



Case Report

Breast and Axillary Lymph Nodes Metastasis five years after Radical Nephrectomy for Renal Cell Carcinoma: A Case Report and Review of the Literature

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ABSTRACT

Breast is an uncommon and rare site for metastasis. Primary and secondary tumors of the breast need to be differentiated as management is different. We present a 67 year old female patient with two breast lumps and an axillary lymph node, 5 years after nephrectomy for Renal Cell Carcinoma (RCC). Mammogram report showed a dense spiculated mass at right upper outer quadrant and a retroareolar mass associated with clustered micro calcifications. Fine Needle Cytology and trucut biopsy were inconclusive. Computer Topography (CT) abdomen did not show evidence of RCC recurrence. After discussion with the patient, she underwent mastectomy with axillary clearance and the final histopathology report was consistent with metastasis from RCC. The management of this case is discussed.

INTRODUCTION

Renal cell carcinoma, which accounts for approximately 3% of all adult cancers, has a tendency to metastasize, commonly to the lungs, bones, liver, adrenal glands and brain. Metastases to the breast from extramammary tumours are uncommon and metastatic renal cell carcinoma to the breast is extremely rare accounting for 3% of the cases [1]. We report metastases to the breast and the difficulty in diagnosis. Thus far, this is the first case reported as in most cases; the metastasis to the breast is part of systemic metastases.

CASE REPORT

The patient is a 67 year old lady, diagnosed with right renal cell carcinoma in 2002 for which she underwent right radical nephrectomy. Histological examination showed a clear cell type. The pathological stage was pT2 N0 M0. Regular follow-ups with computed tomography of the abdomen were negative for 5 years. In March 2007 she noted a lump in the right breast. Clinical examination revealed a 2 x 2cm right breast swelling and a vague retro-areolar mass 1 x 1cm with an enlarged ipsilateral axillary lymph node. There were no nipple discharge or skin changes. Fine needle aspiration cytology was consistent

with poorly differentiated carcinoma. The possibilities include breast carcinoma and metastatic renal cell carcinoma. A true cut biopsy was unable to confirm the diagnosis due to insufficient tissue. Mammogram (Figure 1) revealed a dense spiculated mass at right upper outer quadrant and a retroareolar mass which is associated with clustered micro-calcifications suggestive of malignancy. Breast ultrasound (Figure 2) confirmed these finding. CT thorax and abdomen showed a speculated hyper-dense lesion in the right breast and there was no evidence of local recurrence of RCC or other organ metastasis.

In view of cytological findings, mammogram and absence of distant metastases which suggested a possibility of either multicentric breast carcinoma or metastatic renal cell carcinoma, we proceeded with right mastectomy and axillary clearance. The patient made an uneventful recovery. The final histopathology report was consistent with metastatic renal carcinoma. The patient was referred to the oncologist but unfortunately defaulted further treatment. She is currently well and disease free 24 months after metastatectomy.

