Leiomyosarcoma of the Inferior Vena Cava Presenting as a Renal Mass: a case Report

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Abstract
Leiomyosarcoma (LMS) are rare tumor associated with poor outcomes. Treatment of the condition is challenging due to limited cases in the literature. Here, we present the case of a 46-year-old male who presented with left lower limb deep vein thrombosis, with an ultrasound scan revealing right renal mass. MRI demonstrated a large, well-circumscribed lesion engulfing in the middle and lower right renal poles associated with an invasion of the related part of the IVC, right renal vein and mid-length of the left renal vein. The patient underwent right radical nephrectomy and IVC thrombectomy. Subsequent pathology was consistent with an LMS of the inferior vena cava. We document this case and discuss implications.

Key words
Leiomyosarcoma, Inferior vena cava, Renal mass, Nephrectomy

Background
Leiomyosarcoma (LMS) are rare tumors, accounting for just 6% of all sarcomas [1]. Currently, around 600 cases of LMS of the inferior vena cava (IVC) have been reported worldwide [2,3]. Usually diagnosed in the 5th or 6th decade of life, LMS of the IVC is predominant among females, with a 5:1 to 3:1 ratio of females to males [4,5]. Here, we present the case of a 46-year-old male who was found to have a 14 cm right renal mass. Pathological findings following a right radical nephrectomy and IVC thrombectomy confirmed LMS of the IVC.

Case Presentation
A 46-year-old man, previously healthy, presented with left lower limb deep vein thrombosis and was admitted to the hospital. Incidental findings of abdomen and pelvic ultrasound revealed right renal mass and superficial DVT.

Upon examination, the patient was stable. His abdomen was soft and lax, with no palpable masses. His D-Dimer was 2000, and his serum creatinine 146.

MRI revealed a large, well-circumscribed lesion engulfing most of the middle and lower right renal poles associated with an invasion of the related part of the IVC (extending cranially and ending at the retrohepatic segment), right renal vein, and mid-length of the left renal vein (Figure 1). Subsequent signal void was appreciated in the lower segments of the IVC as well as the examined parts of bilateral common iliac veins. The tumor measured around 14.0 x 12.5 x 9.0 cm in maximum dimensions.

CT scan revealed a large irregular circumscribed lesion seen epic entered within the right lower renal pole invading the related part of the IVC (extending cranially and ending at the retrohepatic segment), right
length of the IVC, whole length of the left common iliac, external iliac and demonstrated part of the femoral vein, and the proximal segment of the left common iliac vein, and mid-length of the left renal vein (Figure 2), Subsequent filling defect is appreciated at the intrahepatic segment of the IVC, as well as the whole length of the IVC, whole length of the left common iliac, external iliac and demonstrated part of the femoral vein, and the proximal segment of the left common iliac
and proximal part of left internal iliac veins. The upper border of the lesion was seen abutting the hepatic capsule at segment VI with no definite line of cleavage appreciated. The lesion was heterogeneously enhanced in the post contract images, measuring 9.7 x 12.5x13.5 cm.

Renal cortical scintigraphy showed normal morphology of left kidney (62% function) and right kidney showed a large photon-deficient area occupying its lower portion partially extending to mid-portion and encroaching on the renal pelvis with upward lateral displacement of the kidney, the remaining part of the right kidney showed good cortical uptake (38% function).

The patient was kept on therapeutic Clexane 0.8 BD (Enoxaparin sodium) subcutaneously. The patient was prepared for elective surgery. The patient underwent right radical nephrectomy and IVC tumour thrombectomy (Figure 3).

On histopathology examination, grossly, a specimen of right radical nephrectomy was received, consisting of right kidney with attached right adrenal gland, showing externally an adherent grey-white tumor thrombus in the inferior vena cava. On slicing, there was a grey, white firm mass involving the renal pelvis, measuring about 17 x 14 x 10 cm (Figure 4).

Microscopic examination revealed a spindle cell sarcoma, composed of spindled cells having cigar-shaped nuclei, scattered mitoses (up to 10-19/10 HPF) and foci of necrosis (about 40%; Figure 5). Focally, the tumor was seen arising from the IVC wall, along with adjacent areas of thrombus formation. Tumor thrombus was also seen in right internal and external iliac veins. Immunohistochemically, the spindled tumor cells were positive for vimentin, H-caldesmon, focally for SMA, CD34 and desmin, while they were negative for CD117, DOG-1, S100, pan CK, renal cell carcinoma antigen (Figure 6). The overall features were of a spindle cell sarcoma, compatible with leiomyosarcoma, most probably arising from IVC wall.

The case was discussed during the multi-disciplinary team meeting and the consensus was for follow-up. Patient follow-up at 3 months post-surgery was uneventful.
Discussion

Clinical features & symptoms

Complicating diagnosis is the presence of non-specific symptoms, such as diffuse abdominal pain, vomiting, nausea and general malaise [4,7]. In more than 80% of symptomatic cases, the main reported symptom is lower back pain [4]. In the present case,
the patient presented with left lower limb DVT. The non-specificity of the symptom presentation enhances the likelihood of misdiagnosis [8]. This contributes to the increased likelihood of diagnosis occurring in more advanced stages.

