

Lung cancer metastasis to the gastrointestinal system: An enigmatic occurrence

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Abstract

Adenocarcinoma of the lung infrequently metastasizes to the gastrointestinal tract. We report a rare case of a 65-year-old male with no respiratory symptoms diagnosed with adenocarcinoma of the lung by histopathological examination of metastatic sites which included an ulcer in the gastric body and a mass in the rectum. Metastatic disease also involved the liver as well. Patient was treated with systemic chemotherapy but unfortunately expired five months after the diagnosis was made.

Key words: Lung cancer; Gastrointestinal metastasis

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Core tip: It is an extremely uncommon finding to discover lung cancer on gastric ulcer and rectal mass biopsy. Also, this patient did not have a pre-existing cancer diagnosis. Computerized tomography did reveal liver lesions as well. With increasing use of endoscopy and colonoscopy in the current era, physicians should be mindful of the uncommon differentials as well.

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INTRODUCTION

Gastrointestinal metastasis of a primary lung cancer although previously reported in literature is a rare presentation. When metastasis does occur, the small bowel appears to be the most common site^[1]. Clinical presentation may vary from being asymptomatic to non-specific abdominal pain and life threatening complications like massive bleeding and perforation requiring emergent surgical interventions^[2]. Our case is first of its kind where in adenocarcinoma of lung is diagnosed by histology from a mass lesion in the rectum and gastric ulcer, in a person with no prior respiratory symptoms.

CASE REPORT

A 65-year-old man presented to our hospital emergency room (ER) with complaints of bilateral flank pain. He denied nausea, vomiting and change in bowel habit. He reported decrease in appetite and loss of 15-pound (lbs.) weight in one month.

His medical history was significant for mild intermittent bronchial asthma, benign essential hypertension, major depressive disorder and prostate cancer treated with radiation therapy 5 years prior to current hospital admission which is currently in remission. He did not undergo any surgical procedures in the past. There were no gastrointestinal malignancies diagnosed in his immediate or distant family members. He never used tobacco products, alcohol or recreational drugs. He was not allergic to any medications.

On initial evaluation he was afebrile with heart rate of 75 beats per minute, respiratory rate of 18 per minute and blood pressure of 150/70 millimeters of mercury (mm of Hg). His oxygen saturation was 95% on room air. Abdomen was non-distended, soft and non-tender to palpation. On auscultation bowel sounds were noted to be normoactive. Digital rectal examination (DRE) revealed a hard palpable, non-mobile mass on the posterior rectal wall. Cardiorespiratory and neurological examination was within normal limits.

Laboratory results were significant for microcytic anemia with hemoglobin of 8.5-g percent with normal white cell counts and platelets. Coagulation parameters were within normal limits. Liver function tests showed elevated alkaline phosphatase of 482 units per liter, with remaining liver parameters being unremarkable. Tumor markers showed mildly elevated carcinoembryonic antigen level of 38.2 nanogram/milliliter and Cancer antigen-125 (CA-125) of 682.8 units/milliliter. Serum prostate specific antigen (PSA) level was 0.12 nanogram/



Figure 1 Computed tomography chest showing lung opacity, pleural effusion and lymph nodes.

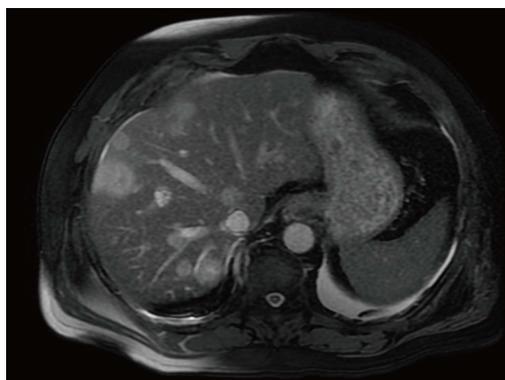


Figure 2 Magnetic resonance imaging showing multiple metastatic liver lesions.

milliliter. Computerized tomography of chest, abdomen and pelvis showed an area of opacity measuring 8.8 cm × 4.6 cm × 6.3 cm in the left upper lobe of the lung, diffuse mediastinal adenopathy and moderate to large left sided pleural effusion (Figure 1). There was diffuse osteo-sclerosis of multiple bones suspicious for osteoblastic metastatic disease. Also, noted were several intrahepatic masses suspicious for metastatic disease and shotty mesenteric and portocaval adenopathy. Magnetic resonance imaging (MRI) confirmed computed tomography (CT) findings of liver metastases (Figure 2).

