

CASE REPORTS

Single Stage Resection of Renal Cell Carcinoma with Right Atrial Extension— A Case Report

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Summary:

Renal cell carcinoma (RCC) is the commonest primary tumor of the kidney which may invade through the renal vein into the inferior vena cava (IVC), and then it can extend intraluminally with subsequent tumor-thrombus formation. Here we report a case involving excision of a primary RCC with tumor-thrombus involving IVC up to right atrium with the use of extracorporeal circulation.

Single stage surgical procedure was performed in collaboration with a urological team aiming complete resection of primary tumor, para-aortic lymphadenectomy and removal of IVC thrombus extending to right atrium

Introduction:

Renal cell carcinoma (RCC) is the commonest primary tumor of the kidney. RCC may invade through the renal vein into the inferior vena cava (IVC), and then it can extend intraluminally with subsequent tumor-thrombus formation, which occurring in 5%–15% of all cases while the tumor may extend up to the right cardiac chambers in 1% of cases¹.

According to Sweeney et al² there are 4 stages of cavo-atrial tumor-thrombus extension: in type I the intravascular tumor has occupied the renal vein but not reached the IVC, in type II the IVC is involved up to the level of the hepatic veins, while in types III and IV the

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with the help of cardiopulmonary bypass. After arresting heart, RA was opened and the mass was removed through RA from IVC and hepatic vein level. Abdominal IVC was opened and the entire residual mass was removed from below also small amount of thrombus removed from left renal vein.

Postoperative venous doppler showed no residual thrombus in venous system. Histopathology report confirmed papillary renal cell carcinoma. The patient was discharged from hospital in the 12th post-operative day without any complication.

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supradiaphragmatic IVC and the right cardiac chamber are involved. In type I and type II radical nephrectomy with excision of the tumor may be done without extracorporeal circulation but cases of type III and IV requires the use of extracorporeal circulation.

In the absence of local infiltration or metastatic disease intra vascular extension does not affect the prognosis adversely, provided complete resection is achieved¹. Here we report a case involving excision of a primary RCC with tumor-thrombus involving IVC up to right atrium (type IV) with the use of extracorporeal circulation.

Case report:

A 48 years old hypertensive female presented with 2 months old history of generalized weakness, loss of appetite, weight loss and abdominal discomfort. On physical examination, patient was anemic, icteric with mild tachycardia. In her laboratory examination, anemia, elevated level of serum bilirubin and liver enzymes (ALT, AST, Alk Phos), raised serum LDH, features of coagulopathy (raised APTT, INR, FDP, D-dimer) were found. Abdominal ultrasonography (USG) showed right renal mass, dilated IVC with echogenic thrombus in right renal vein and IVC extending up to the heart. Contrast CT scan of the whole abdomen and chest showed right

kidney is replaced by a heterogenous density soft tissue mass with extension in right renal vein, IVC, proximal part of left renal vein, confluence of hepatic vein and up to the right atrium (RA) (Fig-1).

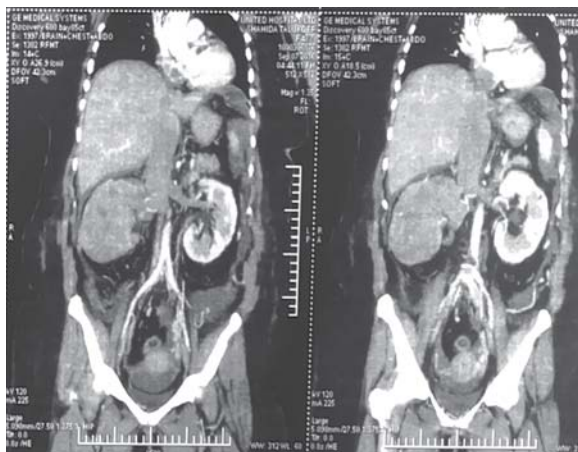


Fig-1: CT scan showing tumor thrombus (arrow) extending to IVC up to RA

There were no hepatic lesion and no para aortic lymphadenopathy. There were no lesion found in intrathoracic great vessels and lungs.

One stage surgical procedure was planned in collaboration with a urological team aiming complete resection of primary tumor, para-aortic lymphadenectomy (if present) and removal of IVC thrombus extending to RA with the help of cardiopulmonary bypass. The right kidney was mobilized by sharp and blunt dissection through a rooftop incision. IVC felt firm with tumor thrombus within. Right nephrectomy was performed. IVC was mobilized gently and taped. Cardiopulmonary bypass (CPB) was established by aortic cannula (24 Fr), venous cannulas were placed in the superior vena cava directly (24 Fr) and right femoral vein (22 Fr). Under moderate hypothermia and low flow, the ascending aorta was cross-clamped and cold blood cardioplegic solution was administered for myocardial protection antegradely. After arresting heart RA was opened and the mass was seen just reaching the IVC-RA junction (Fig-2).

The tumor thrombus was removed through RA from IVC and hepatic vein level. Abdominal IVC was opened and the entire residual mass was removed from below also small amount of thrombus removed from left renal vein. After IVC and RA were closed, the patient was gradually weaned from bypass and cannulas were removed. Total bypass time was 155 minutes and total cross clamp time was 85 minutes.

