

Endobronchial metastases from colorectal cancer

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To the Editor,

Pleural and parenchymal lung metastases are frequent in colorectal cancer but endobronchial involvement is rare. An endobronchial metastasis (EBM) is defined as a bronchoscopically visible lesion with the same histology as the primary tumor from which it derives, in patients with extrapulmonary malignancies associated with or without parenchymal or mediastinal lesions. Invasion of the tracheobronchial tree by parenchymal masses or lymph nodes are not considered EBM.

Recently a 83-year old man presented with an endobronchial tumoral mass with occlusion of the right middle bronchus, retro-obstructive atelectasis and a right-sided pleural effusion (Fig. 1). On bronchoscopic examination, a complete tumoral obstruction of the right middle bronchial branch was seen. Immunohistochemical analysis of the endobronchial biopsies revealed a poorly differentiated cylindric adenocarcinoma, corresponding to the histology of a colorectal carcinoma resected seven years before (at that time staged as pT3N0M0). On CT-scan of the abdomen there were no metastatic lesions.

A variety of tumors have been associated with EBM, including breast, colorectal, renal, ovarian, thyroid, uterine, testicular, nasopharynx, prostate and adrenal carcinomas, sarcomas, melanomas, plasmocytomas, adenocarcinomas of the ampulla of Vater, pheochromocytomas and Hodgkin's disease (1,2,3). Breast, colorectal and renal cancer are the tumors most frequently associated with EBM; colorectal cancers are responsible for 12% to 26% of all EBM cases (4). All studies on EBM from colorectal cancer are retrospective and report on small numbers of patients, however recently a larger series of 24 patients has been published (5).

The symptoms and roentgenographic manifestations of EBM are identical to those associated with primary lung cancer; however many patients (up to 60%) remain asymptomatic (2,3).

EBM probably arise from tumor cells carried to the bronchus by peribronchial lymphatics giving rise to discrete subepithelial deposits of tumor growth on the bronchial wall.

EBM bronchoscopic presentation includes polypoid masses, pedunculated lesions or infiltrating lesions. The use of immunohistochemistry and molecular biological

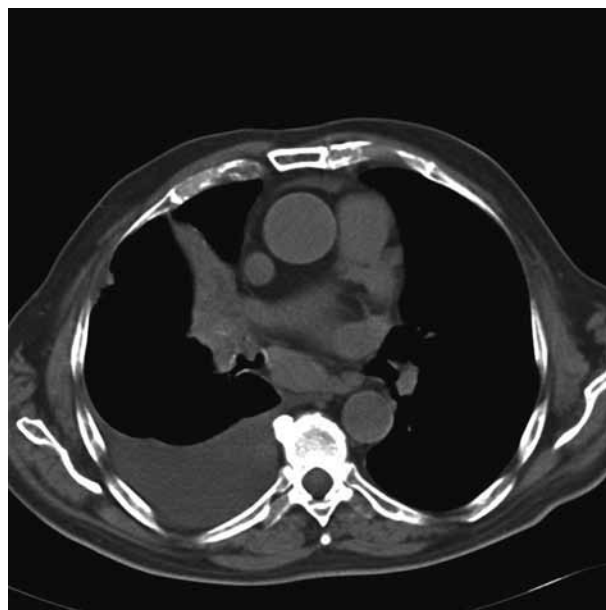


Fig. 1. — CT-scan showing an exofytic endobronchial tumoral mass, a retroobstructive parenchymal consolidation and a right-sided pleural effusion.

tools facilitates the differential diagnosis between EBM and a primary bronchogenic carcinoma.

EBM from colorectal cancer tend to occur at a long interval from the diagnosis of the primary tumor, indicating a slow disease progression; in the series of 24 patients an interval of 53 months was reported (5). In our patient the interval was seven years!

EBM from colorectal cancer are frequently associated with extrabronchial metastatic disease and a poor prognosis with a reported median survival of 14-18.9 months (5,6).

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Treatment in most cases aims at good palliation rather than cure. Due to the advanced stage of the disease, surgery is generally not indicated; in patients with a good performance status, chemotherapy should be considered. Patients with obstructing bronchial metastases can benefit from an interventional endoscopic procedure such as laser-assisted mechanical resection, cryotherapy, stenting and brachytherapy, sometimes in combination with radiotherapy or chemotherapy (5,7).

Our patient presented with an excellent performance status and only minor respiratory symptoms. We started a chemotherapeutic regimen first with 5-FU and oxaliplatin (Folfox 6) and later with 5-Fu and irinotecan (Folfiri), inducing stable disease for 6 months. Recently progression was documented and a combination treatment with folfiri and panitumumab (wild-type KRAS tumor) was started.

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