Gastroenterology consultation was obtained in view of anemia and possible liver lesions. Patient underwent upper gastrointestinal endoscopy, colonoscopy and subsequent endoscopic ultrasound under monitored anesthesia care. Upper gastrointestinal endoscopy showed a 15-millimeter crated gastric ulcer without any stigmata of recent bleeding which was biopsied (Figure 3). Colonoscopy showed a large mass in the rectum (Figure 4) and four polyps in the cecum, all of which were biopsied. Subsequent endoscopic ultrasound (EUS) of the rectal lesion revealed irregular hypoechoic lesion causing thickening of the submucosal layer and irregular out-borders suggestive of malignant nature of the lesion. Patient also underwent CT guided left thoracentesis and liver biopsy.



Figure 3 Gastric ulcer in the body.

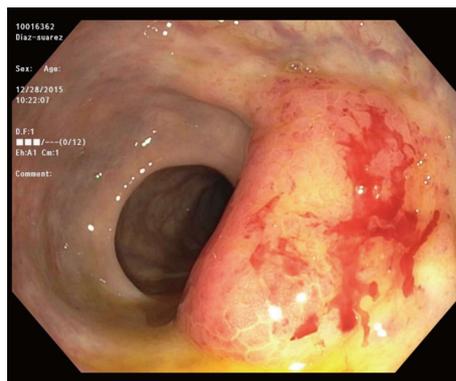


Figure 4 Rectal mass.

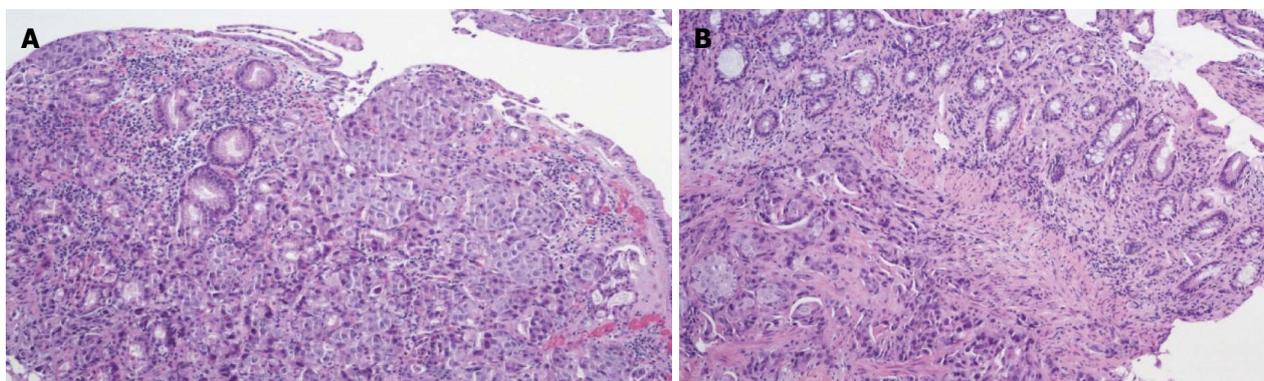


Figure 5 Pathology from both rectal mass and gastric ulcer showed metastatic adenocarcinoma, consistent with lung primary. A: Gastric mucosa with metastatic adenocarcinoma; B: Rectal mass showing submucosa and deep mucosa with metastatic adenocarcinoma.

Table 1 Reported cases of metastatic lung cancer to the colon			
Ref.	Histology	Prior diagnosis of lung malignancy	Presenting clinical scenario
Jevremovic <i>et al</i> ^[13] , 2016	Adenocarcinoma	New diagnosis	Iron deficiency anemia
Miyazaki <i>et al</i> ^[15] , 2015	Squamous cell	Known case	Abdominal pain and anemia
Kaswala <i>et al</i> ^[14] , 2013	Adenocarcinoma	Known case	Surveillance colonoscopy
Sakai <i>et al</i> ^[16] , 2012	Squamous cell	Known case	Abdominal pain
Hirasaki <i>et al</i> ^[17] , 2008	Squamous cell	Diagnosed at the same time	Asymptomatic with positive fecal occult blood testing.
Yang <i>et al</i> ^[2] , 2006	Squamous cell	Known case	Bloody stools
Stinchcombe <i>et al</i> ^[18] , 2006	Squamous cell	Diagnosed at the same time	Asymptomatic with positron emission tomography computer tomography scan done showing increased colonic uptake
Habeşoğlu <i>et al</i> ^[19] , 2005	Squamous cell	Cancer naive	Bowel obstruction
Carroll <i>et al</i> ^[20] , 2001	Squamous cell	Cancer naive	Weight loss and diarrhea
Bastos <i>et al</i> ^[21] , 1998	Squamous cell	Known case	Abdominal pain, diarrhea and bloody stools
Gitt <i>et al</i> ^[22] , 1996	Squamous cell	Known case	Bowel perforation
Gateley <i>et al</i> ^[23] , 1993	Squamous cell	Known case	Gastrointestinal bleeding
Brown <i>et al</i> ^[24] , 1980	Anaplastic carcinoma	Diagnosed at the same time	Abdominal pain, weight loss
Smith <i>et al</i> ^[25] , 1978 (2 cases)	Histology not known	Not known	Intermittent obstruction, bleeding or anemia

