

Pulmonary Metastases from Renal Cell Carcinoma

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A 51-year old woman with previously known renal cell carcinoma presented to our institution with dyspnea on exertion and blood-tinged sputum. Her renal cell carcinoma was known to have been metastatic with a pathologic fracture in the right humerus and limited pulmonary metastases diagnosed the year prior to presentation. Visiting from out of state, records were obtained that showed that she was initially treated with high-dose interleukin-2 but could not continue treatment due to lack of insurance coverage. There appeared to have been an interval lapse in management for several months during which time surveillance imaging was not obtained either. She began pembrolizumab and axitinib approximately six months prior to our evaluation.

On presentation, her oxygen saturation was 85% on room air. Mild crackles were present at the right lung base. She had mild dyspnea at rest. Computed chest tomography revealed innumerable pulmonary nodules, several of which were cavitory (Figure 1). The pulmonary arterial and bronchial trees were both patent without evidence of pulmonary embolism or endobronchial obstruction, respectively.

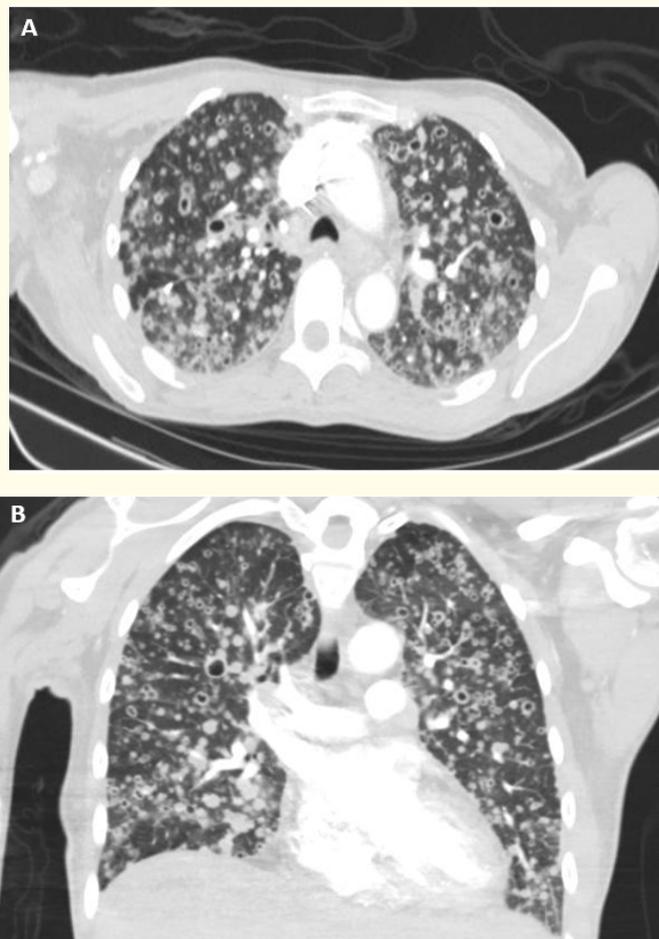


Figure 1: Computed tomography scan of the chest in axial (A) and coronal (B) views.

Despite treatment with broad-spectrum antibiotics and inhaled tranexamic acid, the patient’s respiratory status rapidly declined with worsening hypoxia over the next 48 hours. Ultimately, adequate oxygenation could not be maintained with maximal levels of high-flow nasal cannula. She revised her goals of care and transitioned to comfort measures alone. She expired on the sixth day of admission.

Disclosures

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