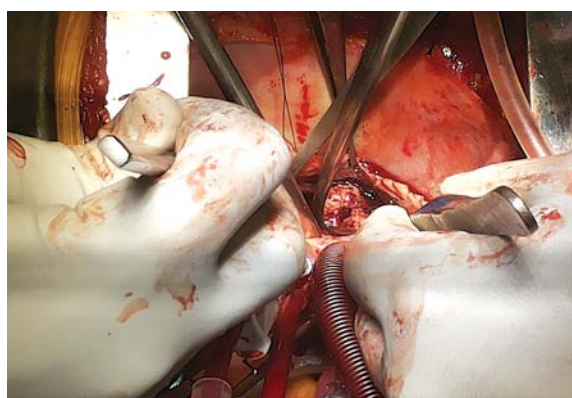


Fig-2: Showing tumor mass (arrow) in the IVC- RA junction

Postoperative venous Doppler showed no residual thrombus in venous system. The specimen (Fig- 3) showed involvement of the perinephric fat as well as ureteric lumen. Histopathology report confirmed papillary renal cell carcinoma of the right kidney with renal capsule infiltration having TNM stage-T3b Nx, Mx. Patient did not have any complications such as pneumonia, wound infection, deep venous thrombosis rather improvement of hepatic dysfunction in the immediate post-operative period. The patient was discharged from hospital in the 12th post-operative day. FDG based PET scan done 9 weeks after surgery which showed hyper metabolic spot only in 6th segment of liver, IVC and left renal vein. She was further planned for targeted therapy with Pazopanib as her follow up treatment.

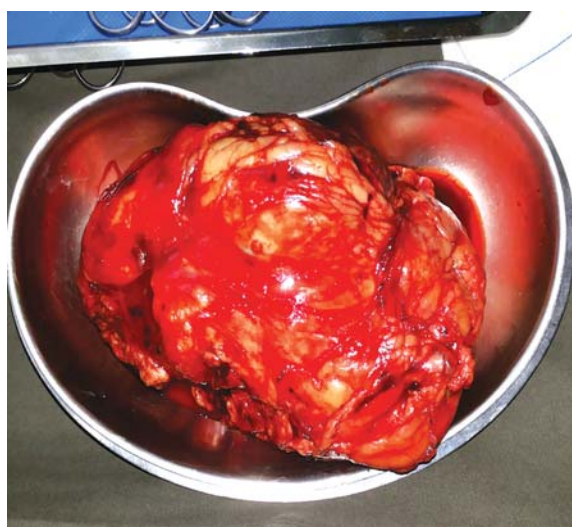


Fig-3: Showing resected specimen of right kidney

Discussion:

In RCC, nephrectomy and vena caval thrombectomy that extended into the IVC was first described by Berg et al in 1913. Presence of intra vascular extension of RCC up to IVC and RA sounds a relative hopeless situation but the current available data indicates a different scenario. Presence of perinephric infiltration of the tumor with disruption of renal capsule, local lymph node involvement and distant metastasis all have a profound influence on disease-free and overall survival. However, the intravascular tumor invasion to whatever degree is not associated with an adverse prognosis, provided complete resection (R0) is achieved¹. Radical nephrectomy with venacaval thrombectomy has operative mortality rates ranging from 2.7% to 13% and an expected 5 year survival ranging from 30% to 72%³. Ioannis and coworkers⁴ reported that prognosis (5 year survival is 50%–68%) is very good for a stage IIIa tumor (with no lymph or distal metastases). However, incomplete tumor resection is associated with poor prognosis (5 year survival: 10%–17%). In 1989, Skinner and coworkers et al also reported that tumor-thrombus, regardless of the degree of extension, if without metastasized local nodes or perinephric fat involvement, has a 5 year survival rate similar to that for a tumor that remains inside the renal capsule. In our patient, complete removal of the tumor was done successfully, though there was tumor cell involvement of the perinephric fat, there was no involvement of local lymph nodes and no gross evidence of distant metastasis found. Moreover, RCC is usually not responsive to conventional chemotherapy or radiotherapy, as a result surgery is the most effective method to eradicate this tumor as early as possible.

The application of CPB here aids in control of blood loss, decreases chances of distal embolism, provides adequate clean exposure to achieve total retrieval tumor thrombus from- IVC, part of hepatic vein and right atrium. Noguchi K et al⁵ reported the use of CPB in combination with hypothermic circulatory arrest (HCA) for complete tumor- thrombus excision. In another report Raghuram et al⁶ used CPB with moderate hypothermia and low

flow for removal of tumor thrombus. In our case we also used CPB with low flow and could achieve adequate clearance of the tumor thrombus without any complication. Commonly the tumor thrombus of RCC does not invade the IVC as a result it can be easily peeled off the IVC wall⁷. Nevertheless preoperative or intraoperative transesophageal echocardiography (TEE) can be helpful to provide accurate information regarding adherence of the thrombus with the IVC or hepatic vein.

Conclusion:

The aggressive one stage surgery should be the choice of treatment for RCC with intravascular extension and can be carried out safely with the help of cardiopulmonary bypass and a combined team effort.

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