

Clinical-Medical Image

A Rare Case of Pancreatic Metastasis of Small-Cell Lung Cancer

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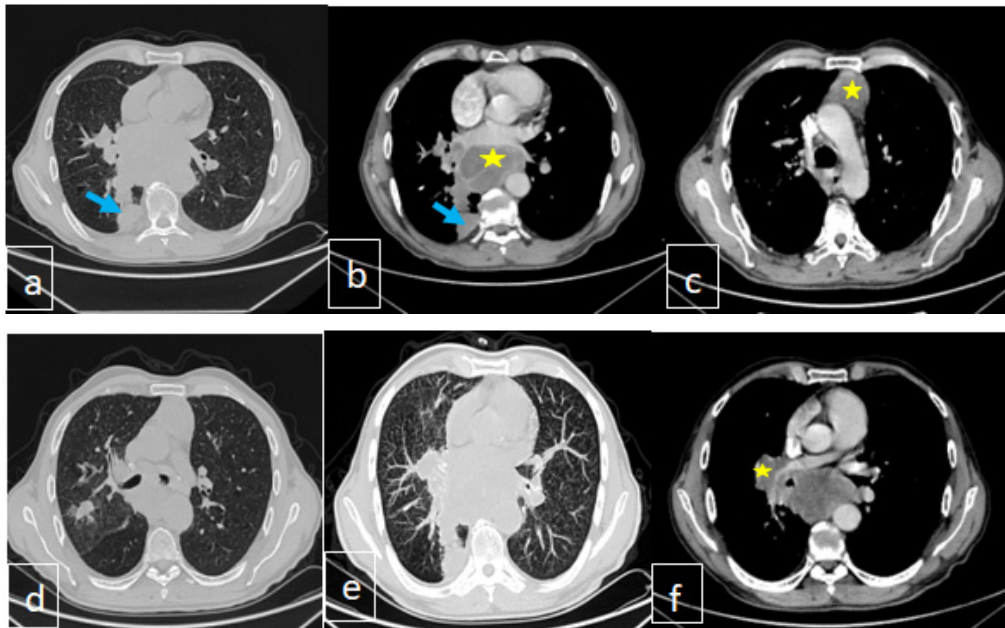


Figure 1: Thoracic CT scan axial sections, Lung parenchymal windows without PIM (a,b) and with PIM (e) showing a suspicious right mediastino-pulmonary tumor mass (blue arrow) with irregular contours, enhanced after contrast, measuring 54 × 47 mm in diameter. Associated with diffuse nodules and micronodules, randomly distributed, secondary in appearance. Mediastinal windows showing mediastinal ADPs (young stars) at the upper mediastinal level in pre-vascular (c), subcarinal (d) and right hilar level (f) encompassing the right pulmonary artery, realizing magma, heterogeneously enhanced after contrast, massively necrotic, secondary in appearance.

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Metastases to the pancreas are rare in general and scares in cases of lungs primary lesion. They are discovered incidentally in most cases. Data on their incidence, diagnosis, prognosis and management remain insufficient. The discovery is usually made at an advanced stage of lung cancer with the presence of metastases to other organs. We reported the case of a patient undergoing oncology follow-up for lung CPC with discovery of adrenal and pineal gland metastases and pancreatic metastatic mass. His management remains palliative chemotherapy. Surgical treatment is not yet codified in these cases and remains at the discretion of the multidisciplinary oncology teams.

Lung cancers are diagnosed at a metastatic stage in 40–50% of cases [1]. Common metastases sites of lung cancers remain liver, adrenal, bone and kidney [1,2]. Pancreatic metastases of lung cancers are rare and incidental. It is usually seen at an advanced stage of the disease with other associated metastases. Data on its incidence, prognosis, diagnosis and treatment remain poor. Its incidence is 12% in post-mortem patients [1]. Its prognosis remains guarded given the often advanced stage of the pathology. Several methods of treatment as surgery management, chemotherapy and/or preoperative radiotherapy were proposed [3]. These metastases may raise a diagnosis issue between primary pancreatic or secondary lung cancer localization. In most cases, this diagnosis is made at a stage of multiple metastases in patients known to have primary lung cancer [3]. In the literature, most of the data have been provided by post-mortem examination of patients with primary lung cancer. However, studies are still needed to improve our knowledge of these pancreatic metastases and to improve the coding of their management.

