeding</td>
<td>Left</td>
<td>Liver</td>
<td>Pazopanib (400 mg)</td>
</tr>
<tr>
<td>Jimenez et al. 2018</td>
<td>54</td>
<td>Vaginal bleeding</td>
<td>Left</td>
<td>Both adrenal glands, retroperitoneal lymph nodes</td>
<td>Nephrectomy + Sunitinib (50 mg)</td>
</tr>
<tr>
<td>Asaad et al. 2020</td>
<td>40</td>
<td>Vaginal bleeding</td>
<td>Left</td>
<td>-</td>
<td>Nephrectomy + Sunitinib</td>
</tr>
</tbody>
</table>

Figure 5: Coronal section of left renal tumor

Figure 6: Literature review