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OCCULT RENAL CELL CARCINOMA PRESENTING AS A PALPABLE SUPRACLAVICULAR VIRCHOW’S NODE

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**CONCLUSION**

Occult Renal Cell Carcinoma metastatic to Virchow’s Node is a very rare presentation requiring a multidisciplinary team to keep the patient functional and symptoms controlled for as long as possible.

- Lateralized nephrectomy with complete metastasectomy compared with incomplete/no metastasectomy increased survival by 40.8 months.
- CT Thorax and Abdominal/Pelvis with IV and PO contrast is the preferred imaging modality for identifying and monitoring RCC and metastasis.
- View thorax in arterial phase and abdomen/pelvis in venous phase.
- Nivolumab (PD-1 inhibitor) and Ipilimumab (CTLA-4 activator) increases T cell activity allowing it to attack cancer cells
- Denosumab (RANKL inhibitor) inhibits osteoclast function, shown to be equal to superior of zoledronic acid (3rd generation bisphosphonate).

**REFERENCES**

5. Rudolf Virchow, M.D. identified Virchow’s Node in 1848. It is the last lymph node in the supraclavicular chain located at the jugulo-subclavin junction where the thoracic duct enters venous circulation.
- Positive Virchow’s node is concerning for abdominal cancer, most commonly gastric cancer.

**Background**

- Renal cancer is the 8th most common cancer in the US with Renal Cell Carcinoma (RCC) making up 85% of these cancers.
- Clear cell subtype makes up 85% of RCC and papillary subtype makes up 10-15%.
- RCC metastasizes in 25-30% of patients. 5 year survival is approximately 10%.
- Common sites of RCC metastases in decreasing frequency: lung (30-50%), mediastinum, bone, liver, kidney, retroperitoneum, and brain.
- Rudolf Virchow, M.D. identified Virchow’s Node in 1848. It is the last lymph node in the supraclavicular chain located at the jugulo-subclavin junction where the thoracic duct enters venous circulation.
- Positive Virchow’s node is concerning for abdominal cancer, most commonly gastric cancer.

**Case Report**

- A 71 year old male presented with altered mental status.
- CT imaging visualized a lingula mass with diffuse lymphadenopathy and lytic bone lesions.
- Excisional biopsy of Virchow’s node revealed Renal Cell Carcinoma Papillary Subtype.
- CT imaging of the abdomen and pelvis showed no renal mass.
- Due to the inability to lateralize the primary tumor a nephrectomy was not offered and metastasectomy was not feasible.
- The patient was started on Nivolumab, Ipilimumab, and Denosumab and discharged home once his altered mental status resolved to be with his family.

**Pathology Results of Virchow Node Excisional Biopsy:**

- +: Pancytokeratin, PAX8, Vimentin, and CD10
- -: CK7, CK20, TTF1, Napsin A, GATA3, Glypican 3, NKX3.1, S100, and CD45

Findings suggestive of Renal Cell Carcinoma Papillary Subtype.

**REFERENCES**