

VAGINAL METASTASIS FROM INSUSPECTED RENAL CELL CARCINOMA

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In about 25-30% of patients with renal carcinoma, metastases are already present at the moment of clinical diagnosis. It is well known that these can be solitary and therefore mimic a primary carcinoma. Vaginal localizations of rare occurrence, but it is important in that it may simulate vaginal neoplasia and therefore delay correct diagnosis.

Up to 1975 about 50 cases had been described of renal carcinoma with vaginal metastases (^{3, 4, 7}). Later Heorni and Coll. (¹) reported 60 vaginal involvements in 110 cases of genital metastases in women. The case herein reported is interesting because of the onset of the disease; on clinical examination it appeared as a primary vaginal disease without any strictly urinary symptoms.

CASE REPORT

The patient, C.M.G., was a 44-years-old woman with an history of 2 full-term pregnancies who had been well until January, 1981. At that time a persistent febricula developed which was accompanied by a considerably increased erythro-sedimentation speed (KI59) with no modifications of hematochemical parameters. Urinary parameters were in the normal range and, in particular, there was no microscopic hematuria. In February of the same year a fungoid growth (about 3 cm in diameter) appeared in the lower portion of the anterior vaginal wall. For this reason the patient was admitted to a gynecologic ward. Laboratory as well as X-ray (thorax) examinations were negative and the patient underwent surgery to remove the growth. The histological diagnosis was mesonephric carcinoma of the vagina. One month later the patient was again hospitalized in the same ward because of the appearance of additional vaginal growths. On this occasion urographic examination revealed an enlargement of the lower pole of the left kidney with deviation and amputation of the inferior calyces (fig. 1). Tomodensitometric examination indicated the presence of an expansive growth in the left kidney (fig. 2) as well as a mass located in the left iliac region. No pulmonary lesions could be found and a liver scintiscan was also negative. The patient was then transferred to a urologic ward where, upon our physical examination, she appeared in a fairly good health condition except for a febricula and a persistent cough. On May 5, left nephrectomy was performed with excision of a neoplastic thrombus,

SUMMARY

The Authors report on a case of renal cell carcinoma with vaginal metastasis, which appeared on clinical examination as a primary vaginal disease without urinary symptoms.

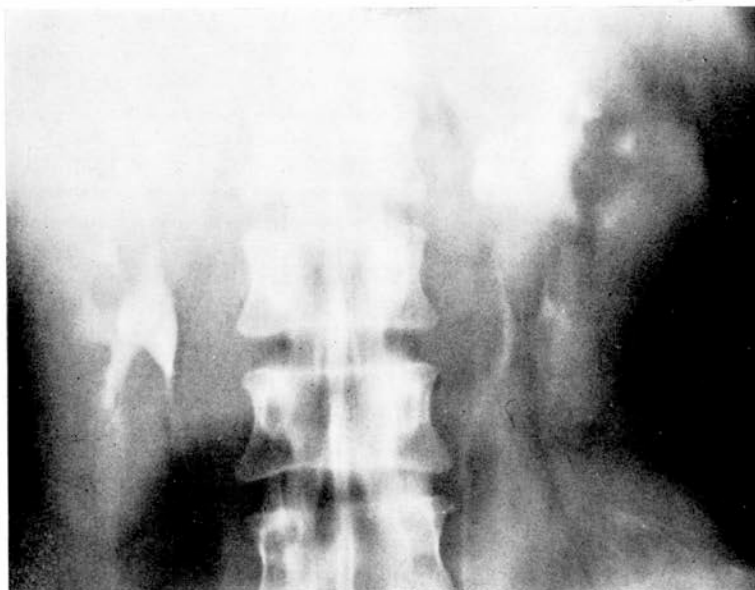


Fig. 1. — Urography: enlargement of the left kidney's inferior pole with stretching and amputation of lower calices.

