Melena: An Unusual Manifestation of Metastatic Lung Cancer

Muge Ustaoglu1, Bahiddin Yilmaz2, Sultan Caliskan3, Ceren Canturk4, Ibrahim Goren1 and Ahmet Bektas1

1Department of Gastroenterology, School of Medicine, Ondokuz Mayis University, Samsun, Turkey
2Department of Medical Oncology, School of Medicine, Ondokuz Mayis University, Samsun, Turkey
3Department of Pathology, School of Medicine, Ondokuz Mayis University, Samsun, Turkey
4Department of Internal Medicine, School of Medicine, Ondokuz Mayis University, Samsun,

ABSTRACT
Lung cancer is the most common cancer around the world, and the leading cause of cancer-related deaths. Clinical manifestations of lung cancer may vary from non-specific respiratory symptoms to symptoms due to metastases. The most common sites of metastases are the lymph nodes, liver, adrenals, bone, and brain. Metastasis of lung cancer to stomach is very rare. Here, we present a case of squamous cell lung cancer in a 71-year male metastasing to the stomach, a very uncommon site of metastasis.

Key Words: Lung cancer, Melena, Metastasis, Stomach.


INTRODUCTION
Lung cancer is considered the most common cause of cancer-related deaths around the world.1 Non-small cell lung cancer (NSCLC) accounts for about 85% of lung cancers. The most common presenting signs and symptoms are chest pain, cough, dyspnea, and hemoptysis.2 Sometimes, patients have symptoms due to metastatic disease. Gastric metastasis is infrequent.3 In this case, we describe a case of a 71-year male presenting with melena due to gastric metastasis from a squamous cell carcinoma (SCC) of the lung. As far as we know, this is the 12th case reported in English literature.

CASE REPORT
A 71-year man visited our Emergency Department with complaints of melena. He was smoking for 30 years and had a smoking history of 50 packs/year. The patient was diagnosed with stage T2N3M0 SCC of the lung 15 months ago; and had received both chemotherapy (paclitaxel, carboplatin) and radiotherapy. He had a history of malaise, anorexia, and anemia for six months. PET/CT scan with [18F]-fluorodeoxyglucose (FDG) showed stable disease.

Cranial radiotherapy was planned because of brain metastasis two weeks before admission. He reported a 10-day history of melena. On physical examination, he was fully conscious, with a normal heart rhythm. The abdomen was soft and lax and digital rectal examination showed melena. On laboratory workup, hemoglobin was 10 g/dL, platelet count was 193000/mm3,2 and international normalised ratio (INR) was 1.1. Esophagastroduodenoscopy was performed and an approximately 1.2 cm diameter ulcerated polypoid lesion was seen in the stomach

Correspondence to: Dr. Muge Ustaoglu, Department of Gastroenterology, School of Medicine, Ondokuz Mayis University, Samsun, Turkey
E-mail: ustaoglu.md@gmail.com

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towards the greater curvature; and the biopsies were taken (Figure 1). Histopathological examination of the endoscopic biopsies revealed the infiltration of malignant cells between gastric glands. The malignant cells, arranged in solid nests, were characterised by large vesicular nuclei with irregular shape and size, prominent nucleoli, and abundant eosinophilic cytoplasm. Immunohistochemically, the neoplastic cells were p40 positive, cytokeratin 7, and TTF-1 negative. The pathological findings supported a diagnosis of gastric metastasis of SCC of the lung (Figure 2). A combination of cisplatin and gemcitabine chemotherapy was started due to advanced and metastatic disease. After the first cycle of chemotherapy, no more chemotherapy was administered because of his poor performance status. Supportive treatment was given to improve the quality of life.

Clinical signs, including laboratory tests that raise suspicion of metastatic disease, are suggested in a meta-analysis. According to this meta-analysis, metastasis should be suspected when hematocrit is under 40 in male patients. In our patient, at the time of diagnosis of lung cancer, hematocrit was 35%. There were no tumor nodules in the contralateral lobe, no pleural or pericardial nodules/malignant effusion, no extrathoracic tumor metastases at the time of diagnosis, and six months before Emergency Department admission on PET-CT scan. When the patient was diagnosed with lung cancer, despite hematocrit being 35%, upper gastrointestinal endoscopy was not performed; thus, potentially delaying the diagnosis.

In conclusion, patients with lung cancer, who have non-specific gastrointestinal symptoms, either at the time of diagnosis or during follow-up, should be evaluated carefully. If necessary, upper gastrointestinal endoscopy should be performed. This may obviate the delay in the diagnosis of metastatic disease.

**PATIENT'S CONSENT:**

The consent of the patient was taken prior to the writing of the manuscript.

**CONFLICT OF INTEREST:**

The authors declared no conflict of interest.

**AUTHORS’ CONTRIBUTION:**

MU: Writing manuscript, design, concept, material, data collection, literature search, analysis and/or interpretation.

BY: Supervision, critical review.

SC: Material, data collection.

CC: Writing manuscript.

IG: Literature research, supervision.

AB: Critical review.

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