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Unusual presentation of metastatic lung cancer in gluteal muscle: A case report

Abstract

Globally, lung cancer is a main cause of cancer-related mortality and morbidity related to cancer. Unfortunately, most cases are not detected and treated until the late stages of disease progression, and 50% of the patients present with established distant metastases. Common locations of distant metastases include the brain, bones, adrenal glands, and liver. However, metastasis to soft tissue, including skeletal muscles, is rare. In this case, we reported a rare presentation of gluteal muscle metastasis as the first complaint of primary adenocarcinoma of the lung in a 79-year-old man. Ultrasound revealed a right gluteal mass that raised the suspicion of an underlying occult malignancy. A histopathological evaluation also showed poorly differentiated adenocarcinoma (Immunophenotype: CK7+/TTF-1+/CK20-), favoring primary lung origin. Although soft tissue metastasis is a relatively rare site of distant spread, our case report underscores the need for a higher clinical sense and a lower threshold for biopsy, as these lesions might indicate an underlying hidden malignancy.

Keywords

Lung cancer; Gluteal mass; Metastasis; Skeletal muscles

Cover Page Footnote

Many thanks to the Clinical Research Centre of An-Najah National University Hospital for the constant support and wise advice. In addition, the authors acknowledge An-Najah National University Hospital as the author's hospital

Unusual presentation of metastatic lung cancer in gluteal muscle: A case report

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ABSTRACT

Globally, lung cancer is a main cause of cancer-related mortality and morbidity related to cancer. Unfortunately, most cases are not detected and treated until the late stages of disease progression, and 50% of the patients present with established distant metastases. Common locations of distant metastases include the brain, bones, adrenal glands, and liver. However, metastasis to soft tissue, including skeletal muscles, is rare. In this case, we reported a rare presentation of gluteal muscle metastasis as the first complaint of primary adenocarcinoma of the lung in a 79-year-old man. Ultrasound revealed a right gluteal mass that raised the suspicion of an underlying occult malignancy. A histopathological evaluation also showed poorly differentiated adenocarcinoma (Immunophenotype: CK7+/TTF-1+/CK20-), favoring primary lung origin. Although soft tissue metastasis is a relatively rare site of distant spread, our case report underscores the need for a higher clinical sense and a lower threshold for biopsy, as these lesions might indicate an underlying hidden malignancy.

Keywords: Lung cancer; Gluteal mass; Metastasis; Skeletal muscles.

INTRODUCTION

Lung carcinoma is a major cause of mortality in cancer patients [1]. By diagnosis, about 50% of patients with primary lung cancer are found to have metastasis [2]. Distant metastasis that occurs through the lymph and bloodstream is highly prevalent in the later stages of the disease [3]. The commonest sites of distant metastasis include the liver (33-40%) followed by adrenal glands (18-38%), brain (15- 43%), bone (19-33%), kidney (16-23%), and abdominal lymph nodes (29%) [4]. Metastasis in soft tissues, including muscles, is unusual [2]. The authors, in this case, the report described a male lung cancer patient who is 79 years old and presented with a right gluteal muscle metastasis as the initial complaint.

CASE PRESENTATION

A 79-year-old ex-smoker male patient initially came to our hospital for a true-cut biopsy of a right gluteal muscle mass. He had a 3-month history of discomfort and limping of the right lower limb, dizziness, headache, and blurred vision, after which he felt a lump in that area. The patient endorsed chronic dry cough but denied hemoptysis or chest pain. He

did not lose weight or appetite. He had a history of smoking cigarettes every day for about 20 years, after which he stopped smoking for 10 years. The patient had no history of occupational or environmental carcinogen exposure, with a negative family history of cancer.

Upon examination, he had stable vital signs; blood pressure was 129/78 mmHg, heart rate was 82 beats/min, and a temperature of 37.5 ° C. Cardiovascular examination was unremarkable. Chest examination revealed clear bilateral lung sounds, with bilateral changes of gynecomastia, normal abdominal examination, without hepatosplenomegaly. Soft tissue nodules or enlarged lymph nodes were not appreciated. Initial laboratory investigations showed a white blood cell count of $8.7 \times 10^3/\mu\text{L}$, hemoglobin of 10.8 g/dL, and platelet count of $168 \times 10^3/\mu\text{L}$. The basic metabolic panel revealed serum sodium of 131 mEq/L, potassium of 3.95 mEq/L, blood urea nitrogen of 17 mg/dL, and creatinine levels of 0.87 mg/dL.