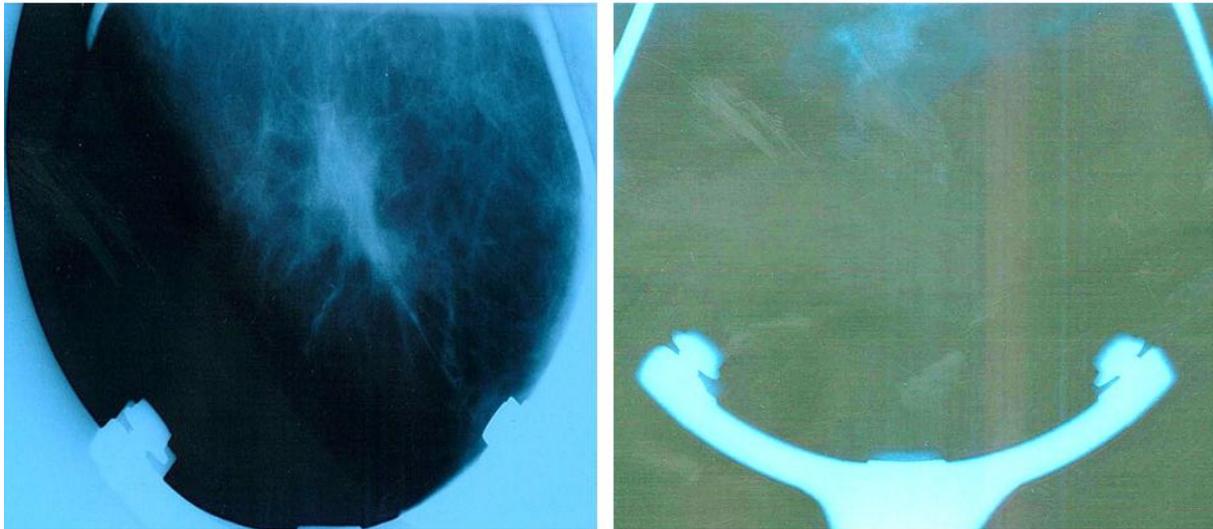


Figure 1: Mammogram: Dense speculated mass at the right upper outer quadrant and a retro-areolar mass with clustered microcalcification

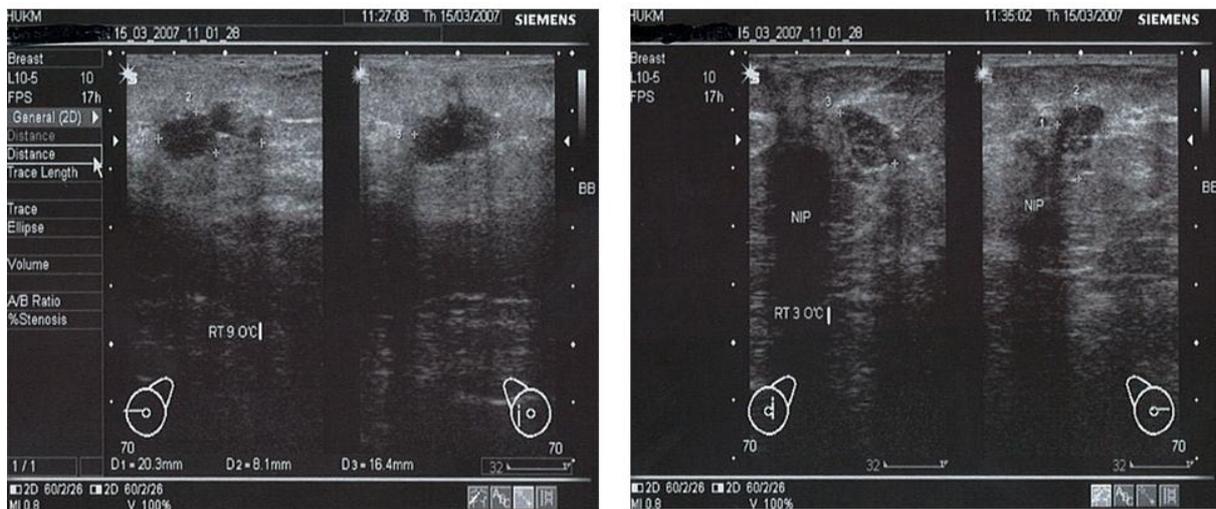


Figure 2: Ultrasound: Irregular mass with acoustic shadow at right 9 o'clock and another well-defined solid mass with irregular margin at 3 o'clock position.

Histological section (Figure 3 and 4) showed: -

Immunohistochemical studies: Positive cytokeratin(CK) , CD10 and CK7 while

negative with CK20 . Only one out of 21 lymph nodes shows malignant cell infiltration. The diagnosis of metastatic renal cell carcinoma to the breast with one lymph node involvement was made.

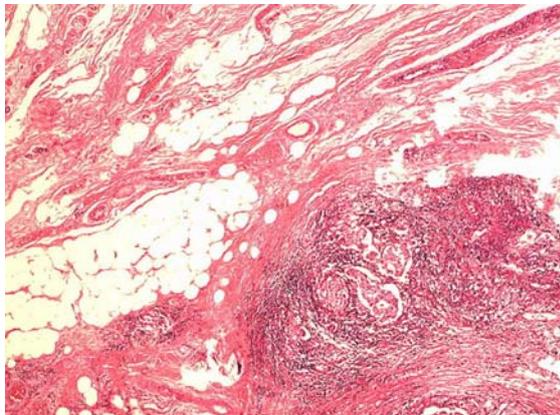


Figure 3: Tumour clusters with normal breast ducts. (2x10, HE)

