At presentation, nearly 25% of patients with renal cell cancer (RCC) either have locally advanced disease or distant metastasis. RCC has the highest preference for the lung (71%), lymph node (49%), and bone (36%). Metastasis to the esophagus and pericardium is exceedingly rare, with less than ten cases documented to date.

**CASE**

We present a case of a 54-year-old male with metastatic RCC, clear cell type. He presented with chest pain, productive cough, and dyspnea for which he received two courses of antibiotics with no improvement. CXR was concerning for pneumonia. On follow-up, CT chest significant bilateral hilar, extensive mediastinal lymphadenopathy, ground glass opacities, infiltrates and 1.5 cm metastatic subcutaneous nodule lateral to the left shoulder joint was noted. Moderate-sized pericardial effusion and extensive hypermetabolic uptake in the neck, chest, abdomen, pelvis, and bones were noted on the PET scan. Oncology was consulted and advised an excisional biopsy of the cervical lymph node. Biopsy revealed metastatic carcinoma of renal origin, clear cell type. ECHO confirmed the pericardial effusion, for which cardiology recommended pericardiocentesis. Pericardial fluid cytology revealed atypical cells. Simultaneously, the patient developed progressive dysphagia for which he underwent two courses of antibiotics with no improvement. CXR was concerning for pneumonia. On follow-up, CT chest significant bilateral hilar, extensive mediastinal lymphadenopathy, ground glass opacities, infiltrates and 1.5 cm metastatic subcutaneous nodule lateral to the left shoulder joint was noted. Moderate-sized pericardial effusion and extensive hypermetabolic uptake in the neck, chest, abdomen, pelvis, and bones were noted on the PET scan. Oncology was consulted and advised an excisional biopsy of the cervical lymph node. Biopsy revealed metastatic carcinoma of renal origin, clear cell type. ECHO confirmed the pericardial effusion, for which cardiology recommended pericardiocentesis. Pericardial fluid cytology revealed atypical cells. Simultaneously, the patient developed new-onset atrial fibrillation and non-sustained ventricular tachycardia for which he was started on sotalol, digoxin, and eliquis. The patient underwent his first chemotherapy session which consisted of nivolumab and cabozantinib, followed by administration of a colony-stimulating factor. A week post immunotherapy patient developed a petechial rash on bilateral lower extremities consistent with leukocytoclastic vasculitis confirmed on biopsy. The patient continued to develop recurrent pericardial effusion requiring a pericardial window. In later stages, the patient developed progressive dysphagia for which he underwent endoscopy. Upper GI endoscopy revealed a completely obstructing, malignant esophageal tumor found in the middle third of the esophagus. Biopsy revealed high-grade poorly differentiated carcinoma, metastatic, favoring kidney origin. The patient’s condition rapidly deteriorated, and hence he was transferred to the palliative care unit.

**INTRODUCTION**

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We present a case of a 54-year-old male with metastatic RCC, clear cell type. He presented with chest pain, productive cough, and dyspnea for which he received two courses of antibiotics with no improvement. CXR was concerning for pneumonia. On follow-up, CT chest significant bilateral hilar, extensive mediastinal lymphadenopathy, ground glass opacities, infiltrates and 1.5 cm metastatic subcutaneous nodule lateral to the left shoulder joint was noted. Moderate-sized pericardial effusion and extensive hypermetabolic uptake in the neck, chest, abdomen, pelvis, and bones were noted on the PET scan. Oncology was consulted and advised an excisional biopsy of the cervical lymph node. Biopsy revealed metastatic carcinoma of renal origin, clear cell type. ECHO confirmed the pericardial effusion, for which cardiology recommended pericardiocentesis. Pericardial fluid cytology revealed atypical cells. Simultaneously, the patient developed new-onset atrial fibrillation and non-sustained ventricular tachycardia for which he was started on sotalol, digoxin, and eliquis. The patient underwent his first chemotherapy session which consisted of nivolumab and cabozantinib, followed by administration of a colony-stimulating factor. A week post immunotherapy patient developed a petechial rash on bilateral lower extremities consistent with leukocytoclastic vasculitis confirmed on biopsy. The patient continued to develop recurrent pericardial effusion requiring a pericardial window. In later stages, the patient developed progressive dysphagia for which he underwent endoscopy. Upper GI endoscopy revealed a completely obstructing, malignant esophageal tumor found in the middle third of the esophagus. Biopsy revealed high-grade poorly differentiated carcinoma, metastatic, favoring kidney origin. The patient’s condition rapidly deteriorated, and hence he was transferred to the palliative care unit.

**DISCUSSION**

- Nearly 2/3 of cases of metastatic RCC, present with metastasis to more than one site; lung (45-60%), bone (40%), lymph node/ liver (30%), and adrenal gland/ brain (10%).
- Classification of RCC based on molecular subtype is significantly better at predicting overall and progression-free survival compared to the International metastatic RCC consortium (IMDC) score.

**CONCLUSION**

- Our case highlights atypical site for RCC metastasis; esophagus, challenges associated with diagnosis and the need to tailor the management based on the individual’s performance status, goals of care, complications and disease prognosis.
- Atypical site should be worked up to differentiate between metastasis or a new primary.
- Multidisciplinary approach is crucial in effective management.
- Palliative care should be consulted within 8-weeks of the patient’s diagnosis.

**REFERENCES**