

Clinical note

Numb chin syndrome as a manifestation of jaw metastasis diagnosed in a bone scan[☆]

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ABSTRACT

In many cases, numb chin syndrome (NCS) may represent a banal pathology. However, as it can be associated with malignant processes, its presence should alert the clinician of a possible occult disease. In patients already diagnosed with cancer, it often represents an ominous sign that indicates poor prognosis, due to the rapid progress of the disease.

The case of a 62-year-old man diagnosed with synchronous lung and bladder cancer, who suddenly complained of numbness in the chin, is presented. The bone scan confirmed the suspicion of metastatic bone disease, and the patient died two months after the appearance of this sign.

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Hipoestesia mentoniana como manifestación de metástasis mandibular diagnosticada en la gammagrafía ósea

RESUMEN

El síndrome del mentón entumecido (*numb chin syndrome* [NCS]) en muchos casos puede representar una patología banal, pero al poder asociarse con procesos malignos, su presencia debe alertar al clínico como posible manifestación de una enfermedad maligna oculta. En pacientes previamente diagnosticados de una neoplasia, representa a menudo un signo ominoso que indica mal pronóstico por el rápido progreso de la enfermedad.

Se presenta el caso de un paciente de 62 años diagnosticado de cáncer de pulmón y de vejiga que aqueja sensación de «acorchamiento» en zona mentoniana. La gammagrafía ósea confirma la sospecha de enfermedad metastásica ósea falleciendo a los 2 meses de manifestarse este signo.

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Palabras clave:

Signo de Roger

Hipoestesia

Mentón entumecido

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Introduction

Numb chin syndrome (NCS) is an infrequent situation in the clinical practice, being more often a synonym of a banal pathology. Nevertheless, its possible association with malignant processes makes it mandatory to be alert and look for an occult neoplastic disease.¹ When NCS is from a metastatic etiology, even if it presents as the initial manifestation of a malignant process, or in the context of an already known neoplasm, it is an indicator of bad prognosis, as it implies a rapid progression of the disease.

In the current note, the case of a male diagnosed with synchronous adenocarcinoma of the lung and high-grade urothelial carcinoma of the bladder is presented. Numbness in the chin starts

seven months after both diagnoses. A bone scan to rule out bone metastasis is performed.

Clinical case

A 62-year-old man with a history of chronic obstructive pulmonary disease (COPD) and kidney transplantation in 2006 was diagnosed of a pulmonary lesion in a routine chest X-ray in 2012. PET/CT confirmed a mass in the inferior lobe of the right lung without either nodal nor distant spread (cT2aN0M0), and a synchronous urothelial carcinoma (T1N0M0), both histologically proved. A transurethral resection and a right lower lobectomy of the lung were performed, in both situations with a curative intention.

Four months later, the patient referred progressive dyspnea. A chest CT showed post-surgical changes and an important volume of loculated pleural effusion in the anterior part of the right hemithorax, without evident parenchymal nor pleural lesions.

The patient was hospitalized and, two days later, started complaining of pain in the jaw, which diminished with analgesia, and hypoesthesia of the right lower lip.

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A CT of the cranium and skull base was set to rule out leptomeningeal spreading, but it could not be completed due to an anaphylactic reaction to the contrast media; available images did not show pathology.

After that, a bone scan with ^{99m}Tc -HMDP was performed, acquiring whole body images (Fig. 1) and a low-dose SPECT/CT of the cranium and thorax, where two lesions of pathologic radiotracer uptake were located: one in the right jaw (Fig. 2) and another one in the posterior portion of the third right rib (Fig. 3), both suspicious of metastasis.

A subsequent brain MR (T1, FFET2, T2, FLAIR and diffusion sequences) confirmed a lesion in the jaw (Fig. 4).

The patient started chemotherapy, but died as a consequence of progressive oncologic disease two months after the diagnosis of NCS.

Discussion

NCS (as known in the English literature,¹ or Roger's sign in the French²) was first reported by Bell in 1830³ in a patient with breast cancer. It is described as anesthesia/hypoesthesia in an area innervated by the mental nerve, terminal branch of the inferior alveolar nerve, which, in turn, depends of the third branch of the trigeminal nerve.⁴ In 1937, Roger and Pallais described a possible association between mental neuropathy and a neoplastic disease, owing to this approach the name of "Roger's sign". Later on, in 1963, Calverley and Mohnac reported five cases of mental neuropathy associated to systemic cancer, coining the term of numb chin syndrome.¹

