

A rare case of large cell lung carcinoma with gastric metastasis

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Dear Editor,

Lung cancer (LC) is the leading reason of death from cancer the world-wide. It is usually silent, and about 50% have extra-thoracic metastasis the initial diagnosis. Metastatic spread of LC usually may involve the adrenal glands, brain, bone, liver, and lymph nodes. Metastases to the digestive tract, particularly to the stomach, are very rare. Symptomatic gastric metastasis from lung carcinoma was 0,5 %. Large cell carcinoma and small cell carcinoma of the lung are more likely to result in digestive metastases than are the other cell types (1).

A 67-year-old man came to our hospital complaining of progressively increasing right-sided chest pain, abdominal pain, anorexia, and weight loss (20kg) since four months. He smoked two packs of cigarettes a day for the past 45 years. He had past history of coronary artery disease underwent percutaneous coronary intervention for the deployment of a stent one year ago. 2 months later, he noticed bright red blood in his sputum. But, he didn't admit to the hospital. A chest radiograph was done, and shows a paravertebral opacity with an air-fluid level at the right upper zone. Thoracic and abdominal computed tomography was carried out. This demonstrated subpleural infiltrative metastatic soft tissue masses expanding and destructing the adjacent right 5th rib and left 4th rib, hepatic metastases, the distal gastric wall thickening, and multiple lymphadenopathies in abdomen (figure a,b). The patient underwent bronchoscopy which showed no endobronchial lesion. Percutaneous transthoracic CT-guided needle biopsy was taken from the subpleural mass in the right upper lobe. Upper gastrointestinal endoscopy revealed a 3 cm ulcer with sharply demarcated, raised, and rounded edges on the anterior wall of the proximal corpus and a 5x6 cm ulcer on the pyloric antrum (figure c,d). Needle biopsy and both gastric

ulcer biopsies showed large-cell lung cancer metastases (Figure E-F). The patient died one month after receiving at the time of diagnosis.

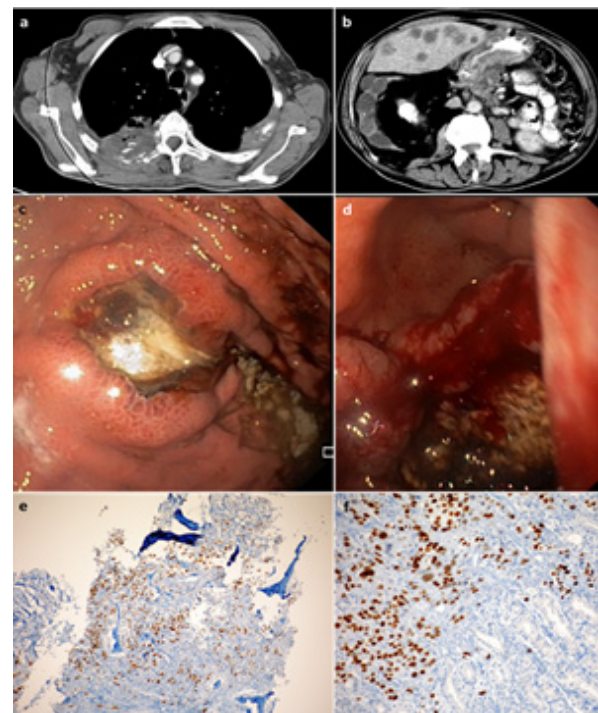


Figure 1. CT of the chest and abdomen reveals destruction of left and right 4th ribs (a), liver metastases, and the distal gastric wall thickening (b). Endoscopic images of large cratered ulcers in corpus (c) and antrum (d). Large lung cancer cells infiltrating costa (e) and the gastric mucosa (f) are positive for TTF-1 (brown color indicates a positive reaction) (immune peroxidase, x100, and x200 respectively). On the right side of figure b, the nuclei of the gastric glands are painted with TTF-1 negative.

At autopsy, gastric metastases are present 14% of all patients with LC. Gastric metastatic lesions have a particular endoscopic aspect, demonstrating as

“volcano-like” lesion. It has been published a high percentage of gastric metastases in the fundus and cardia (2). In our patient, the lesions are present in the gastric corpus and antrum regions. Metastatic le-

sions in the stomach are commonly asymptomatic or present chronic bleeding, anemia, hematemesis and epigastric pain. Patients with gastric metastases seconder to LC have poor prognoses (3,4).

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