Brisk bleeding after gastric lesion biopsy – possible needle tract seeding after endoscopic ultrasound-guided fine-needle biopsy of a pancreatic metastasis from renal cell carcinoma

A 62-year-old patient had undergone left-sided partial nephrectomy due to renal cell carcinoma. The postoperative tumor classification was pT1a, pNx, L0, V0, G2, R0. The patient presented 6 years later with abdominal pain and unintended weight loss. Computed tomography (CT) imaging indicated multiple pancreatic lesions, therefore an endoscopic ultrasound (EUS)-guided transgastric fine-needle biopsy was performed using the Procore 19G needle (Cook Medical, Limerick, Ireland) (▶Fig. 1). Recurrence of the renal cell carcinoma was diagnosed. The tumor board decided for a pancreatectomy with splenectomy as there were no further metastases.

The patient was readmitted 6 months later because of neck swelling. The CT scan revealed a nodular goiter and a pneumomediastinum of unknown origin. Subsequent bronchoscopy and gastroscopy excluded perforation as the cause of the pneumomediastinum, which remained unclear. However, a mucosal lesion presenting an aberrant vascular pattern was detected on the posterior wall of the gastric body (▶Fig. 2). Forceps biopsy led to arterial bleeding (▶Fig. 3). An over-the-scope-clip (OTSC; Ovesco, Tübingen, Germany) was applied to control the bleeding (▶Video 1). Histological examination showed a renal cell carcinoma underneath the gastric mucosa (▶Fig. 4). Since the location of the gastric lesion corresponded to the fine-needle biopsy site, it was most likely the procedure had caused needle tract seeding to the gastric wall. Because fine-needle biopsy of the nodular goiter also revealed metastases of the renal cell carcinoma, a thyroidectomy and gastric wedge-resection were performed (▶Fig. 5).

Pancreatic metastases are rare, with a reported incidence varying from 1.6% to 11% [1]. The most common metastasis to the pancreas is renal cell carcinoma [2]. EUS-guided fine-needle biopsy is considered a safe technique with few adverse events. However, needle track seeding,
although uncommon, is a serious adverse event that may impair patient’s outcome [3]. Considering the associated risk, EUS-guided fine-needle biopsy should be carried out only when the results obtained are useful for therapeutic decision-making [4], and the needle tract line should be placed within the surgical resection margins.

The authors

Simone Freund1, Tina Schaller2, Claus Schöler3, Helmut Messmann1, Stefan K. Gölder1
1 Department of Gastroenterology, University Hospital Augsburg, Germany
2 Institute of Pathology, University Hospital Augsburg, Germany
3 Department of General, Visceral and Transplantation Surgery, University Hospital Augsburg, Germany

Corresponding author

Simone Freund, MD
Department of Gastroenterology, University Hospital Augsburg, Stenglinstr. 2, 86156 Augsburg, Germany
simone.freund@uk-augsburg.de

References


Competing interests

The authors declare that they have no conflict of interest.

Fig. 4 Histological examination of the gastric biopsy revealed a clear cell renal cell carcinoma growing underneath the gastric mucosa.

Fig. 5 Intraoperative image during the gastric wedge resection showed the renal cell carcinoma metastasis caused by needle tract seeding.