Pathology from both rectal mass and gastric ulcer showed metastatic adenocarcinoma, consistent with lung primary (Figure 5). Immuno-histochemical staining was positive for cytokeratin 7 (CK 7), thyroid transcription factor-1 (TTF-1) and napsin-A antibodies (Figure 6). It was negative for PSA, prostate specific acid phosphatase, CK 20, CDX-2, cancer antigen 19-9 (CA 19-9) and P504 antibodies consistent with lung primary. Results from thoracentesis and liver biopsy yielded similar results sh-

owing metastatic adenocarcinoma of the lung origin. Patient was started on chemotherapy with combination of Carboplatin and Paclitaxel. After receiving two cycles of chemotherapy, patient and family opted for palliative care and he expired five months after the diagnosis was made.

DISCUSSION

Lung cancer is the most common cancer worldwide

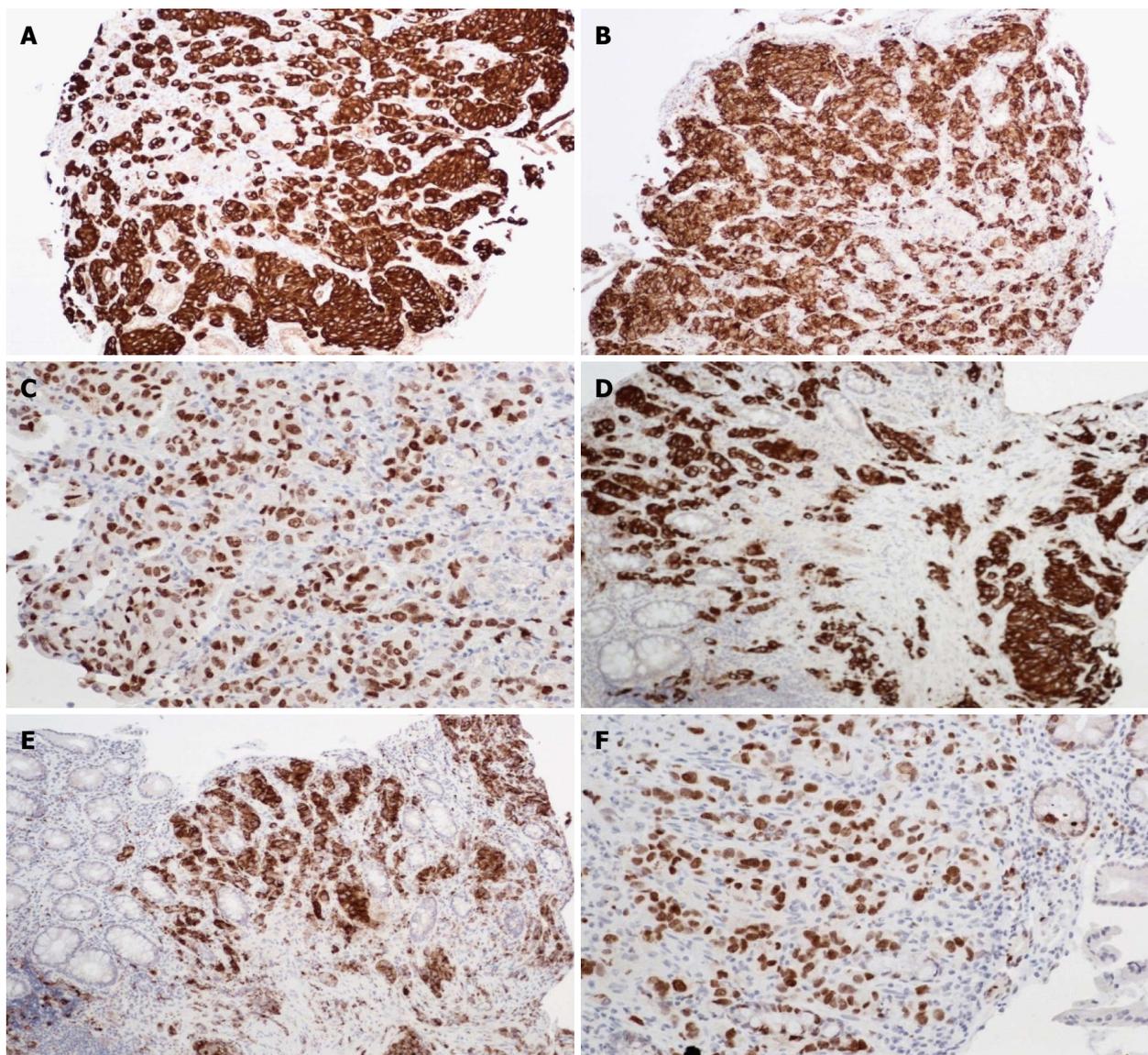


Figure 6 Immunohistochemical staining. A: Gastric biopsy showing positivity to CK 7; B: Gastric biopsy showing positivity to Napsin-A; C: Gastric biopsy showing positivity to TTF-1; D: Rectal biopsy showing positivity to CK 7; E: Rectal biopsy showing positivity to Napsin-A; F: Rectal biopsy showing positivity to TTF-1. CK 7: Cytokeratin 7; TTF-1: Thyroid transcription factor-1.

accounting for 19.4% of all the cancer related deaths^[3].

Adenocarcinoma of the lung is known to metastasize to liver, lung, brain and bone with half of the patients harboring metastasis at the time of presentation^[4]. Gastrointestinal tract is an infrequent site of metastasis. In a large retrospective study done by Kim *et al*^[5] gastrointestinal metastasis was found in 0.19% of all the cases with small bowel being the most common site, although autopsy studies revealed higher rates of metastatic disease^[1]. Metastatic lung cancer has known to spread to any location from the oral cavity to the anus^[6] with lymphatic and hematogenous routes being the possible modes of spread^[7].

Symptomatology spectrum ranges from being totally asymptomatic to bleeding^[8], pain and dysphagia in case of esophageal involvement^[9]. Peritonitis, perforation^[10] and bowel obstruction are among the acute complications that were reported^[11]. Laboratory analysis may reveal iron deficiency anemia.

Diagnosis is based on endoscopy with biopsies. On gastrointestinal endoscopy variable endoscopic appearances have been described including ulcerated lesion, nodularity, diffuse mucosal involvement, polyp or mass lesions^[12]. Small bowel endoscopy (SBE) may be needed for evaluation of small bowel lesions. Histological examination of post-surgical specimens usually reveals diagnosis. On colonoscopy lesions, may vary from sub-centimeter lesions to more larger mass lesions as in our case. So far, review of literature shows 15 cases of metastatic lung cancer to the colon^[2,13-25] (Table 1). The most common reported histology appears to be squamous cell carcinoma followed by adenocarcinoma being the less common variant^[13,14] (Table 1).

