Renal cell carcinoma diagnosed during pregnancy: a case report and literature review

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Abstract
Diagnosing cancer during pregnancy is uncommon. Although pregnancies with concomitant malignancies have been reported, urological tumours are possibly the most rarely identified tumours during pregnancy. Renal cell carcinoma appears to be the most common urological malignancy during pregnancy. In this case report, we discuss successful management of a patient who was diagnosed with renal cell carcinoma during the antenatal period.

Keywords
Renal cell carcinoma, pregnancy, urological tumour, haematuria, malignancy, ultrasonography

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Introduction
Although receiving a diagnosis of cancer during pregnancy is rare, approximately one in every 1000 pregnancies is diagnosed with cancer during the antenatal period. While cervical cancer and breast cancer are among the most commonly identified cancers during pregnancy, gastrointestinal, urological, and lung cancers have a lower rate of incidence.¹ Among urological tumours, which are rarely identified tumours during pregnancy, renal cell carcinoma (RCC) appears to be the most common urological malignancy during pregnancy.² In this case report, we describe...
successful management of a patient who was diagnosed with RCC during the ante-natal period and discuss our case in the context of the relevant literature.

Case report

A 36-year-old patient at 16 weeks of pregnancy presented with the complaint of haematuria. Urinary ultrasonography showed a heterogeneous, well-demarcated mass with an approximate diameter of 12×9 cm on the upper pole of the right kidney. Magnetic resonance imaging was then performed (Figure 1), and the lesion that was identified by ultrasonography was observed to extend exophytically up to the inferior vena cava. Fine needle biopsy was performed for the patient, who was strongly suspected of having a renal tumour. A pathological examination confirmed a renal tumour. At 21 gestational weeks, right radical nephrectomy was performed in the patient by carrying out preterm prophylaxis (a Ca²⁺ channel blocker was applied for tocolysis). The surgical team were cautioned about hypotension.

A pathological examination after surgery showed chromophobe RCC without capsular invasion. No pathology was detected during routine antenatal follow-ups of the patient. The patient did not require any adjuvant treatment during the postoperative period. She was delivered by caesarean section at the 38th week of pregnancy because of a previous caesarean section. She was discharged on the second postoperative day because of her good general condition, as well as that of her newborn. The patient provided verbal consent for publication.

Discussion

Although renal tumours are approximately 10 times more common in developed countries than in non-developed, they rarely appear during pregnancy. Although environmental factors are influential in the aetiology of renal tumours, chronic diseases (e.g., obesity, hypertension, and diabetes) may also play a role. This situation is slightly different for RCC. Elevated levels of oestrogen and progesterone increase the risk of RCC in multiparous women compared with nulliparous women. The presence of hypertension is the most important risk factor for RCC, and approximately 18% of these patients have hypertension. Genetic abnormalities have also been detected in development of RCC, especially Xp 11.2 translocation, which is the most common mutation.

Although pathological examination of tissue and/or samples is necessary for diagnosing RCC, radiological imaging methods are also important. While ultrasonography is the easiest antenatal imaging technique, computerized tomography is not suitable for pregnant women. Magnetic resonance imaging is an option for identifying RCC. RCC may be asymptomatic and appear as a completely incidentally detected renal mass during the antenatal period. However, RCC may also lead to complaints of abdominal pain, distention, urinary tract infection,
| Reference                | Number of patients | Age of patient during diagnosis (years) | Gestational week during diagnosis | Gestational week during treatment | Treatment      | Mode of delivery            |
|--------------------------|--------------------|----------------------------------------|----------------------------------|----------------------------------|----------------|-----------------------------|
| Simon et al.⁷             | 1                  | N/A                                    | First trimester                  | First trimester                  | RN             | Aborted                     |
| Bovio et al.⁴             | 1                  | 20                                     | N/A                              | N/A                              | N/A            | N/A                         |
| Van der Veldt et al.⁸     | 1                  | 20                                     | 18th week                        | N/A                              | N/A            | N/A                         |
| Yin et al.⁹               | 1                  | 32                                     | N/A                              | 19th week                        | Lap. nephrectomy| N/A                         |
| O'Conner et al.¹⁰         | 1                  | 34                                     | 11th week                        | 19th week                        | Lap. nephrectomy| Spontaneous delivery        |
| Lee et al.¹¹              | 1                  | 39                                     | First trimester                  | 19th week                        | Lap. nephrectomy| Spontaneous delivery        |
| Fyn et al.¹²              | 1                  | N/A                                    | 12th week                        | 24th week                        | RN             | CS at the 24th week         |
| Pearson et al.¹³          | 1                  | N/A                                    | 28th week                        | 32th week                        | RN             | CS at the 34th week         |
| Stojnic et al.¹⁴          | 1                  | 22                                     | First trimester                  | Second trimester                 | RN             | CS at the second trimester  |
| Buda et al.¹⁶             | 1                  | N/A                                    | Second trimester                 | 17th week                        | RN             | CS at the second trimester  |
| Stroup et al.¹⁵           | 1                  | 52                                     | N/A                              | N/A                              | N/A            | N/A                         |
| Van Basten et al.¹⁶       | 1                  | 30                                     | N/A                              | 16th week                        | RN             | N/A                         |
| Casella et al.¹⁷          | 1                  | N/A                                    | N/A                              | 22nd week                        | RN             | N/A                         |
| Sainsbury et al.¹⁸        | 1                  | 30                                     | N/A                              | 11th week                        | Lap. nephrectomy| Spontaneous delivery        |
| Ceglowska et al.¹⁹        | 1                  | N/A                                    | 32nd week                        | N/A                              | RN             | CS at the 38th week         |
| Armah et al.²⁰            | 1                  | 26                                     | 14th week                        | 15th week                        | RN             | Spontaneous delivery        |
| Bettez et al.²¹           | 1                  | 28                                     | 21st week                        | 36th week                        | RN             | CS at the 36th week         |

RN radical nephrectomy, CS caesarean section, Lap. laparoscopic, N/A not available.
hypertension, and haematuria. The only complaint of our patient was haematuria. However, cases of RCC that resulted in inferior vena cava thrombosis, haemolytic anaemia, and hypercalcemia have also been reported.5

Even though treatment for RCC is surgery, it should be individualized and a multidisciplinary approach should be established because it is rare. Surgery for RCC can be safely performed at every trimester for a patient who is diagnosed during the antenatal period. Precautions should also be taken to prevent uterine contractions in the second and third trimesters, and uterine manipulations should be avoided. Additionally, hypotension should be avoided because it negatively affects uteroplacental perfusion during this period. A case of RCC, in which surgery was postponed until the 28th week (threshold period for lung maturation), has also been reported.6 Surgical laparotomic and laparoscopic approaches should be carried out by individualization. The characteristics of patients who were diagnosed with RCC during the antenatal period, and the surgical and pregnancy outcomes from 2004 to the present day are shown in Table 1.4,6–21

Postoperative adjuvant therapy is used in patients with metastatic RCC. In recent years, classical chemotherapy and hormone therapy have been replaced by multikinase inhibitors (sunitinib, sorafenib), mammalian target of rapamycin inhibitors (everolimus, temsirolimus), and anti-angiogenic agents (bevacizumab).3 In our case, adjuvant therapy was not administered because no metastasis was detected.

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The authors declare that there is no conflict of interest.

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