Tracheal Metastasis In A Patient With Colon Cancer

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Citation

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Abstract

Colon cancer is a common malignancy. Parenchymal lung metastasis can be seen in up to 20% of series. In contrary, endotracheal metastasis due to colon adenocarcinoma is a rare finding and as the initial manifestation of recurrence it even more rare. It entitles a grim prognosis with 1-2 years survival. We report a case of an endotracheal metastasis due to Adenocarcinoma of the colon six years after of the initial diagnosis.

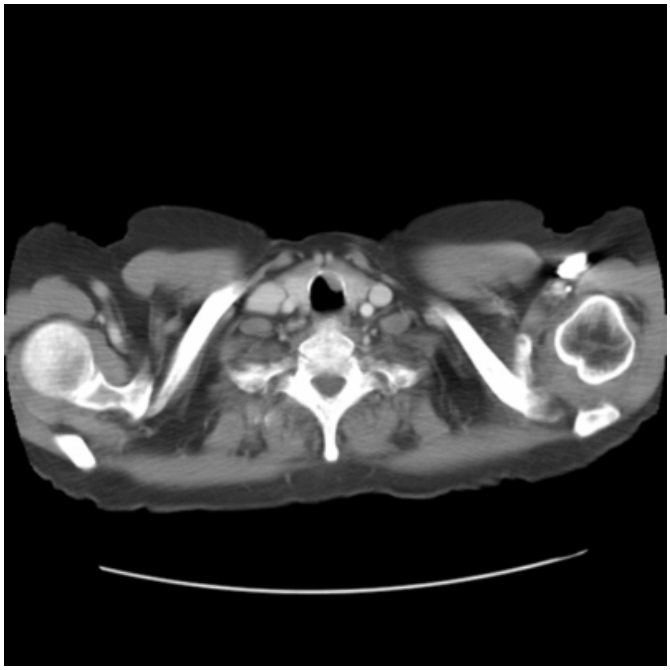
INTRODUCTION

Endotracheal metastasis from colon cancer as the first manifestation of recurrent disease is extremely rare. We report a case of patient who presented 6 years post hemicolectomy with stridor and hemoptysis. She subsequently diagnosed as having endotracheal metastasis from her primary disease.

CASE REPORT

A 74-year-old woman was evaluated for hemoptysis and stridor. She had a history of colon cancer for which she underwent hemicolectomy followed by adjuvant chemotherapy 6 years previously. Although her hemoptysis had been problematic for almost a year, the stridor was a new complaint. Computed tomography (CT) of the chest revealed a soft tissue mass in the antero-lateral proximal subglottic trachea to the left of the midline (figure 1). The examination was otherwise normal. This finding was not present on a study performed 13 months previously. Fiberoptic bronchoscopy revealed a 15mm polypoid lesion in the upper trachea corresponding to the abnormality noted on the CT scan. The biopsy specimen showed groups of epithelial cells with elongated nuclei and necrosis consistent with a metastatic adenocarcinoma from the intestinal tract.

Figure 1



DISCUSSION

Tracheal metastases from a distant primary malignancy although rare, have been documented since 1890. The most common primary cancers are breast, kidney, thyroid and colon although varieties of other tumors are described. The respiratory symptoms frequently are non-specific and this can cause a delay in diagnosis. Symptoms may progress due to tumor growth and eventually it can cause airway obstruction. Treatment options include local control by brachyradiation therapy, metal stent insertion, laser therapy and surgery, combined with systemic chemotherapy. The overall prognosis is poor with survival of 1-2 years after

diagnosis.

LEARNING POINTS

1. Malignant tracheal metastasis should be considered in the evaluation of patients with cough, hemoptysis, wheezing or stridor and history of malignant solid tumor.

2. Chest X-ray and CT tend to underestimate the size of the tumor and the diagnosis should be made by bronchoscopy and endo-tracheal biopsy.

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References

1. Morency G, Chalaoui J, Samson L, Sylvestre J. Malignant neoplasms of the trachea. Can Assoc Radiol J. 1989; 40(4): 198-200.
2. Shapshay SM, Strong MS. Tracheobronchial obstruction from metastatic distant malignancies. Ann Otol Rhinol Laryngol 1982;91(6):648-51.

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