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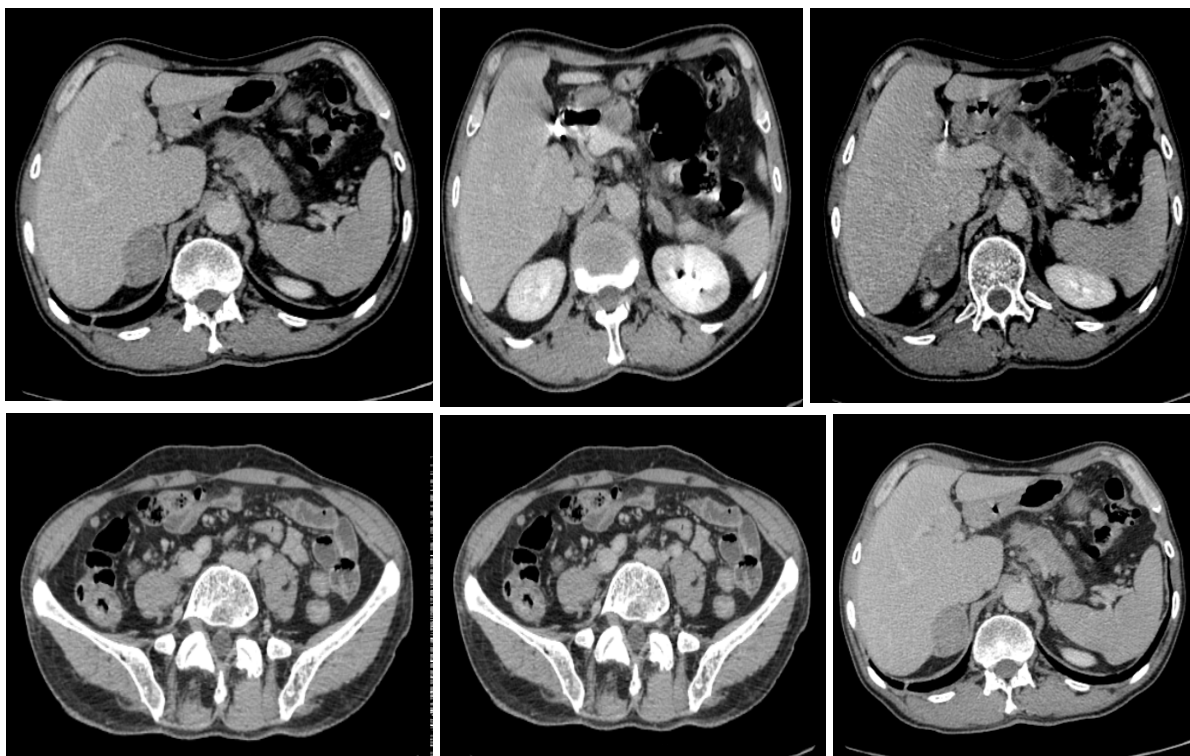


Figure 2: Abdominopelvic CT scan after PDC injection at venous time showing bilateral adrenal lesions (yellow star), heterogeneously enhanced after contrast. Pancreatic body and isthmus lesions, heterogeneously nodular (blue arrow) peripancreatic and perigastric adenopathies (yellow arrow) and peritoneal nodules at the level of the GPC (red arrow).

