

CASE REPORT

Atypical Presentation of Carcinoma Lung- Experiences of 5 Cases Series in NIDCH

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Abstract:

Lung carcinoma often manifests with some atypical symptoms which delay the diagnosis of malignancy. Primary Lung cancer is one of the most common cancers in Bangladesh with relatively poor prognosis compared to other types of cancers. In early stages of lung cancer there are usually no signs or symptoms. Many of the symptoms are nonspecific and their onset is gradual. Therefore, early detection and timely curative treatment remains a challenge. We present five cases of lung cancer patients with atypical presentations to a secondary care centre in Bangladesh followed by discussion on the importance of awareness of these symptoms among healthcare professionals and need for high index of suspicion for lung cancer in high-risk groups.

[Chest Heart J. 2019; 43(1) : 52-58]

DOI: <http://dx.doi.org/10.33316/chab.j.v43i1.2019601>

Introduction:

Lung cancer, the most common cause of cancer related death in men and women, is responsible for 1.3 million deaths worldwide annually.¹ The vast majority of primary lung cancers are carcinomas of the lung, derived from epithelial cells. The main types of lung cancer are small cell lung carcinoma (SCLC) and non-small cell lung carcinoma (NSCLC). Beside these epithelial cancers primary mesenchymal tumors of the lung account for less than 1 % of all primary lung cancers. Early diagnosis of any cancer improves prognosis. That's why being aware of atypical presentation and undergoing age- and risk-

appropriate screenings where available can improve outcomes for many cancer patients. However, lung cancer typically has few symptoms early in the disease. By the time individuals notice something is wrong, their cancer is usually at an advanced stage. Many tumors in the lung never cause symptoms. So without screening, three-quarters of patients presented in advanced stage for surgery. There are no nerve endings in the lungs, so patient can have a large tumor in the lungs without noticing. Most lung cancer patients are diagnosed from symptoms that result from the spread (metastasis) of the cancer to another site, such as the spine or liver. The most typical

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Submission on: 1 January 2019

Accepted for Publication: 24 January 2019

Available at <http://www.chabjournal.org>

symptoms are shortness of breath, coughing, hemoptysis and weight loss. Only 30% of these carcinomas are diagnosed in surgically treatable stage, usually presenting with long lasting cough and hemoptysis.² There is an overlap between these symptoms and those of chronic respiratory conditions that can delay diagnosis and early treatment, which may contribute to the poor prognosis. Also, there is considerable delay in investigating patients with atypical symptoms like joint pain, back pain, shoulder pain, visual disturbance, fatigue or even asymptomatic than with typical symptoms. We will present four cases of lung cancer patients with atypical presentations to NIDCH in Bangladesh. Our aim is to create awareness about these symptoms among health professionals.

Case 1:

A 65 years aged gentleman with history of accidental fall from height 1 months back. He went to local doctor and CXR (fig:1) done. On admission he gave no history of any respiratory complaints and examination revealed no significant abnormality. So we did CT Scan (Fig:2) of Chest and Fiber optic bronchoscope (FOB).