Immuno-histochemical staining of the tissue is useful in streamlining the diagnosis^[26] with TTF-1 and napsin-1 being specific for lung adenocarcinoma^[27].

Prognosis appears to be poor in patients with gastro-

intestinal metastasis. Palliative resection has been described as treatment option especially in small bowel lesions to prevent further complications.

In summary, our case describes an extremely rare occurrence of synchronous metastasis of adenocarcinoma of lung presenting as gastric ulcer and rectal mass in an asymptomatic patient. To the best of our knowledge, our case is the first case described in literature of such a presentation. This again throws light that metastasis to the gastrointestinal tract may be considered among the differential while encountering such lesions in the gastrointestinal tract and appropriate diagnosis and prompt treatment may be helpful in these cases.

COMMENTS

Case characteristics

A 65-year-old man with anemia, weight loss and liver lesions noted to have gastric ulcer on endoscopy and rectal mass on colonoscopy.

Clinical diagnosis

Lung cancer presenting as metastatic gastric ulcer and rectal mass in a cancer naïve patient.

Differential diagnosis

Metastatic lung cancer to the gastrointestinal system.

Laboratory diagnosis

Laboratory results were significant for microcytic anemia with hemoglobin of 8.5 g percent. Alkaline phosphatase was 482 units per liter. Tumor markers showed mildly elevated carcinoembryonic antigen levels of 38.2 units/milliliter and cancer antigen -125 of 682.8 units/ milliliter.

Imaging diagnosis

Computed tomography revealed lung lesion with mediastinal adenopathy and metastasis to liver.

Pathological diagnosis

Histopathology from gastric ulcer and rectal mass revealed adenocarcinoma of lung.

Treatment

Chemotherapy.

Related reports

Prior reports of gastrointestinal metastasis from lung cancer included mostly autopsy series with small bowel being the most common site. There have been no reports of synchronous metastasis of lung cancer to stomach and rectum as in the case.

Term explanation

Adenocarcinoma of the lung is one the types of lung cancer with malignant potential.

Experiences and lessons

This is a unique presentation of lung cancer metastasis.

Peer-review

The case is well drafted and references are adequate.

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