



# Gastric Metastasis Masquerading as a Polyp

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## Introduction

- Renal cell carcinoma is the most common renal tumor and accounts for 3% of all cancer deaths.
- Metastatic renal cell carcinoma (mRCC) commonly metastasizes to the lung (70%), bones (30-40%), liver (20%), adrenal (10%), and brain (8%)<sup>3-5</sup>.
- Gastric metastasis is a rare event with a reported incidence of 0.2-0.7%<sup>1</sup>.
- We present a rare case of a metastatic lesion appearing as a gastric polyp.
- We highlight the importance of the necessity of polypectomy regardless of size during any endoscopy.

## Case Description

78 year-old male with past medical history of GERD, RCC status-post radical nephrectomy (2000) with metastatic relapse of Lung (2013) on a Tyrosine Kinase Inhibitor for 10 years who presented with dysphagia. EGD done for stricture and dilation however, incidentally patient was found to have multiple erythematous polyps in the gastric body. Largest polyps >1 cm at the proximal gastric body along the greater curvature that did not indent with forceps. Biopsy positivity for CAM5.2 and PAX8, confirmed the diagnosis of a mRCC.

Figure 1: EGD Gastric Polyps

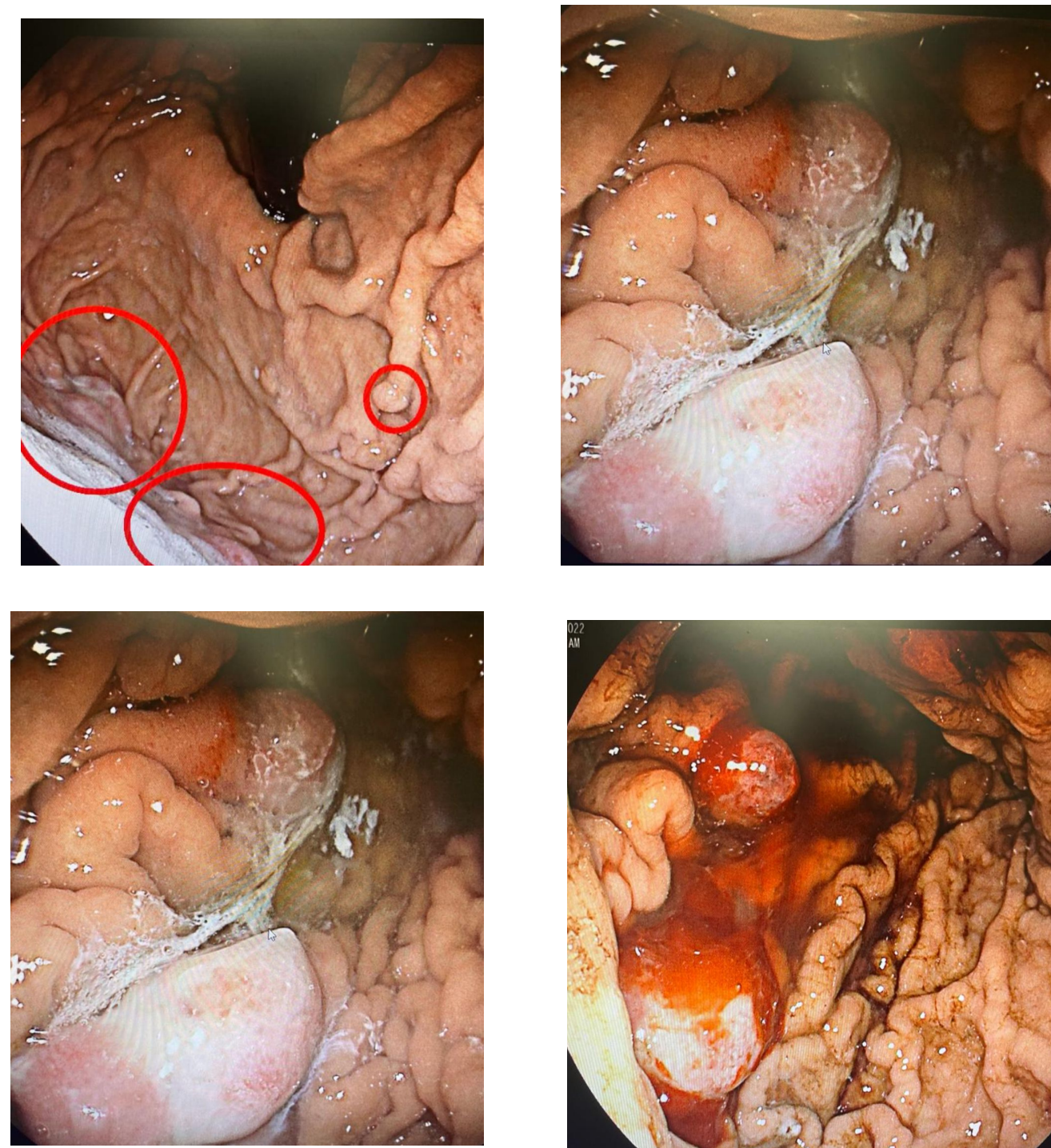


Figure 1: Metastasis of Renal Cell Carcinoma presenting as gastric polyp on upper endoscopy



