Mets Here, Mets There, Mets Everywhere....

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40 years old male, smoker, presented with shortness of breath, cough, hemoptysis and chest pain since 4 days. He had blood pressure of 100/70 mmHg, tachypnea and tachycardia. Normal S1, S2. No murmurs. Air entry was decreased on right basal area. There were no added sounds. Well’s Criteria To Assess Clinical Likelihood Of Pulmonary Embolism was 5.5. ECG showed sinus tachycardia. Chest Xray showed cannon ball opacities in right upper and mid zones. Cotton fluffy opacities involving right lower, left mid and lower zones. Obliteration of right costophrenic angle. 2D echo showed ball opacities in right upper and mid zones. Cotton fluffy opacities involving right lower, left mid and lower zones. Obliteration of right. CTPA + CT thorax and CT abdomen showed right pulmonary artery embolism. Bilateral pulmonary parenchymal metastasis. Right renal cell carcinoma. Pretracheal, prevascular, subcarinal, precardinal and aortopulmonary window lymph node mets, vertebral mets at L5. USG Guided biopsy of right renal mass done revealed Clear cell carcinoma (Renal cell carcinoma).

Uncommon presentation of Malignancy are common. In our case RCC presented as pulmonary embolism. Secondary or metastatic cardiac tumors are 30 times more frequent than primary. “Surprises are bound to happen”. Treatment for cardiac metastasis should be done along with that of primary malignancy. In carefully selected patients resection of cardiac metastasis provide symptom relief, improved quality of life and prolong survival. Multispeciality approach is the key in management of such patients.

References


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