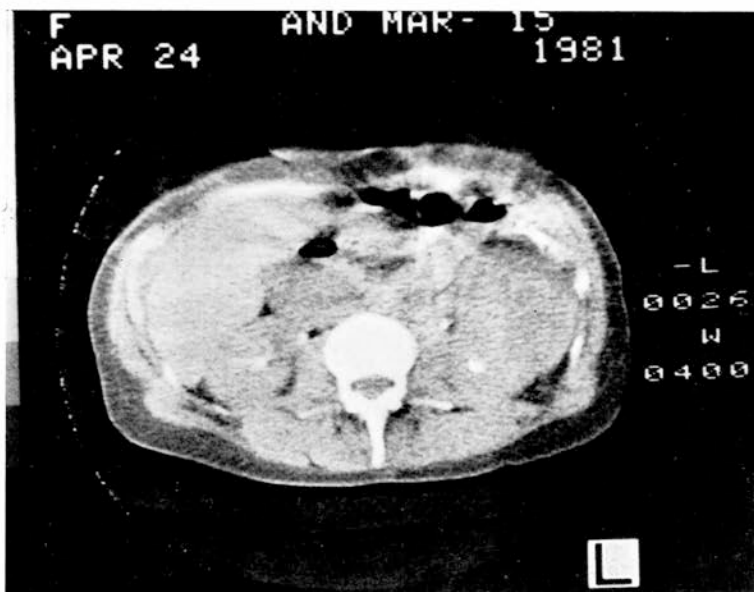


Fig. 2. — C.A.T. with contrasting media: an expansive growth is apparent in the left kidney.

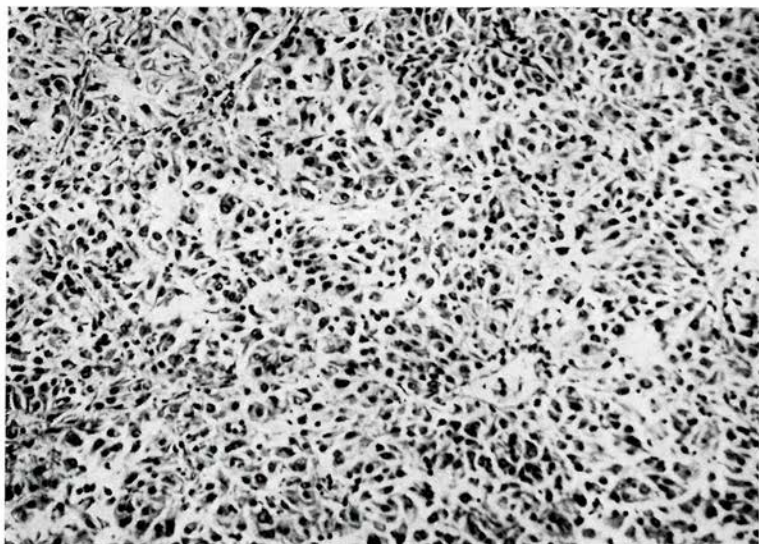


Fig. 3. — Histological examination of the renal neoplasia: highly atypical tissue made of cells in cords and nests. Also present are tubular formations with light-coloured cytoplasm (paint ematossilina-eosina).

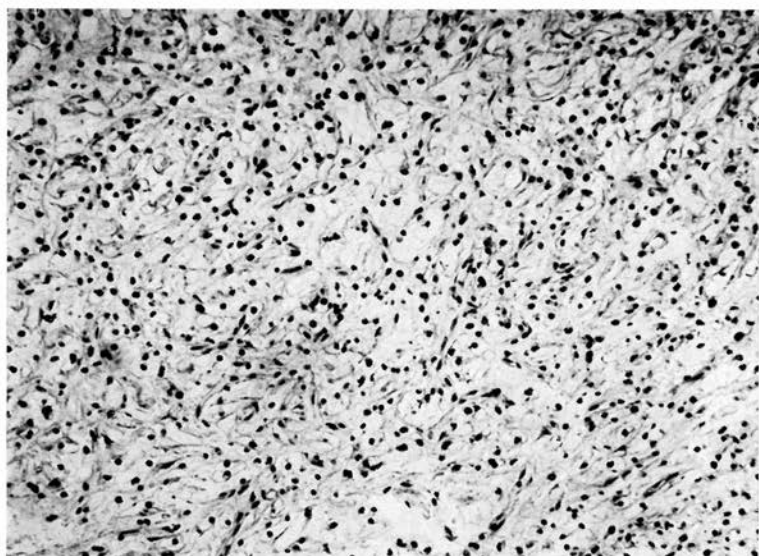


Fig. 4. — Histological examination of the ovarian neof ormation. No portion of normal ovarian tissue can be seen in the figure (paint ematossilina-eosina).

6.5 cm long, occupying the lumen of the renal vein.