After a discussion with the patient about a tru-cut biopsy of the right gluteal region mass, the true-cut biopsy was taken under U.S. guidance with no immediate or delayed

complications. The samples were sent to our histopathology laboratory, which showed enlarged hyperchromatic cells with coarse chromatin and prominent nucleoli (Figure 1). Additionally, tumor cells were reported to be

positive for cytokeratin-7 (CK7) and thyroid transcription factor 1 (TTF-1) but negative for cytokeratin-20 (CK20), consistent with lung adenocarcinoma (Figure 2).

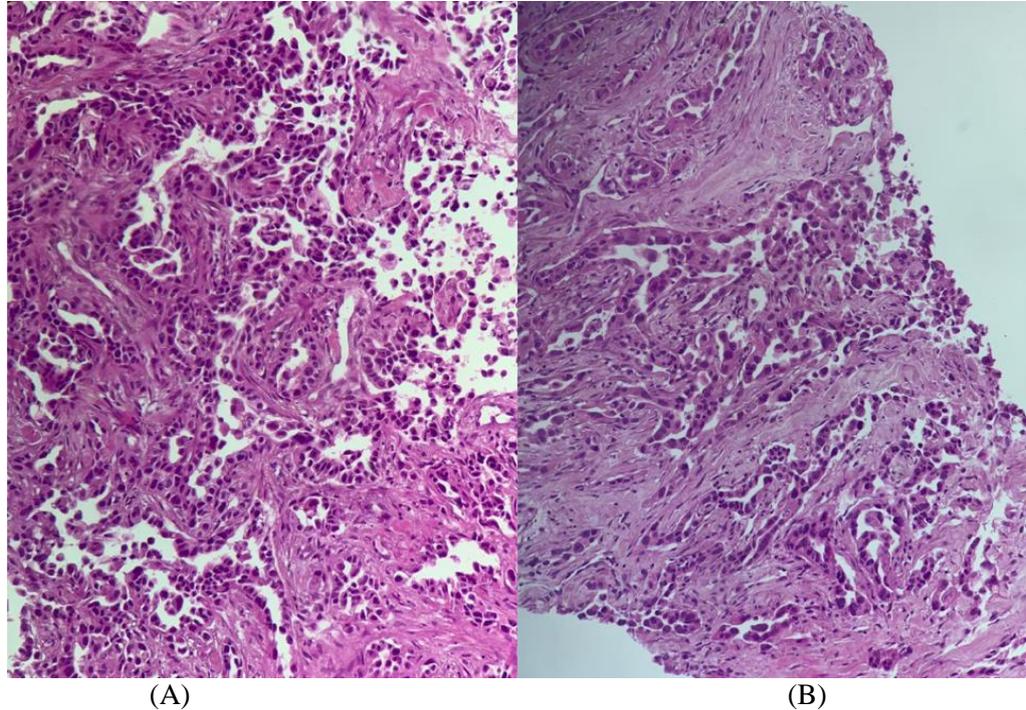


Figure (1): Gluteal mass biopsy showing a poorly differentiated tumor composed of hyperchromatic cells with coarse chromatin and prominent nucleoli (A and B).

