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ORIGINAL ARTICLE

Exsanguinating Hemorrhage from an Anterior Abdominal Wall Metastasis of an Asymptomatic Renal Cell Carcinoma

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Abstract
Renal cell carcinoma is the most frequently encountered urological malignancy and accounts for 3% of all adult malignancies. The classically described triad of hematuria, palpable mass, and flank pain is rarely encountered, and most patients are diagnosed by screening done for other reasons. It is notorious for unusual sites of metastatic spread. We present a case of an asymptomatic renal cell carcinoma that presented as an anterior abdominal wall swelling and its neglect led to ulceration, and torrential and exsanguinating hemorrhage to which the patient succumbed.

Keywords Renal cell carcinoma · Exsanguinating hemorrhage · Metastasis

A 72-year-old lady presented with an asymptomatic swelling on the anterior abdominal wall of 7-month duration, which had gradually grown. There was no pain or discharge from the swelling. General examination was unremarkable. Per-abdominal examination revealed a subcutaneous, 6 × 4 cm firm, nodular, non-tender, irreducible supraumbilical lump, with restricted mobility (Fig. 1a). A differential diagnosis of a desmoid tumor (as patient had undergone hysterectomy previously) and an anterior abdominal wall lipoma was made. Routine blood investigations and a chest x-ray were normal. A contrast-enhanced computed tomography (CECT) scan was done which revealed a lump that confirmed the clinical findings and was not communicating with the abdominal cavity. There were areas of patchy necrosis within the tumor. Incidentally, there was a left renal neoplasm with hilar lymphadenopathy (Fig. 1b). The patient refused further evaluation and hence was discharged against medical advice. Twenty-two days later, she was brought to the emergency triage in an exsanguinated state (non-responsive) secondary to spontaneous ulceration and uncontrollable hemorrhage from the abdominal swelling (Fig. 2a). As bilateral carotid pulsations were palpable, cardiopulmonary resuscitation (CPR) was done, but the patient could not be revived. A biopsy done from the ulcerated nodule showed neoplastic cells having a clear cytoplasm, arranged in nests with intervening blood vessels and hemorrhage (Fig. 2b), thus confirming the diagnosis of a subcutaneous metastasis from the left renal carcinoma.

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Discussion

Renal cell carcinoma (RCC) accounts for about 85% of primary renal neoplasms and is one and a half times more common in males, primarily occurring in the sixth to eight decades of life [1]. According to the SEER registry between 2005 and 2011, around 16% of RCC patients had metastatic disease at presentation [2].

The metastatic pathway for RCC is not clearly defined, partly because of its complex lymphatic drainage. It commonly metastasizes to the lungs (70%), lymph nodes (55%), bones (42%), liver (41%), adrenal gland (15%), and brain (11%). However, there may be metastasis to unusual sites, even decades after the primary tumor has been removed, without involvement of these more common sites [3–5]. Surgical resection of metastatic RCC if solitary improves the outcome of the disease, with 5-year survival between 35 and 50% after metastasectomy [3].

Skin and subcutaneous metastases have been reported to be present in around 3% of cases of RCC, and usually occur at a late stage of the disease, often years after nephrectomy. Very rarely, they may occur before diagnosis of primary tumor, as in our patient. However, skin metastasis is associated with

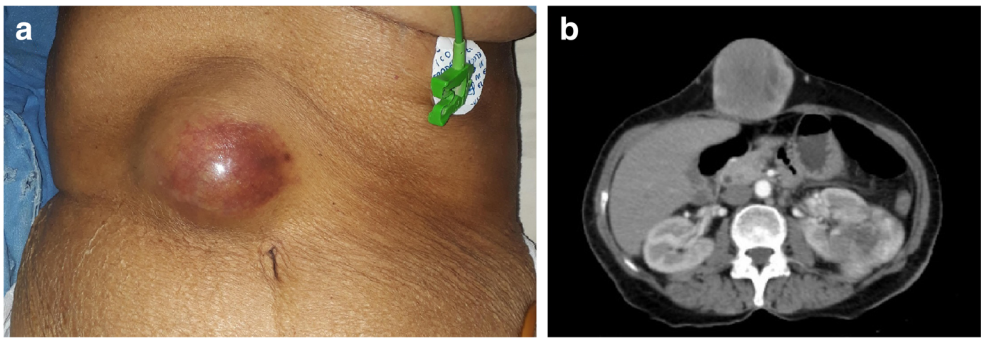

Fig. 1 **a** Supraumbilical lump. **b** CECT showing a left renal neoplasm with hilar lymphadenopathy

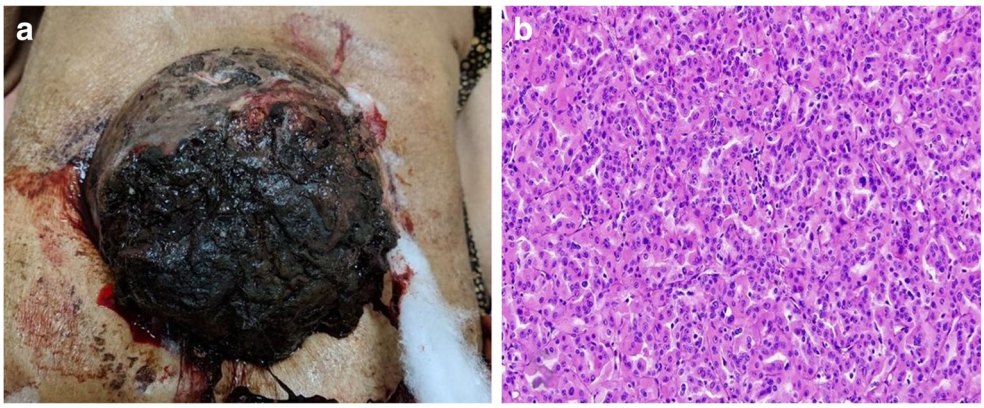

Fig. 2 **a** Spontaneous ulceration of the abdominal lump causing exsanguinating hemorrhage. **b** Biopsy confirming the diagnosis of a subcutaneous metastasis from the left renal carcinoma

synchronous visceral metastasis in up to 90% of the cases and is associated with a poor prognosis, with the patient usually succumbing within 6 months [10]. Most of the cases of RCC with skin and subcutaneous metastasis have been described in patients previously diagnosed with RCC. A study done in India over a 12-year period, reviewing 306 cases of RCC, found only 10 cases of skin and subcutaneous metastasis [4]. A Japanese study reviewing 75 cases of RCC with skin metastasis showed that the commonest site of metastasis was the trunk (40%), with the scalp (25%) and face (8%) being involved less commonly [5].

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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