Regional lymph nodes appeared uninvolved upon surgical exploration. The exploration of the left iliac region led to recognition of an oviform mass which was removed. The excision of the vaginal growth, by then approaching 7 cm in diameter, was performed as radically as possible (it was in close connection with the urethra) in consideration of the palliative nature of the surgery.

The post-surgical course was regular. The pathology of the surgical specimens confirmed the

renal vein with a long thrombus, was renal carcinoma with metastatic spread to ovary and vagina.

Four months after surgery, pulmonary metastasis became obvious and the exitus took place in November, 1981.

CONCLUSION

It is perhaps worth emphasizing some aspects of the present case which are particularly interesting. Firstly, it should be

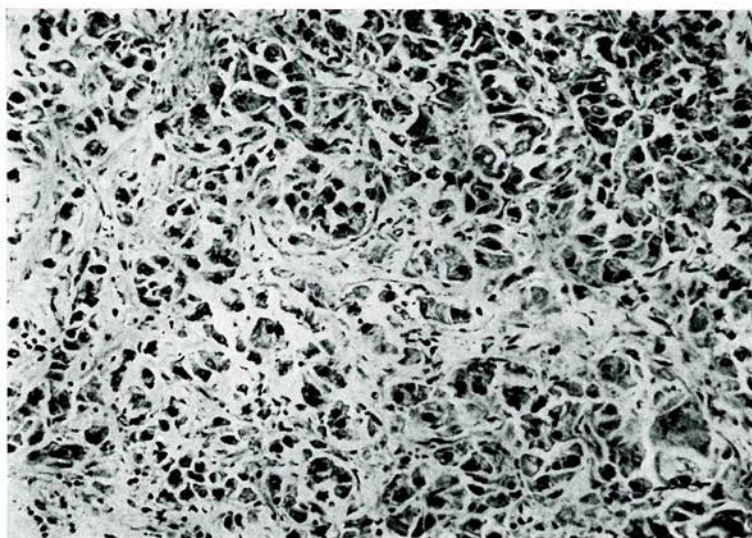


Fig. 5. — Histological examination of the vaginal neoplasia. The morphology is distinguishable from that of kidney and ovary specimens (paint ematossilina-eosina).

presence of a solitary neoplastic mass, 6.4 cm in diameter, at the lower pole of the kidney, associated with neoplastic thrombus of the renal vein. The cut surface of the kidney tumor was variegated with areas of a yellowish colour mixed with necrosis and hemorrhagic areas. The regional lymph nodes lacked microscopic alterations. The ovary measured 4×3, 5×2.5 cm and was mostly replaced by a tissue very much resembling that of the neoplastic renal growth. The fungoid formation of the vagina was fragmented and mostly necrotic. On pathologic examination, all the neoplastic growths from the different sites had a granular aspect and were in nest-like formations (figs. 3, 4, 5). The examined lymph nodes were affected by hyperplastic adenitis. The pathologic diagnosis, also in consideration of the macroscopic data, as well as the invasion of the

noted that the appearance of a vaginal growth was the first and only onset manifestation of an otherwise silent neoplasia, as proved by total lack of micro- and macrohematuria with no clinical symptoms attributable to a renal pathology. The presence of slight persistent febricula can be considered as a part of the symptomatology of renal carcinoma but its lack of specificity is of little help in making diagnosis. Secondly, the contribution of histo-pathological examinations was, as already reported in the literature, somewhat misleading.

The difficulty of a differential histological diagnosis between mesonephric adenocarcinoma of the vagina and the renal cell carcinoma, both characterized by the presence of cells with light coloured cytoplasm, should always suggest a renal neoplasia in metastatic form thus calling for an accurate examination of the upper urinary tract. The definitive histo-pathological diagnosis relied to some extent on microscopic data and on the biologic patterns of both mesonephric (or metanephric) carcinoma of the ovary and renal carcinoma as well.

As for the origin of the vaginal metastasis, there is general agreement on the possibility of backward venous seeding through the ovarian vein, the pampiniform plexus and the utero-vaginal plexus.

The greater occurrence of vaginal metastasis from left kidney tumors as compared to that from the right one supports this view since it is known that the flow

of the left renal vein favours backward flowing into the ovarian vein whereas on the right the flow of the cava protects the ovarian vein from such an occurrence. The presence of a left ovary metastasis, associated in our case with the vaginal metastasis, argues for the validity of this interpretation.

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