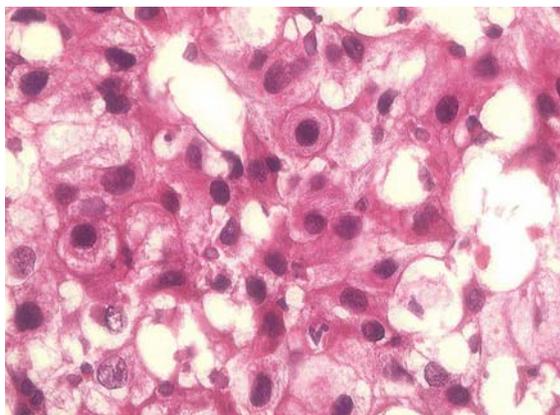


Figure 4: Malignant cells with clear to slightly eosinophilic cytoplasm. (40x10, HE)

DISCUSSION

All malignancies have the capacity to metastasize. The incidence of secondary metastasis to the breast is uncommon and rarely reported. It is represented by nearly up to 2% of all breast swelling which account for nearly 400 cases that have been reported in the literature [2]. Malignant melanoma, leukaemia and lymphoma are the most common among all malignancies that have been described metastasizing to the breast [2].

15 cases of breast metastasis from renal cell carcinoma have been reported. 8 cases presented as the initial sign of metastasis from RCC while the rest occur after nephrectomy done for RCC. The cases presented are usually found 1 to 18 years following nephrectomy for RCC [3,4]. In the case presented, the metastasis occurred 5 years after nephrectomy. The survival rates for the

patient with renal cell carcinoma, 5-year and 10-year post nephrectomies were 95% and 91% for pT1; 80% and 70% for pT2; 66% and 53% for pT3a; 52% and 43% for pT3b; and 43% and 42% for pT3c, respectively [5].

The most common extra mammary metastasis in mammography finding was a well circumscribed mass with increased density but without speculation, calcifications or other signs that characterize the majority of primary carcinomas

[6]. Micro calcifications are unusual and are mostly associated with metastatic carcinoma of the ovary, in which psammoma bodies may be abundant [7]. However, in our study, the case presented with microcalcifications as shown in the mammography study along with dense speculated mass at RUQ area. This produce suspicious of primary breast carcinoma with metastatic disease from RCC as a provisional diagnosis.

Treatment for metastasis from RCC after a long-term cancer-free survival is removal of the tumour bloc in total followed with Immunotherapy, targeted therapy and chemotherapy. This is based on a clinical trial indicating that metastasectomy RCC (MRCC) whereby solitary and fully resectable lung metastasis, together with adequate performance status, then the treatment of choice should be metastasectomy [8]. (I do not understand this paragraph from the linguistic point of view) Best outcomes are seen with single site of RCC metastasis to lung where 50 % 5 years survival is seen compared with 19%, in patients who had more than one site of cancer removed [9].

Usually, RCC metastasis to other tissue is diagnosed after tissue biopsy and most of the time, cytological biopsy is enough to confirm the diagnosis [10]. However, this is not seen in all cases. As in our case, the Fine Needle Aspiration Cytology (FNAC) which was repeated twice suggests metastatic disease (the presence of malignant cells with predominant eosinophilic cytoplasm with minority of them having cytoplasmic clearing cells) but cannot exclude primary breast carcinoma. Due to this limitation, tissue biopsy with Immunohistological staining (IHC) is mandatory for the definitive diagnosis.

Definitive diagnosis is important such as to prevent unnecessary mastectomy in extramammary tumour such as RCC metastasis. Treatment for metastasis from RCC after a long-term cancer-free survival is

removal of the tumour bloc in total followed with Immunotherapy, Targetted therapy and chemotherapy. Alpha interferon and interleukin (IL)-2 are the two most frequently used types of immunotherapy in Metastatic Renal Cell Cancer. Unfortunately, long-term results of clinical trials indicate that only approximately 15% of patients with advanced renal cell carcinoma have an anticancer response when treated with high-dose interleukin 2 and interferon [11].

In the presented case, we have proceeded with mastectomy and axillary clearance after full discussion with the patient and the family as cytological and mammogram study were strongly suspicious of breast carcinoma with no evidence of recurrence of RCC and patient opted for mastectomy.

IN SUMMARY

Primary and secondary breast carcinomas may mimic each other in clinical and radiological findings. Careful assessment and adequate tissue examination is paramount to confirm the diagnosis. Resection of isolated metastasis from RCC is feasible and can achieve long term relapse free survival.

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