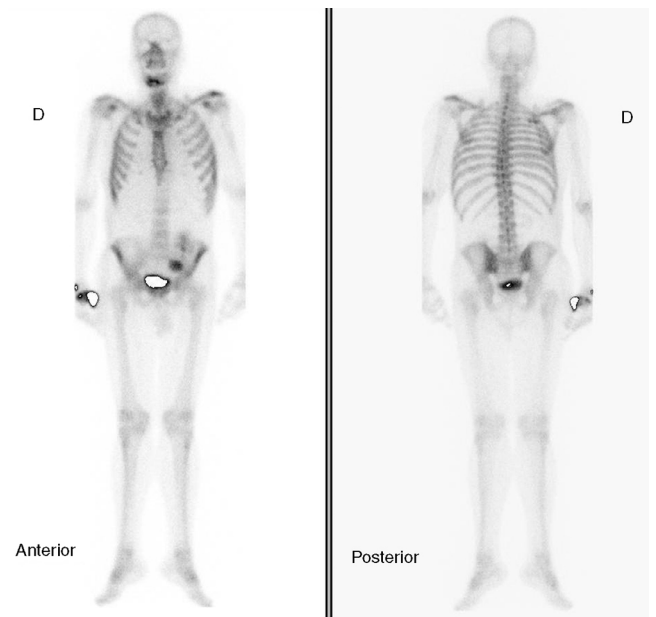


Fig. 1. Bone scintigraphic with ^{99m}Tc -HMDP in anterior and posterior projection. There are two uptakes of the radiotracer indicative of metastasis; one in the right jaw and the other in the third right posterior rib. There is also an area of uptake of the radiotracer in left iliac fossa, which corresponds to the renal graft transplanted in 2006.

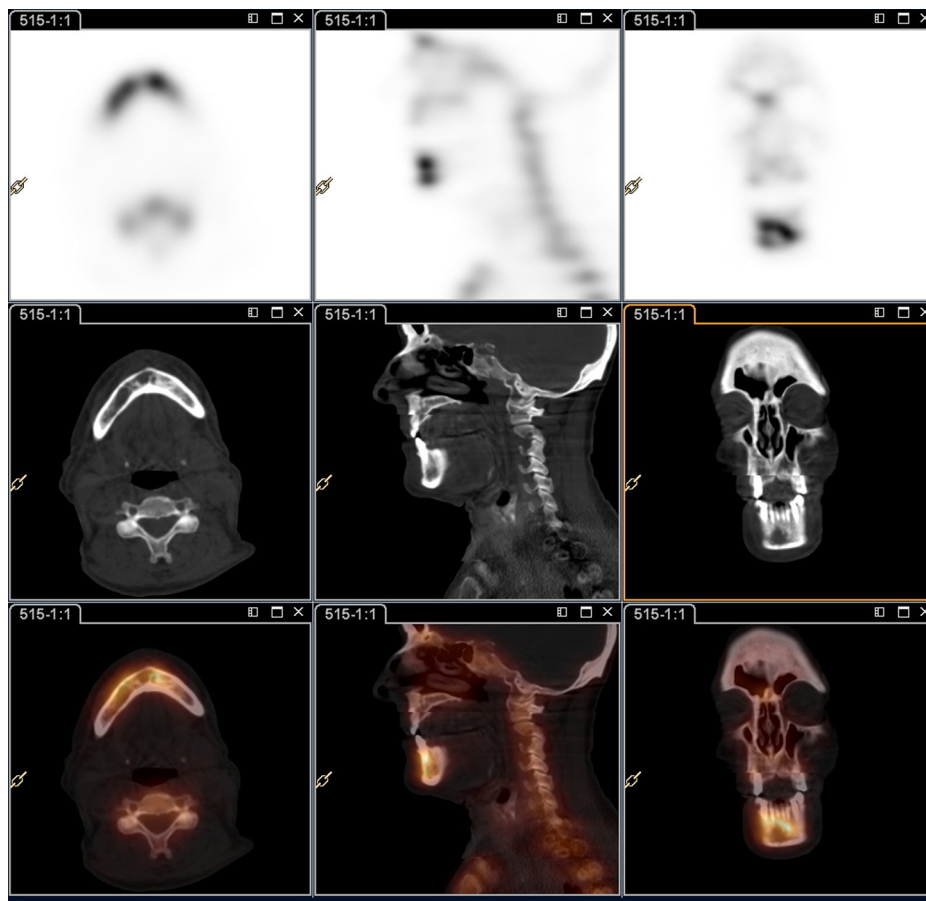


Fig. 2. SPECT/CT in axial, sagittal and coronal axis showing moderate increased uptake of radiotracer and linear morphology in the lower right jaw, coinciding with lytic, poorly delineated lesions and cortical thinning, especially at level of the symphysis of the Chin, indicative of metastasis. This lesion is in relation to the sign of Roger affecting the patient.

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