Fig.-1: CXR P/A View

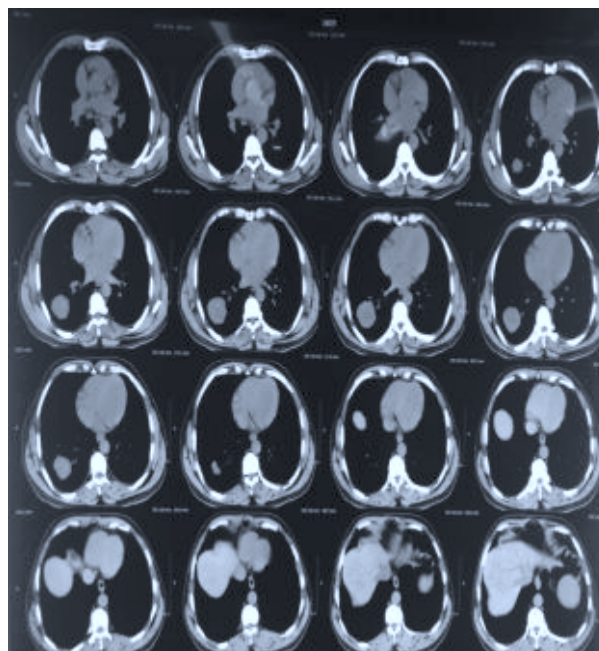


Fig.-2: CT Scan Mediastinal view

FOB reveals external compression of right lower lobe bronchus with no mucosal abnormality. And CT Scan guided FNAC revealed no malignancy or granuloma. After giving conservative treatment with antibiotics lung mass did not resolve. With the suspicion of malignancy we decided to do thoracotomy and right lower lobectomy with mediastinal lymph nodes dissection was done. Final histopathology report, lung mass: Chondrosarcoma low grade. Lymph nodes : Reactive change.

Case 2: A 45-years aged male smoker of 20 pack year with history of moderate chronic obstructive pulmonary disease and hypertension presented with bilateral knee pain for 4 months. No current respiratory symptoms however had history of weight loss of about 5 kg in 3 months. His examination revealed finger clubbing but was otherwise unremarkable.

Knee x-ray (Fig:4) revealed bilateral periosteal reactions affecting the distal femur and proximal tibia suggestive of hypertrophic pulmonary osteoarthropathy. Chest x-ray (Fig:5) demonstrated a left lung lesion. CT chest (Fig:6) revealed a 3.3cm spiculated left lung mass associated with left hilar lymph nodes. CT guided lung biopsy confirmed primary lung adenocarcinoma.



Fig.-3: X-Ray Knee joint



Fig.-4: CXR P/A



Fig.-5: CT Scan of chest.

Case 3: 52 years old smoking male presented to emergency department with complains of extreme right sided shoulder joint pain progressively worsening over 3 weeks, radiating to his right arm and neck. His vital signs were normal. He had no digital clubbing or palpable cervical lymphadenopathy on examination. Shoulder and systemic examination were normal. Shoulder x-ray (Fig:7) revealed no fractures or dislocation. however a lung mass was noted.

Subsequent chest x-ray (Fig:8) demonstrated lung mass in the right upper zone. CT scan (Fig:9) demonstrated a large irregular solid mass in the right upper lobe. CT guided biopsy confirmed undifferentiated adenocarcinoma, most likely of lung origin.

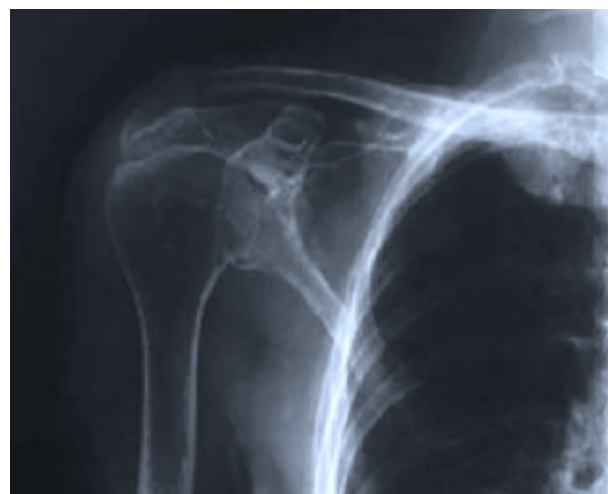


Fig.-6: X-ray of shoulder joint



Fig.-7: CXR P/A View

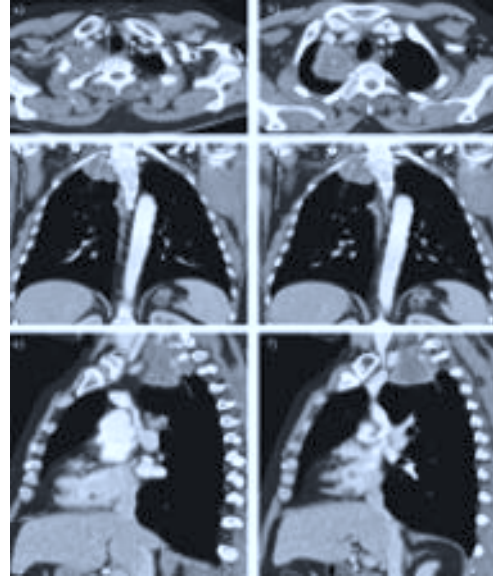


Fig.-8: CT Scan of the chest.

