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.

References


Competing interests

The authors declare that they have no conflict of interest.

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

Bibliography

Endoscopy
DOI 10.1055/a-1541-7061
ISSN 0013-726X
published online 2021
© 2021, Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany