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Case Report

Successful Treatment of Synchronous Solitary Ipsilateral Axillary Lymph Node Metastasis from Non-Small Cell Lung Cancer with Radical Resection and Perioperative Chemotherapy

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Abstract.

Lung cancer is the leading cause of death from cancer worldwide. Almost 60% of patients with non-small cell lung cancer present with metastasis at the time of diagnosis. Without treatment, the median survival for patients with metastatic non-small cell lung cancer is only 3-4 months. While targeted therapy has improved median overall survival to 12 months and even longer in patients with driver mutations, most patients with initial response to targeted agents ultimately develop disease progression. On the other hand, several studies have shown resection of solitary brain or adrenal metastases may achieve long-term survival in selected patients. However, in patients with solitary extra-cranial, extra-adrenal metastases, the results of metastasectomy have rarely been reported. Herein, we report a case of synchronous solitary axillary lymph node metastasis from non-small cell lung cancer. Surgical resection of both the primary lung tumor and metastasis combined with perioperative chemotherapy achieved prolonged disease-free survival in this case. To date, the optimal treatment strategy for patients with solitary distant lymph node metastases and resectable primary lung tumors has not been established. The addition of metastasectomy to primary lung cancer surgery may provide a chance for long-term survival for such patients.

Keywords **:** non-small cell lung cancer, solitary metastasis, axillary lymph node metastasis, metastasectomy

病例報告

經根除性手術合併手術前後化學治療成功之非小細胞肺癌併同側腋下淋巴節同時性單一轉移

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中文摘要

肺癌位居全世界癌症死亡原因之第一位。約 60%非小細胞肺癌病患診斷時已發生轉移。轉移性非小細胞肺癌病患未治療的中位數存活期僅約 3 至 4 個月。即使標靶治療用於部分具有突變基因的病患可延長總存活期至 12 個月甚至更長，但多數起初對於標靶治療有反應的病患最終疾病仍惡化。另一方面，部分研究指出手術切除轉移病灶對於單一腦部或腎上腺轉移的病患可能達成長期存活。但對於其它位置單一轉移的病患，轉移病灶切除的效果很少被提及。我們在這裡提出一個非小細胞肺癌合併同時性單一腋下淋巴節轉移的臨床案例。經同時手術切除原發性肺腫瘤及轉移病灶後，這個案例達到延長的無疾病存活。目前針對非小細胞肺癌原發處可切除但併有單一遠端淋巴節轉移的最佳治療策略尚未確定。轉移病灶切除配合原發肺腫瘤手術有機會延長此類病患的存活期。

***關鍵字*:** 非小細胞肺癌、單一轉移、腋下淋巴節轉移、轉移病灶切除

INTRODUCTION

It is recognized worldwide that lung cancer is the leading cause of cancer death [1]. Approximately 80% of lung cancers are non-small cell lung cancers (NSCLC) [2], and almost 60% of patients with NSCLC present with metastatic disease at diagnosis [3]. Metastatic NSCLC used to be considered as an incurable disease. Conventional cisplatin-based chemotherapy was shown to result in modest benefit with a median overall survival of 8-11 months [4]. Previous studies have shown that subgroups of patients with metastatic NSCLC benefit from novel targeted agents, such as epidermal growth factor receptor (EGFR)-tyrosine kinase inhibitors, and inhibitors against anaplastic lymphoma kinase (ALK) gene rearrangement or ROS-1 gene rearrangement products, and therefore achieve improved survival [5,6]. Most patients with initial response to targeted agents, however, ultimately develop disease progression [7]. Long-term survival for patients with metastatic NSCLC remains elusive in the era of novel targeted therapy. Therefore, it is worth noting that selected patients with solitary metastases may benefit from surgical resection. A growing size of literature has shown selected patients with primary resectable NSCLC and solitary brain metastases can achieve long-term survival following metastasectomy [8-10]. Similarly, local radical therapy of solitary adrenal metastasis from NSCLC has produced long-term survivors when radical resection of the primary lung tumor is possible [11-14]. However, in patients with solitary extra-cranial, extra-adrenal metastases from NSCLC, the results of surgical resection have rarely been reported. Herein, we report a case of synchronous solitary axillary lymph node metastasis from NSCLC, who achieved prolonged disease-free survival of at least 24 months after surgical resection combined with perioperative chemotherapy.

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CASE REPORT

A 63-year-old man with a smoking history of 20 pack-years presented to our hospital with fatigue and right axillary lymphadenopathy. The patient had been well until approximately 3 months before presentation. He had a common cold, fatigue and a fixed, non-tender nodule in the right axilla. Over the next two months, the nodule gradually enlarged and fatigue persisted. Two weeks prior to presentation, he visited a local hospital, where ultrasonography showed an irregular-shaped, hypoechoic and homogeneous nodule, approximately 1.5 cm in diameter, in the right axilla. There were no abnormal lymph nodes in the cervical or supraclavicular region. Excisional biopsy

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