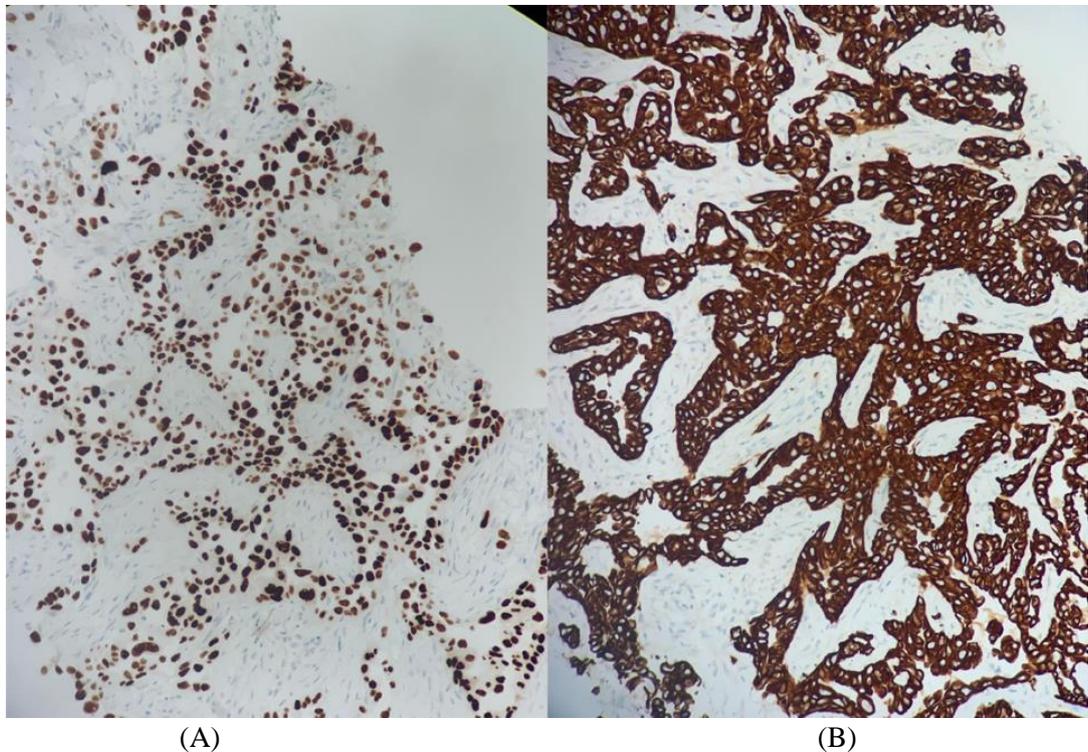


Figure (2): Immunohistochemistry showing tumor cells strongly immunoreactive to cytokeratin 7 (C.K. 7) (A) and thyroid transcription factor 1 (TTF1) (B).

After that, a discussion was made between the radiologist, pathologist, and his referral physician, and the decision was to perform a pan C.T. scan with IV contrast to look for the primary mass. A chest C.T. scan with IV contrast showed a large lobulated right soft lung tissue mass without calcifications or fat component, associated with prominent

mediastinal lymph nodes (Figure 3). The abdomen/pelvis C.T. scan with IV contrast portal-venous phase showed a large lobulated right gluteal mass originating from the right gluteal muscles and extending into the right subcutaneous tissue—furthermore, some mildly enlarged retroperitoneal lymph nodes (Figure 4). The brain and neck C.T. scans were unremarkable.



Figure (3): The chest C.T. / lung window with IV contrast shows a large lobulated soft tissue mass lesion with no calcifications or fat component associated with mildly enlarged mediastinal lymph nodes.

Physical examination and analysis of tumor markers are two diagnostic utilities. Our patient had no painful masses or clinically obvious soft tissue lesions suspicious of metastasis, and the tumor markers were negative. To determine the main origin, additional procedures such as immunohistochemistry were required. Expression of TTF-1, napsin-A, and CK7 proves primary lung origin. In a study involving 120 patients with primary lung adenocarcinoma, 79% were napsin A+/TTF-1+ve. 8% had TTF-1 / napsin-A +, and only 3% had TTF-1+/napsin-A-, concluding high sensitivity and specifying TTF-1 and napsin-A in detecting primary adenocarcinoma of the lung [7]. CK7 and CK20 were found to be of diagnostic significance in differentiating primary lung adenocarcinoma (CK7+/CK20-) from extrapulmonary adenocarcinoma of colonic origin (CK20+/CK7-) [10]. Another study showed that CK7 and TTF-1 were expressed in 100% and 80% of biopsies with primary lung adenocarcinoma [11]. The biopsy was CK7+/TTF-1+/CK20-, a panel strongly suggesting primary lung origin.

The impact therapy affects the patient's age, tumor stage, and histologic grade. Palliative radiation, chemotherapy, and immunotherapy are all alternatives for treatment. Prompt diagnosis increases survival chances.

CONCLUSIONS

As the first presentation, we described a rarely encountered case of primary adenocarcinoma of the lung presented as a right gluteal muscle soft tissue mass lesion. This reported case emphasizes the need to raise clinical suspicion and lower the biopsy threshold in patients presenting with lesions in the soft tissue, as it could represent a rare manifestation of occult malignancy. These lesions can also provide convenient and easily accessible biopsy sites that reduce the need for invasive procedures. Furthermore, our case report also highlights the importance of immunohistochemistry in diagnosing.

Ethics approval and consent to participate

The Institutional Review Board (IRB) of An-Najah National University has approved conducting and publishing the manuscript.

Consent for publication

Written consent was obtained from the patient. IRB was also obtained.

Availability of data and materials

The data sets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Authors' Contributions

MA and MM: wrote the manuscript. **MM and MS:** performed the histological examination and were major contributors to the writing of the manuscript. **MM:** performed the radiological examination and the true-cut biopsy. All authors approved the final manuscript.

Competing Interests

The authors declare that they have no competing interests.

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