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Case report

Unusual presentation of non-small cell lung cancer with clival metastases: Case report

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ABSTRACT

A 37-year-old female with unusual presentation of metastatic non-small cell lung cancer (NSCLC), as she presented with symptoms related to clival bone metastases. This case highlights the unpredictable presentations and the variety of metastatic sites of which metastatic NSCLC could be presented.

1. Introduction

NSCLC has been well known to metastasize to various sites in the body; however, an initial presentation of patient's symptoms from metastatic sites that may lead to the diagnosis of NSCLC is rare. It has been addressed in the literature that NSCLC could be presented with different unusual presentations.[1] Several reports documented the bizarre behavior of NSCLC metastatic disease.[2–5]

2. Case description

Our patient is a 37-year-old female, who did well with no medical illness until she started to feel headache with difficulty in swallowing for four months duration, then she complained of neck pain that radiated to the shoulders where she sought medical advice. She had no history of smoking, no cough, no shortness of breath and no bone pain. Upon examination, the patient had tongue deviation to the left side (hypoglossal nerve involvement).

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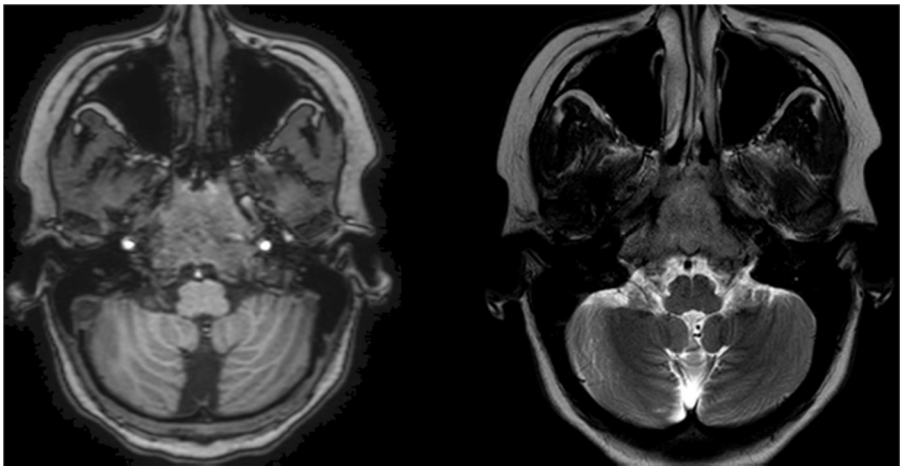

Fig. 1 – Left image: axial T1 weighted MRI image showing a destructive clival lesion that appear hypointense. Right image: axial T2WI MRI showing the mass as hypointense.

CT scan for the head and neck showed that a soft tissue mass lesion infiltrating the clivus slightly encroached on the nasopharynx and bulging into the right recess of the sphenoid sinus. MRI scan (Figs. 1–2) for the head and neck showed a destructive lesion involving the clivus and petrous apices without associated vascular encasement, no intracranial extension or brain parenchymal invasion soft tissue component extending into the pars nervosa of the jugular foramen and hypoglossal canals with high probability of associated lower cranial nerves (IX–XII) invasion/encasement at this level. Metastatic disease was the radiological impression as there is no choroid formation within the mass which excluded chordoma to be the primary disease. CT scans for the chest, abdomen and pelvis showed speculated, peripherally located necrotic nodule in the lateral segment of the lower lobe of the right lung, measuring about 2.6 cm in maximum diameters (Fig. 3) with multiple hilar, subcarinal and paratracheal lymph node enlargement.

CT-guided biopsy from the right lower lobe lung mass revealed adenocarcinoma of the lung, with atypical infiltrative glands surrounded by desmoplastic stroma as shown in Fig. 4.

The tumor was an EGFR wild type and negative for ALK-rearrangement.

FDG PET/CT scan demonstrated a hyper-metabolic lung mass consistent with the primary NSCLC as well as hyper-metabolic lung nodules and mediastinal lymph nodes in keeping with metastases. Multiple hyper-metabolic lesions seen in multiple vertebrae and clivus consistent with bone metastases were also evident (shown in Fig. 5).

The patients' symptoms were improved after she was started on oral dexamethasone 4 mg.

The case was discussed at our thoracic multidisciplinary clinic and the management plan was to proceed with palliative radiotherapy as 30 Gy/10 fractions followed by palliative chemotherapy. Clival mass biopsy was not recommended as

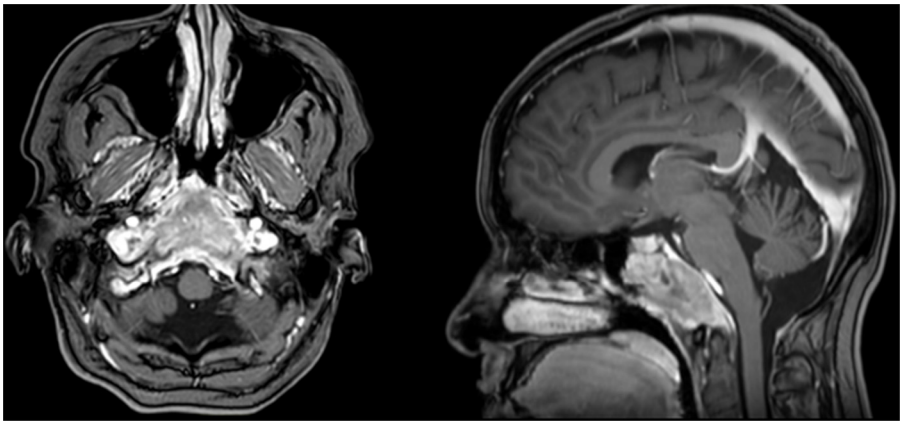

Fig. 2 – Left image: post contrast axial T1 MRI showing the mass with extra osseous soft tissue component extending to both jugular foramen and hypoglossal canals. Right image: sagittal post contrast MRI showing the lesion expanding the clivus and anteriorly invading the sphenoid sinus and superiorly reaches the floor of the sella turcica.