Painless jaundice as an initial presentation of lung adenocarcinoma

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CASE REPORT

A 53-year-old male with no previous medical history was admitted to hospital due to painless jaundice with hyperbilirubinemia of 15 mg/dl and a wasting syndrome of a three month duration. An abdominal ultrasound and a subsequent body computed tomography (CT) were performed which showed an amputation of the intrapancreatic bile duct occupied by soft-tissue density material. This was suggestive of cholangiocarcinoma and multiple liver and locoregional lymph node metastases. A spiculated nodule measuring 2 cm in the lingual was also identified (Fig. 1). An endoscopic retrograde cholangiopancreatography (ERCP) was performed and infiltrative-like duodenal mucosa was identified via endoscopy and choledocian stenosis with retrograde dilation via cholangiography (Fig. 2). Furthermore, duodenal biopsies and choledocian cytology were performed that revealed findings of poorly differentiated lung adenocarcinoma. The immunohistochemical study was performed on these samples and this allowed the early design of the chemotherapy regimen.

DISCUSSION

Obstructive jaundice due to metastatic lung neoplasms may be secondary to diffuse parenchymal liver involvement, locoregional lymph node involvement, pancreatic head metastases or, exceptionally, periampullary or biliary metastases (1). The high metastatic potential of lung neoplasms is well known and represents approximately one third of patients with symptoms related to extra thoracic spread at the time of diagnosis, especially in aggressive subtypes, such as small cell lung cancer and adenocarcinoma (2). However, obstructive jaundice due to metastases in the periampullary region as an initial presentation of lung adenocarcinoma is an exceptional finding, with only one described case in the literature (3). Since clinical, laboratory and image findings are similar to those of primary biliary tumors, other studies are required to differentiate between them. Thus, in this case, the immunohistochemical study was the most important tool that allowed the diagnosis and early design of targeted treatment.

Fig. 1. CT images. A. Abrupt amputation of the intrapancreatic bile duct until the junction with the Wirsung, which appears occupied by soft-tissue density material with enhancement in the portal venous phase with persistence in late phase, conditioning retrograde dilation of bile duct. All of these findings are suggestive of an intrapancreatic bile duct cholangiocarcinoma. B. A 19.6 x 18.6 mm spiculated nodule located in the cardiophrenic angle at the lingual lower left segment, probably malignant.

Fig. 2. ERCP and endoscopic images. A. Edematous and congestive duodenal second portion mucosa with large irregular ulcers. B. Intra and extrahepatic biliary dilatation up to the mid-level of the bile duct, where it is amputated until the papilla.
REFERENCES

