

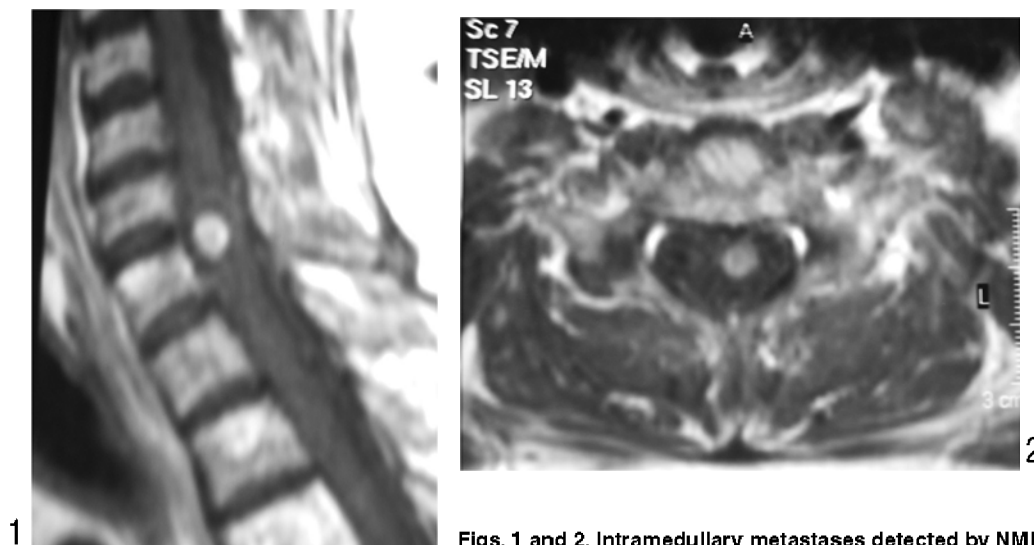
INTRAMEDULLARY METASTASES DUE TO NON MICROCYTIC LUNG CARCINOMA

To the editor:

Intramedullary metastases appear in approximately 0.5% of the patients with non microcytic lung carcinoma, and in 0.2% of the patients with microcytic lung carcinoma¹. They are usually located in the caudal spinal cord, and often are multiple focus metastases, and generally start with paresthesia or pain in the lower members. Physiopathologically, the vascular insufficiency is more important than the spinal cord compression². Most usually, they appear as a late complication feature of the disease; however it can also be the initial presentation³. The contrast image resonance has been here the chosen diagnosis procedure. The therapeutic options are very limited. Radiotherapy with or without concurrent chemotherapy can lead to a response, and consequently, to an improvement of the neurological symptoms⁴, in a selected group of patients. On the other side, intrathecal chemotherapy has been described as one of the options that can better contribute to a clinical benefit; nevertheless, its benefit in the global survival in non microcytic lung carcinoma is much lower, specially in those patients that present the disease at other levels⁵.

We hereby present a case of a 48-year-old-man who initially presented symptoms in November 2004 with a simple partial crisis on the left superior member

and slight paresis of the said member. He was an active smoker of 80 packs/year, with no other interesting clinical records. He underwent cranial CAT and NMR, revealing a focal lesion on the right upper frontal gyrus level, highly suggestive of a metastases or primary neoplasia. In the extension study, a mediastinic subcarinal mass of 2.6 cm of neoplastic characteristics was also revealed. In December 2004, he underwent a craniotomy with exeresis of the frontal lesion. The anatomical pathology analysis (immunohistochemical) revealed a carcinoma of a probable pulmonary origin. With a diagnosis of pulmonary adenocarcinoma stage IV with a sole resected brain metastasis, a chemotherapy treatment started with cisplatin 75 mg/m²-docetaxel 75 mg/m² every 21 days, together with holocranial radiotherapy, receiving a total dose of 35 Gy. After five cycles of treatment, an evolution of the disease was detected, with adenopathies at a paratraqueal and right subcarinal level, with an increase in size, compared to the previous, subcentimetric nodule in right superior lobule and subpleural nodules in right inferior lobule, and also a nodule in the right main bronchus of 2 cm. In the control cranial NMR, post-surgery changes in the right frontal lobule and in the hyper-capturing lesions of less than 1 cm in left frontal lobule and right corona radiata, highly suggestive of metastases were detected. A second line treatment with chemotherapy of gemcitabine 1250 mg/m² days 1.8 and 15 every 21 days was then initiated. After the third cycle, he pre-



Figs. 1 and 2. Intramedullary metastases detected by NMR.

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sented cervicalgia with pain spread to the left superior member that had recently appeared. As a consequence, an urgent spinal cord NMR was requested (figs. 1 and 2) revealing an intramedullary cervical metastases of 7 mm, at the level of the left side of the cervical-

medullary cord, which is located at the level of the intervertebral disk C6-C7, with an associated intense oedema, from C3 to D3. Haemangiomas in vertebrae D5, D12 and L5 were detected. The extension study with cranial-thorax-abdomen CAT was updated, with no sign of progression of the disease at other levels; it even presented a significant reduction in volume of one of the metastases located in the depth of the left pre-central sulcus, and disappearance of the rest, without appearance of new lesions. A study on mutations of EGFR in brain metastases biopsy resulted negative. Given the situation of the disease and the response at other levels, the gemcitabine treatment continued. He received 4 cycles of gemcitabine, presenting afterwards a unique bone metastatic lesion on left femur, establishing then a treatment with Pemetrexed for 6 cycles. At re-assessing the treatment, a progression at pulmonary and intramedullary level with size increase of the previous existing lesion, without clinical repercussion was observed. The patient continued presenting a good general state, and requested an active treatment; for that reason, a treatment with oral vinorelbine was initiated. However, after just one vinorelbine cycle, an important clinical damage was revealed, with loss of strength in the

forth extremities that led to inability to walk and, due to this fact a symptomatic palliative treatment was started.

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