Case 4 :A 60 years old housewife, non -smoker presented with blurring of vision. She also complained of headache over the previous few weeks. She had no significant past medical history and systemic enquiry was unremarkable. Her examination revealed a left homonymous hemianopia with a normal systemic examination.

Blood results were normal. CT scan of brain (Fig: 10) showed a right parieto-occipital mass with surrounding white matter oedema and mass effect that was confirmed on MRI Brain (Fig:11). Subsequent investigation with chest x-ray (Fig:12) revealed left upper lobe lung mass and was confirmed on CT chest (Fig:13). FNAC confirmed primary lung adenocarcinoma.

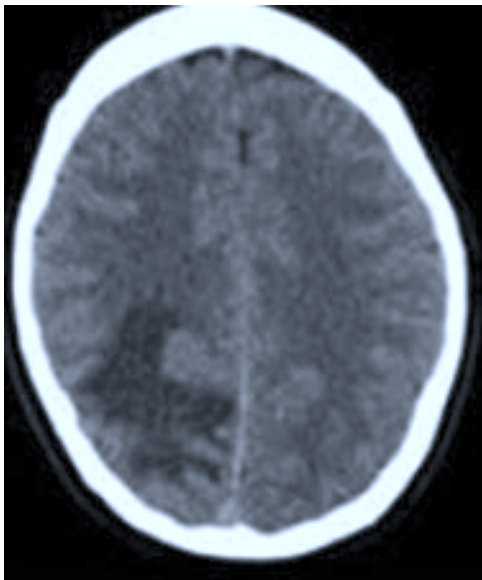


Fig.-9: CT Scan of Brain

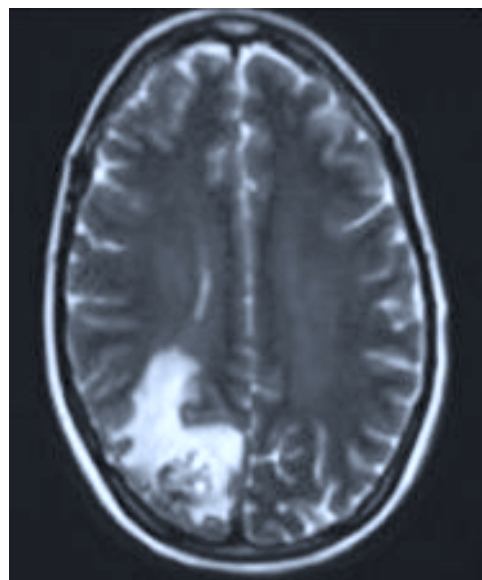


Fig.-10: MRI of Brain



Fig.-11: *Chest X-Ray*



Fig.-13: *Abdominal x-ray*

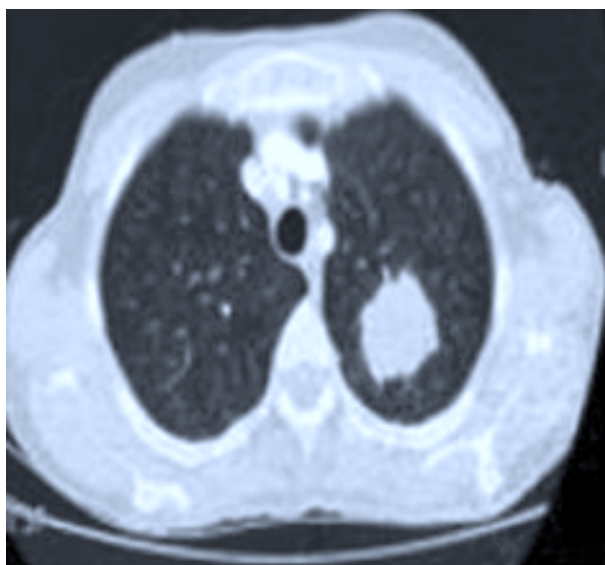


Fig.-12: *CT Scan of chest.*



Fig.-14: *CT Scan of Chest*

Case 5: A 55 years gentleman smoker presented with abdominal pain and distension with occasional vomiting for 7-10 days. He had no significant past medical history and systemic enquiry was unremarkable. Abdominal distension subsided with conservative treatments. Blood results were normal. Subsequent investigation with abdominal and chest x-ray (Fig: 14) revealed right upper lobe lung mass and was confirmed on CT chest (Fig: 15). FNAC confirmed primary lung adenocarcinoma.

Discussion:

lung cancer commonly presented with persistent cough, haemoptysis, dyspnoea, chest pain, and weight loss. Haemoptysis is the most important symptom associated with lung cancer, but this is reported as the first symptom in less than 5% of cases³. Some less common un important symptoms include fatigue, anorexia and hoarseness of voice. There are some atypical symptoms that can delay diagnosis and early treatment. which may contribute to the poor prognosis. In most cases,

lung cancer was detected with subjective symptoms, but 6.5% of cases had no symptoms indicative of lung cancer at the time of diagnosis.⁴⁻⁶ Asymptomatic patients received surgery in 60.0% of cases, and they showed significantly longer survival times than symptomatic patients. In our case 1, patient was asymptomatic at the time of admission but through investigation reveals only mass lesion in the right lower lobe. Our final diagnosis was chondro sarcoma which showed better outcome after surgery though asymptomatic. In