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A case of acute small bowel obstruction due to metastasis of undiagnosed primary carcinoma of the lung

Tanı konmamış primer akciğer kanseri metastazına bağlı gelişen akut ince barsak obstruksiyonu olgusu

To the Editor,

A 75-year-old man was admitted to our department with abdominal pain, nausea and vomiting. He was a heavy smoker (a packet/day/60 years) with chronic obstructive pulmonary disease. There were diminished breath sounds and dullness over the left lung, and examination of the abdomen revealed a diffusely tender abdomen with rebound and guarding. Rectal examination revealed Hematest–negative stool. Abdominal plain X-ray demonstrated air–fluid levels. Preoperative chest X-ray showed irregular increased density in the left lung hilus (Figure 1). Thorax computed tomography (CT) showed a tumor at the carina level in the left lung hilar area with vascular invasion. At laparotomy, a mass was found in the ileum that obstructed the ileum completely with invasion of its mesentery. Segmental ileal resection with end-to-end anastomosis was performed. Subsequent histological section of this tumor revealed metastatic adenocarcinoma of the lung. Sputum cytology revealed malignant epithelial cells. Bronchoscopy on the fourth postoperative day revealed endobronchial lesion, which was totally obstructing the left upper and lower segments. Bronchial brushing demonstrated adenocarcinoma of the lung. The patient was accepted as stage IV lung carcinoma. Postoperatively, hospital pneumonia developed and after its treatment, the patient was disc-

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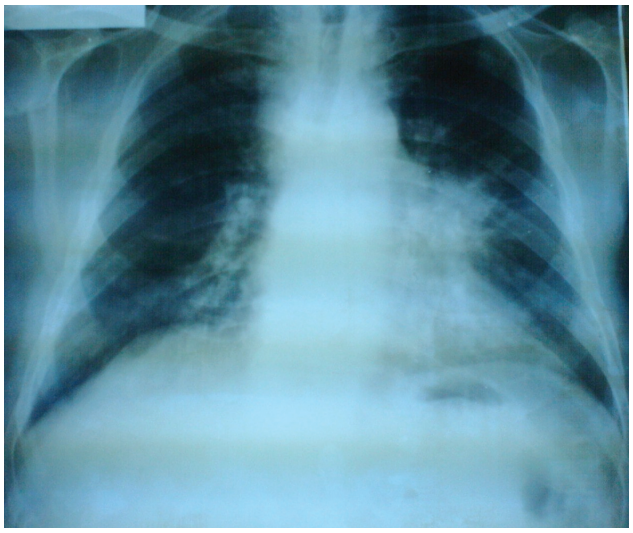

Figure 1. Preoperative chest X-ray showed irregular increased density in the left lung hilus.

harged on the 20th day. During follow-up, the patient died in the 10th week postoperatively at home with tumor progression.

In a report of 54 patients with small bowel tumors, 42 had malignant lesions and 6/42 (14%) were metastases (1). Small bowel hematogenous metastases are a rare clinical occurrence and originate typically from breast cancer, lung cancer and malignant melanoma (1, 2). Small bowel metastases may occur in every cell type of primary lung cancer. Our patient was not known as primary lung carcinoma, and he was admitted with the sign of intestinal obstruction.

In most of the cases, clinical findings of small bowel metastases consist of acute symptomatology such as perforation and peritonitis, small bowel obstruction or hemorrhage. Moreover, other symptoms, such as asthenia, anemia following occult intestinal chronic bleeding, abdominal pain and weight loss, and nausea and vomiting are generic and specific (4, 6). Symptomatic small bowel metastases may require a surgical approach. The procedure of choice is theoretically resection of the involved small intestine with primary enteroenterostomy (7). Nevertheless, the prognosis is considered to be very poor. Optimal management of treatment remains controversial, with no operative policy or aggressive surgery. Aggressive abdominal surgery, despite its poor prognosis, provides good palliation and reasonable survival in a select group of patients (8).

If a patient has acute intestinal obstruction and suspicious tumoral lesion on chest X-ray or on thorax CT, the possibility of small bowel metastasis from primary lung carcinoma should be kept in the mind despite the rarity of its occurrence.

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