**Classification and growth patterns**

The most widely used classification system for IVC tumor thrombus in patients with locally advanced renal cell carcinoma is that of the Mayo Clinic thrombus classification [9]. In Level I, the tumor thrombus is either at the entry at the renal vein or within the IVC, fewer than 2 cm from the confluence of renal vein and IVC. Classification as Level II requires that the tumor thrombus extends within the IVC, 2 cm above the confluence of renal vein and IVC but is still below the hepatic vein. Involvement of the intrahepatic IVC leads to classification as Level III. Finally, Level IV classification requires extension either into the right atrium or above the diaphragm [9].

LMS can also be classified as one of three types according to locations in various segments of the IVC [10]. Segment I corresponds to the IVC below the entrance to the renal veins (infra-renal). Segment II, or the middle segment, which is the most commonly affected region [11], corresponds to the IVC located between the end of the hepatic veins and the renal veins. Finally, segment III, or the hepatic segment, corresponds to the IVC located between the right atrium and the hepatic veins. In the present case, the patient exhibited IVC LMS in the middle segment. Patients with localization in the middle segment often present with right upper quadrant pain and nephrotic syndrome due to renal vein drainage obstruction [8].

In addition, LMS of the IVC exhibits three main tumor growth patterns: extraluminal, which accounts for 62% of all cases; intraluminal (5%); and a combination of both (33%) [6]. Tumor growth is typically slow and lateralized to the right side due to limited resistance of fatty tissue [4]. Differentiated LMS of the IVC that exhibit extraluminal growth may be confused with other retroperitoneal tumors [12].

**Imaging features**

Diagnosis is difficult, particular in the presence of a predominant extraluminal component [1]. Due to the diagnosis rarity of LMS, no imaging protocols currently exist, and no studies have compared the accuracy of CT versus MRI in diagnosing LMS [8]. The role of MRI is thought to be limited to differentiating neoplastic invasion of thrombus [1] or as an adjunct in characterizing adjacent invasions [13]. By contrast, CT is helpful in deciphering the origin of the tumor as well as invasion and metastasis [8] suggest using non-contrast CT and intravenous contrast-enhanced CT images to aid with imaging in arterial, portal venous, and delayed phases. Characteristic findings on the CT include invasion and dilation of the lumen, as well as irregularly distanced IVC with complex, lobulated, and heterogenous soft tissue mass, are pathognomonic of LMS of the IVC [8,14]. According to Webb et al. [14], diagnostic features of LMS on a CT include the sign of imperceptible cava lumen, which is useful in identifying retroperitoneal mass. A biopsy is not required if the mass is removable [1]. In the present case, MRI urography, CT angiography, and renal cortical scintigraphy were used to aid in identifying and diagnosis the tumor.

**Histology**

Histological and immunohistochemical findings are used to make a definitive diagnosis of LMS [1]. These findings reveal elongated, spindle-shaped cells arranged in a bush and positive for alpha-smooth muscle actin, vimentin, and desmin [15]. In the current case, histo tumor cells may also be positive for CD34 (Bilgo et al., 2021) [1] and epithelial membrane antigens [16]. Immunohistochemical findings are negative for CD117 and the ki-67 proliferative index is low [17]. In the present case, tumor cells were positive for CD34 and H-caldesmon, and weakly positive for SMA. Some immunohistochemical markers have also been associated with survival and tumor recurrence. For example, high expression of cytoplasmic B-catenin and IGF-1R may be predictive of recurrence and poor survival [18].

**Management**

In the present case, the patient underwent right radical nephrectomy and IVC tumour thrombectomy. Due to the rarity of LMS of the IVC, information pertaining to effective treatment approaches is largely based on case studies as opposed to comprehensive systematic analyses. Consequently, there are no existing guidelines for management [8]. Because LMS of the IVC appear to be resistant to radiation and chemotherapy, though there have been reports of successful neoadjuvant chemotherapy and radiation before resection [19], radical en bloc resection with adequate margins is the main treatment approach [11,19,20]. Although an R0 excision with confirmation of venous return to concerned areas minimizes recurrence [21], complications following surgery are frequent, with up to 20% reporting lower extremity edema or renal failure [3]. As in the present case, patients often receive anticoagulation therapy, either prophylactically or long term [8].

**Prognosis**

Prognosis following surgery remains poor, with a 5-year survival rate of less than 50% and a 10-year survival rate of less than 30% [22]. Recurrence is a significant problem, with 25 months being the median time-to-recurrence [5,21]. In LMS of the IVC, hematogenous metastases are frequent and occur via the lymphatic system. Common metastatic locations
include lung, liver, and lymph nodes. Lung, though lymphatic dissemination is rare [13]. Predictors of poor short-term survival include level III tumor staging, macroscopically incomplete surgery, endoluminal tumor bud presence, right atrial extension of the tumor, and compromised liver function [23].

**Conclusion**

LMS of the IVC is a rare tumor that is predominant in women. Here, we presented a case of LMS of the IVC presenting as a renal mass in a 46-year-old man. Clinical symptoms were unspecific. An MRI identified a 14 cm renal mass and invasion of the nearby IVC. Although management practices are not well delineated owing to the rarity of the condition, our patient was managed via right radical nephrectomy and IVC thrombectomy. The patient did not receive post-operative neoadjuvant therapy. Histopathology confirmed diagnosis of LMS of the IVC. Despite successful outcomes, ongoing follow-up is required as recurrence is frequent.

**Declarations**

**Ethical approval and consent to participate**

Informed consent was obtained from subject.

**Consent for publication**

Consent for publication was obtained from subject.

**Competing interests**

The authors declare that they have no conflicts of interest.

**Funding**

No financial support.

**Acknowledgements**

No acknowledgements.

**References**


