Dear Editor,

The most common locations for colorectal metastases are liver, lung and peritoneum (1). Metastases arising in colon, small bowel, adrenal glands or ovaries are a rare event.

Lung metastases from colorectal cancer arise in the pulmonary parenchyma; however metastases on the tracheobronchial wall are anecdotal (2).

Case report

We present a 76-year-old asthmatic woman with two lung metastases from a well differentiated rectal adenocarcinoma (pT2N0M1, stage IVa), located in the middle lobe and the left inferior lobe. The patient received neoadyuvant radio-chemotherapy, rectal surgery and chemotherapy. Because of a good response to treatment she underwent pulmonary resection of metastases one year later. No other comorbidities were reported.

In her annual medical exam, one year after lung surgery, the patient presented with intermittent inspiratory stridor and dyspnea. She needed 2 litres/min flow of oxygen to maintain 95% arterial oxygen saturation.

Conventional chest X-ray revealed multiple bilateral different sized pulmonary nodules and a loss of right lung volume. Computed tomography showed a 15 mm solid lesion located 5 mm below the vocal cords. A similar lesion was blocking the right main bronchus. There were many small nodules in both lungs. No abdominal disease was reported.

A rigid bronchoscopy was performed showing an obstruction of 90% of the tracheobronchial lumen (Fig. 1) and multiple 2-3 mm sessile metastases. The biggest lesions were treated using Nd:YAG laser and argon plasma coagulation, relieving the airway obstruction without any complications. Histological analysis demonstrated rectal adenocarcinoma tissue. Endobronchial brachytherapy after local ablative therapy was not necessary although new ablative sessions were considered if required to maintain our patient’s quality of life.

Discussion

Endobronchial metastases due to solid organ primary tumors are uncommon and generally caused by head and neck cancer. Twenty six percent of these lesions are due to colorectal cancer (2). One single case of anal origin has been reported (3). Tracheo-

Fig. 1. Tracheal lesion seen through the vocal cords.
Bronchial metastases often occur later in the course of the disease after parenchymal dissemination so they have a poor prognosis (4,5) and benefit from palliative and symptomatic management. The main symptoms are dyspnea, cough and hemoptysis, although 50% produce no symptoms. Radiological findings have poor sensitivity and detect up to 55% of tracheobronchial metastases. It is appropriate to perform a bronchoscopy to better characterize these lesions. Treatments employed should be individualized and are determined by the histology of primary tumor, location, symptoms and patient’s performance status (5), including chemotherapy, brachytherapy, local resection as well as other techniques. In our case no retreatment was required after 15 months but the patient finally died because of her cancer disease.

We should consider the presence of tracheobronchial metastases in patients with colorectal cancer and parenchymal pulmonary spread. Survival and quality of life depend on these lesions. Although their prognosis is poor, these patients may benefit from endoscopic palliative management in experienced hands.

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