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Immunotherapy and Gamma knife "stop and go" therapy in a mRCC patient

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INTRODUCTION/OBJECTIVES: Incidence of kidney cancer is 3 % of the overall population, with most common type being clear cell kidney carcinoma (mccRCC). Our objective is to report a successful treatment of mccRCC with long survival.
CASE PRESENTATION: The patient is a 78-year-old man, ECOG 0 with hypertension, diagnosed with a left kidney ccRCC stage III (T3N0M0) in 2008. A left nephrectomy was performed. In 2010 PETCT-FDG showed lung and right kidney metastases. As our patient belongs to favourable prognostic risk group (MSKCC), he was treated with sunitinib. Skin rash, mucositis and hypertension were observed as side effects. A half year pause in therapy resulted in relapse during 2015. Sunitinib was reintroduced and remission was kept until 2018 when he had an epileptic episode caused by two brain metastases confirmed by brain MR. The lesions were treated with gamma knife (GK) and second line therapy - nivolumab was introduced. After 10 months nivolumab was stopped due to rash and extreme itching that was treated with prednisolone. A CT scan in 2020 showed a relapse in the mediastinal lymph nodes and stationary mass in pancreas. Nivolumab was reintroduced and continued until late 2021 when a new brain lesion was shown on MR and treated by GK.
CONCLUSION: Immunotherapy and gamma knife resulted in the benefit regarding the treatment of mccRCC. Eleven years since diagnosis and 4 years since brain metastases the patient is alive with ECOG 0.

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Intraocular non-Hodgkin lymphoma mimicking uveitis

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Keywords: Immunomodulatory Therapy, Lymphoma, Uveitis

INTRODUCTION/OBJECTIVES: Uveitis is an intraocular inflammation that affects the middle eye layer and causes permanent structural damage and loss of visual function. It is most commonly caused by non-infectious factors, while infection occurs in 10-20% of uveitis cases. However, there is no actual intraocular inflammation in 3-5% of patients with clinical manifestations of uveitis. In these patients, some neoplastic and non-neoplastic processes may manifest as uveitis.
CASE PRESENTATION: A 51-year old male patient was diagnosed with bilateral panuveitis after experiencing pain and blurred vision. He was treated with systemic and local corticosteroids for a month, with no adequate response to medication. Several diagnostic tests were conducted, including infectious causes and vitreous body biopsy. All tests were negative, and vitreous body biopsy showed no tumor cell presence. However, during diagnostic and treatment, the patient developed neurological symptoms like confusion and could not concentrate. NMR of the brain was recorded, showing large mottled hyperintense lesions on both middle cerebellar peduncles in the caudal parts of the cerebellar hemispheres and multifocally in the subcortical and deep white matter. A stereotaxic brain biopsy was performed, and it showed infiltration constructed from clusters of large atypical centroblast-type lymphatic cells. Immunohistochemically, tumor cells corresponded to diffuse large-cell non-Hodgkin's lymphoma of the B-immunophenotype. The patient was later treated according to oncology protocol.
CONCLUSION: We should always consider the underlying neoplastic process in uveitis that doesn't respond to immunomodulatory therapy. On-time diagnosis and treatment could save not only visual function but also lives.