Bleeding from gastroduodenal metastases as the first manifestation of lung adenocarcinoma

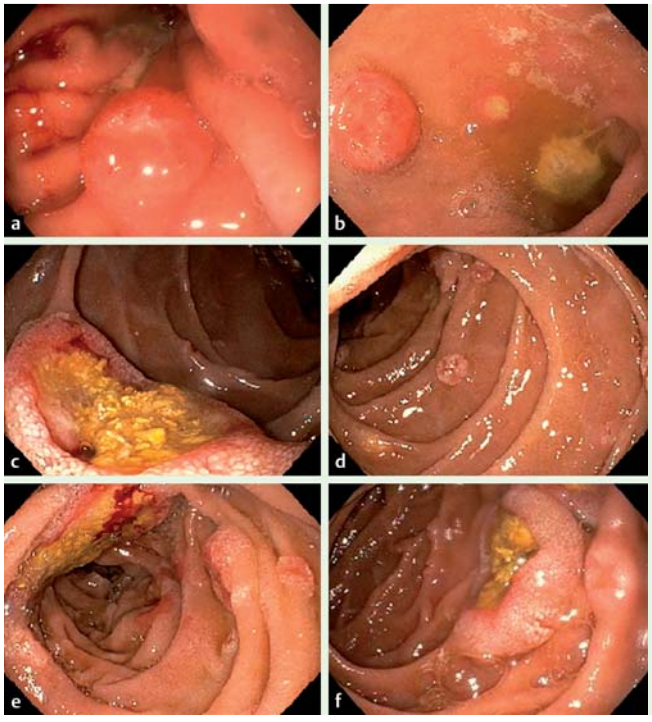

Fig. 1 Findings at upper gastrointestinal endoscopy. **a** Inflammatory nodular lesion of the fundus with small ulceration on top. **b** Inflammatory nodular lesion of the first duodenum with superficial ulceration, yellowish bottom, and inflammatory edges. **c–f** Nodular lesions of the second duodenum: some have small ulcerations on top, other larger ones are ulcerated with inflammatory edges.

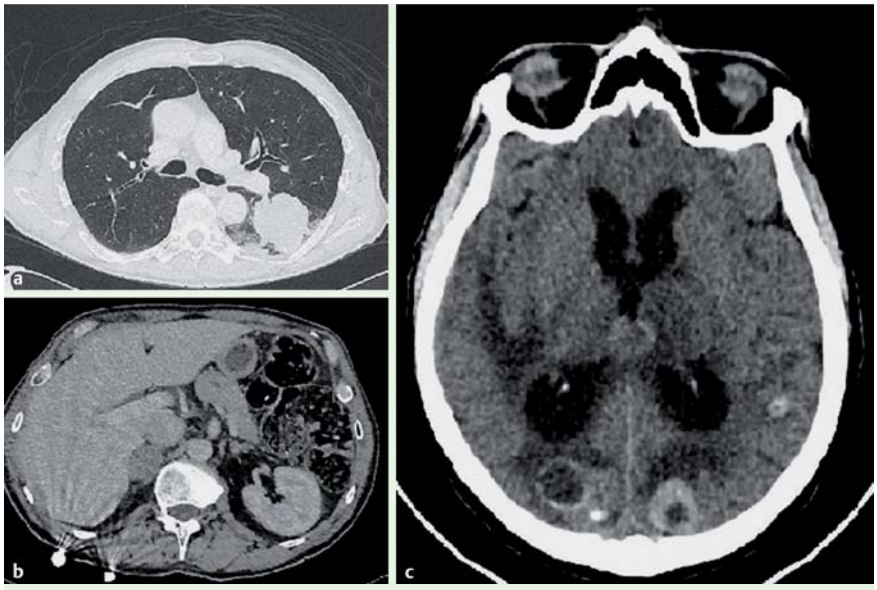

Fig. 3 Body computed tomography scan. **a** Thorax: hyperdense nodule with spiculated margins and contact with pleura. **b** Abdomen (injected, portal phase): hypodense nodules in the right adrenal gland and in the body of the pancreas. **c** Brain (injected): occipital on both sides, left temporal and mesencephalic nodules with target patterns.

Gastrointestinal metastases from lung cancer are rarely symptomatic [1]. They can cause gastrointestinal bleeding [2,3], acute abdominal pain [4], and perforation [5]. We describe herein a case of acute anemia secondary to gastroduodenal metastases, revealing a lung adenocarcinoma.

A 64-year-old man was referred for asthenia, 2-kg weight loss, progressive dyspnea, and headache for 2 months. He had a medical history of depression, alcoholism, smoking, and amyloid angiopathy with two cerebral bleeding episodes. He was receiving escitalopram and zopiclone medication.

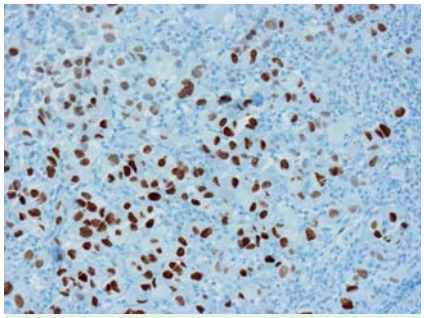

Fig. 2 Immunohistochemistry on suspicious duodenal lesions. Brown spots correspond to thyroid-transcription factor 1 immunofixation.

Physical examination revealed pallor, dyspnea at rest, bilateral rhonchi, cerebellar syndrome, and confusion. Laboratory work-up showed iron-deficiency anemia (hemoglobin level 8.5 g/dL, mean corpuscular volume 96 fL, serum ferritin level 25 µg/L). Upper gastrointestinal endoscopy showed multiple fundic and duodenal lesions of 2 – 30 mm in size, with yellowish ulcerations surrounded by inflammatory edges (▶ **Fig. 1**). Biopsies revealed carcinoma proliferation, infiltrating the mucosal and submucosal layers. Immunohistochemistry showed increased expressions of cytokeratin 7 and thyroid-transcription factor 1, with no expression of cytokeratin 20; these findings were highly suggestive of metastases from a lung adenocarcinoma (▶ **Fig. 2**). A computed tomography scan showed a 70-mm apical lesion on the inferior lobe of the left lung, with contact with pleura, plus many possible secondary adrenal, pancreatic, and intracerebral lesions (▶ **Fig. 3**).

Intravenous steroids, radiotherapy, and chemotherapy were rapidly initiated. However, the patient's neurological condition quickly worsened, and he died within a month.

Gastrointestinal secondary lesions are only rarely found first, thus leading to the diagnosis of the primary cancer outside of the gastrointestinal tract. As in the present case, immunohistochemistry on digestive samples can help to make a precise diagnosis, and therefore avoid unnecessary biopsies of the primary cancer.

Endoscopy_UCTN_Code_CCL_1AB_2AD_3AB

Competing interests: None

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DOI http://dx.doi.org/10.1055/s-0034-1377540
Endoscopy 2014; 46: E474–E475

Stuttgart · New York
ISSN 0013-726X

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