A general overview of this case's timeline

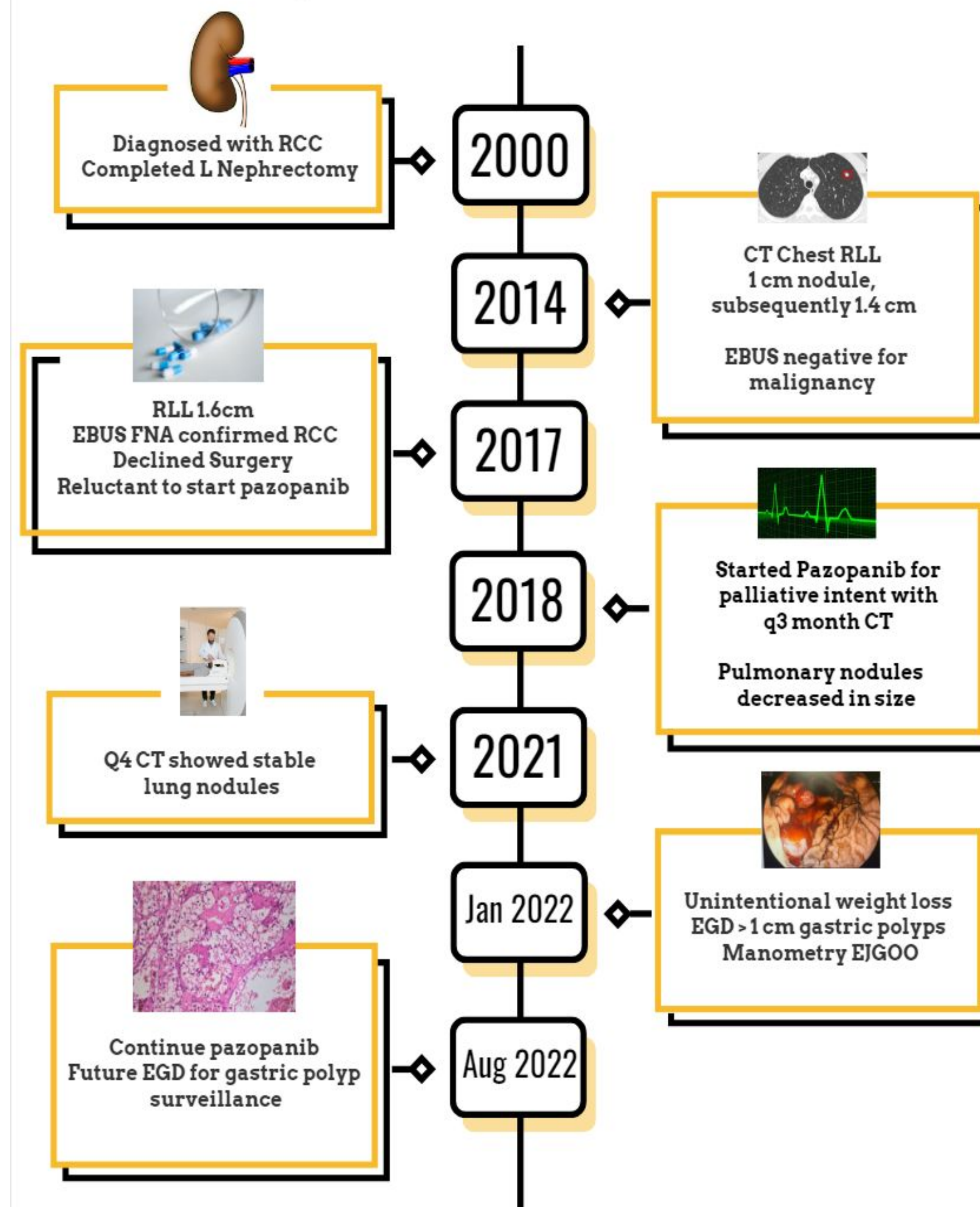


Figure 2: Timeline above represents the patient's chronological course with mRCC<sup>8,9</sup>

## Discussion

- Metastasis can occur in 30% of patient with RCC even if treated with radical nephrectomy
- Given mRCC's variable dormant nature, regardless of chemotherapy status, clinicians should not hesitate to rule out possible mRCC as lesions can have very slow growth rate ranging from 0.31–211.93 cm<sup>3</sup>/year and may be clinical silent for decades<sup>6</sup>.
- Due to mRCC slow-growing nature, they result in several false-negative chest X-ray/abdominal CT screenings within the first 10 years and mRCC may resurface decades later with alarm symptoms<sup>7</sup>.
- Slow growing metastasized lesions are still malignant; the patient's malignant polyp may have been growing 0.045cm/year for two decades.
- The minimum size cutoff for polypectomy is clinician-dependent with some guidelines recommending a 2-cm minimum and others recommending resection of all polyps greater than 0.5cm<sup>6-7</sup>.

## Conclusion

- Currently, we have limited information to know
- Unknown how long mRCC has been present for prior images
- Gastric metastasis have been present since metastasis progression and stable for the duration of his current treatment TKI.
- Despite stability of his lung metastasis, gastric disease is new and progressing.
- We kept the treatment with pazopanib at current dose due to the indolent behavior of his RCC in the past and currently asymptomatic.
- Endoscopic surveillance will continue

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