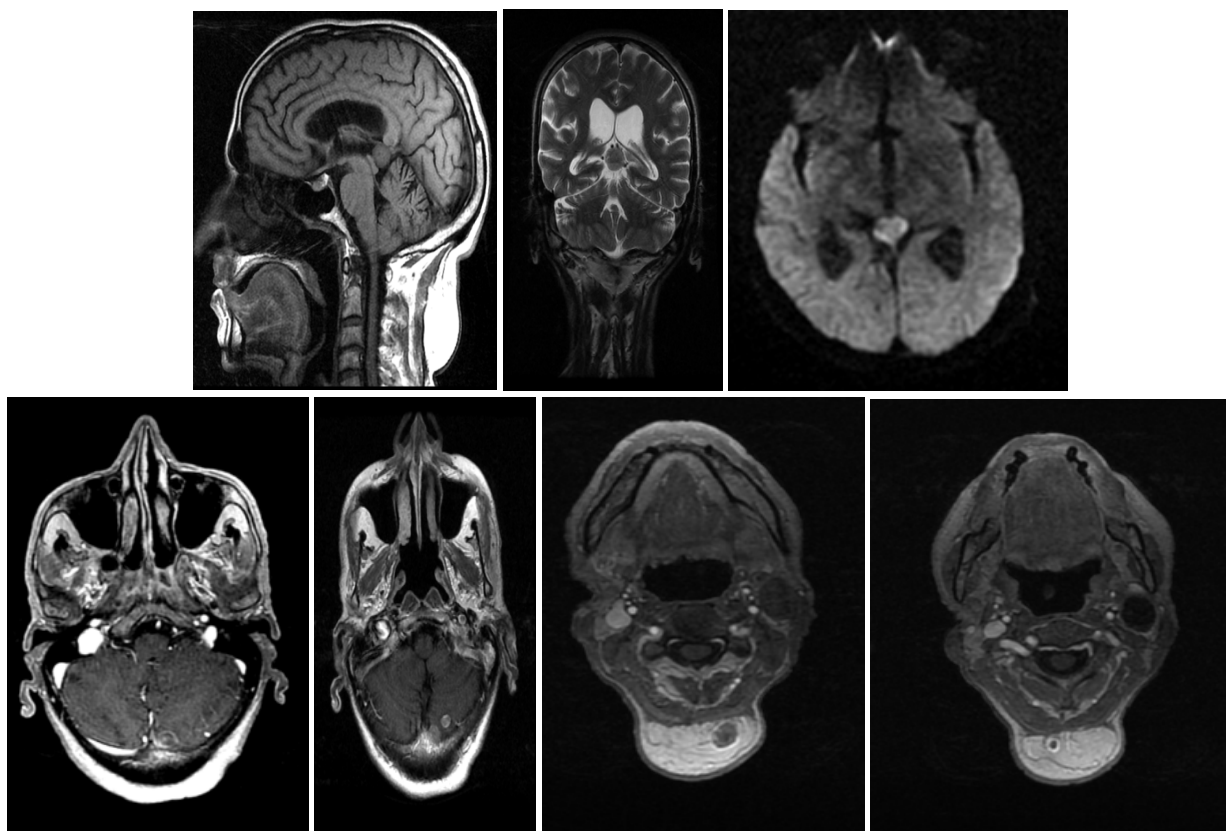


Figure 3: Brain MRI showing: An extra-axial lesion centered on the pineal gland (yellow arrow), oval in shape, well limited, with lobulated contours, described in T1 isosignal (a), T2 isosignal (b), diffusion restrictive (c), heterogeneously enhanced after contrast (d), secondary in appearance. Presence of two left cerebellar hemispheric nodular lesions (blue arrow) (e,f), annularly enhanced after contrast, secondary in appearance. Multiple nodular tissue lesions in the nuchal region (red arrow), roughly rounded, heterogeneously enhanced after contrast, related to permeation nodules. These lesions are located with a lipomatous formation resting on the trapezius muscle containing a few thin non contrast-enhanced septa measuring 62 mm in diameter.

Imaging examinations, in particular the computed tomography (CT) scan, play an essential role in the discovery of these pancreatic metastases. It remains the routine imaging examination for monitoring patients in oncology.

Case report

We reported a case of 66-year-old male, chronic smoker, followed for lung cancer, type CPC, metastatic.

On extension workup done by CCTAP CT at the University Hospital:

- Suspicious right mediastino-pulmonary tumor process, associated with mediastinal ADPs
- Secondary locations in the lung, lymph nodes, adrenal, pancreatic, peritoneal and pineal

Keywords: Small-cell lung cancer; Pancreatic metastasis

Conflict of Interest

None of the authors has any conflicts of interests to disclose.

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