

DISCUSSION

Metastases in pancreas are rare, comprising 2-5% of pancreatic tumours. The most frequent corresponding primary tumours are RCC, lung, breast or colorectal cancer and melanoma (2,9).

At the time of initial RCC diagnostics, MTS are present in 20-30% of cases. In clinically localised disease (I-II stage), cancer progression after nephrectomy is observed in 20-40%, mostly (93%) in the first 5 years (4,6). The time and probability of tumour progression depends on T characteristics. The frequency of MTS and average time from nephrectomy to MTS is 7%/ 38 months in T1, 26%/ 32 months in T2 and 39%/ 17 months in T3 RCC. Similarly, the higher is nuclear grade, the more frequent and early is RCC progression (4,9). The RCC recurrence and spread involves local relapse and MTS in lungs, bones, liver, lymph nodes and contralateral kidney (2). MTS of other localisation are considerably less frequent (2,5,9). Pancreatic MTS of RCC constitute 0.25-3% of pancreatic tumours (5,9) and usually are solitary, delayed and frequently (35-50%) asymptomatic (2,3,7,9). The average time from the nephrectomy to the development of pancreatic MTS is 10.5-11.4 years (3,10) but can be as long as 25-32.7 years (8,10). Symptomatic patients develop obstructive jaundice, abdominal pain, gastrointestinal bleeding, pancreatitis and diabetes (7,9). Asymptomatic MTS are found by radiologic follow-up. RCC metastases are hypervascular in the arterial phase of CT, but primary pancreatic cancer is hypovascular (2) except neuroendocrine tumours. Endoscopic US and FNA are additional diagnostic tools (1,2). Surgical resection of MTS considerably improves the 5-year survival rate from 47% in non-operable cases to 88% in surgically treated patients (3,5,9-11). Distal pancreatic resection or pancreaticoduodenectomy is applied depending on the location of the MTS. Some authors suggest atypical resection as duodenum-preserving pancreatic head resection, middle pancreatectomy or tumour enucleation as RCC metastases are usually well-constrained. However, in order to expect favourable prognosis, only negative resection lines (R0) is the acceptable histological finding. Therefore, considering high relapse risk, atypical resections should be applied in certain exceptional cases only (3). There are no doubts that surgical removal of pancreatic MTS significantly improves patients' life expectancy and is the best solution for treatment of such patients, whenever possible.

In conclusion, nephrectomy for RCC can ensure prolonged survival. Considering the risk of delayed MTS, regular radiologic lifetime follow-up is required for RCC patients and can provide timely diagnostics of MTS before any clinical symptoms appear. The RCC metastases can involve both frequent sites of tumour spread, including lung, and unusual locations, including pancreatic gland, therefore the radiological investigations must be thorough. Early detection of MTS permits successful surgical treatment to limit tumour spread.

Conflict of interest: None

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