case 2 patient presented with bilateral knee pain and X-Ray revealed hypertrophic pulmonary osteoarthropathy. And subsequent investigation showed left lower lobe adenocarcinoma. Hypertrophic pulmonary osteoarthropathy (HPO) is a rare paraneoplastic syndrome that is frequently associated with lung cancer. The incidence of clinically apparent HPO is not well known. The recent few studies have shown that the incidence is around 1.8%-4.5%⁷⁻⁹. About 10% cases of lung cancer may presented with para neoplastic syndrome. In case 3 a smoking male presented with excruciating shoulder joint pain with no digital clubbing but X-ray and CT Scan showed Right upper lobe mass. FNAC suggested adenocarcinoma of lung origin. Shoulder joint pain is one of the common symptoms in general practice but can be a clue for underlying lung cancer.

The incidence of shoulder joint pain associated with lung cancer is 16%.¹⁰ Pancoast tumour can present with such type of shoulder joint pain and other associated features. In case 4 patient complaints of blurring of vision with headache over the previous few weeks without any history of smoking. CT scan of brain & MRI Brain showed mass effect. Subsequent investigation with chest x-ray revealed left upper lobe lung mass and was confirmed on FNAC primary lung adenocarcinoma. The visual disturbance was due to brain metastasis secondary to lung cancer. The exact incidence of lung cancer with brain metastasis in initial presentation is unknown. Around 10% patients presented with brain metastasis with lung cancer in initial period. In case 5 the patient had presented with abdominal pain and distensions raising the possibility of abdominal metastases of lung cancer. Following further investigations, he was found to have lung

cancer. Abdominal metastases of lung cancer are rare and are commonly clinically silent. The largest reported series have evaluated gastrointestinal (GI) metastases from lung cancer by autopsies: only 12% of patients with lung cancer present with GI metastases.^{10,11}

Conclusion:

Different literatures review suggested that about 25% cases of lung cancer presented with atypical presentation. Atypical presentation is an important factor for delay in diagnosis with poor prognosis. To overcome this, every physician related to respiratory diseases should evaluate the patient properly for early diagnosis of lung cancer.

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