A Rare Case of Isolated Chronic Cough caused by Pulmonary Lymphangitic Carcinomatosis as a Primary Manifestation of Rectum Carcinoma

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Abstract:
A 36-year old man was referred to our hospital due to isolated chronic cough that was refractory to anti-asthma medications, including inhaled corticosteroids/long-acting β2 agonists. Chest X-ray showed diffuse nodular and enhanced vascular shadows with Kerley lines in both lungs. A blood analysis showed elevated serum CEA and CA19-9 levels. A transbronchial biopsy revealed well to moderately differentiated adenocarcinoma, the origin of which was immunohistochemically suspected to be the gastrointestinal tract. Colonoscopy confirmed the diagnosis of primary rectum carcinoma. Pulmonary lymphangitic carcinomatosis was therefore regarded as the origin of the cough. Lymphangitic carcinomatosis is an uncommon diagnosis but important to consider in patients with persistent cough.

Key words: chronic cough, pulmonary lymphangitic carcinomatosis, rectum carcinoma

Introduction

Although cough is one of the most common symptoms of lung cancer (1), the frequency of lung cancer as a cause of chronic cough as the sole symptom is less than 2% (2). Among lung tumors, pulmonary lymphangitic carcinomatosis shows a poor prognosis of three to six months (3). Respiratory symptoms, such as cough, dyspnea, and hemoptysis, progress rapidly and are usually accompanied by body weight loss, appetite loss, and a fever (4, 5).

We herein report a case of pulmonary lymphangitic carcinomatosis of rectal origin, which solely presented with a chronic cough.

Case Report

A 36-year old man with no smoking history was referred to our hospital because of nighttime predominant chronic cough lasting for 2 months. He had already received a treatment of inhaled corticosteroid, long-acting β2 agonist, and leukotriene antagonist under a tentative diagnosis of cough-variant asthma; however, the cough was refractory to such intensive anti-asthma therapies.

At the first visit, he complained of only a persistent cough, with no other symptoms, such as a fever, dyspnea, hemoptysis, body weight loss, fatigue, anorexia, abdominal pain, obstipation, diarrhea, and melena.

Chest X-ray revealed enhanced vascular shadows and bronchial wall thickening, with diffuse small nodules of both lungs. Kerley A, B, and C lines were also visible on whole-chest X-ray (Fig. 1A). Chest computed tomography (CT) demonstrated diffuse nodular shadows, thickening of the bronchovascular bundle and interlobular septa, hilar and mediastinal lymphadenopathy, and a small amount of bilateral pleural effusion (Fig. 1B). Among a number of differential diagnoses based on the radiological findings, the elevated serum levels of carcinoembryonic antigen (CEA) and carbohydrateantigen19-9 (CA19-9) strongly suggested pulmonary lymphangitic carcinomatosis (Table). A transbronchial biopsy revealed well to moderately differentiated adenocarcinoma. Immunohistochemical analyses showed posi-
Figure 1. Chest X-ray and computed tomography findings. (A) Chest X-ray showed enhanced bronchovascular shadow and diffuse small nodules in both lungs. Kerley A, B, and C lines were also visible on whole-chest X-ray. (B) Chest computed tomography demonstrated diffuse nodular shadows, ground-glass opacities, and thickened bronchovascular bundles and interlobular septa in the whole pulmonary area. A small amount of bilateral pleural effusion was also noted.

Table. The Differential Diagnosis and the Corresponding Clinical Examination Results of the Case, Based on Radiological Findings.

<table>
<thead>
<tr>
<th>Causative Diseases</th>
<th>Clinical examinations</th>
<th>Results (normal ranges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miliary tuberculosis</td>
<td>Interferon-γ release assays</td>
<td>Negative</td>
</tr>
<tr>
<td>Sarcoidosis</td>
<td>Serum angiotensin-converting enzyme, IU/L</td>
<td>8.3 (8.3-21.4)</td>
</tr>
<tr>
<td>Malignant lymphoma</td>
<td>Soluble interleukin-2 receptor, U/mL</td>
<td>396 (145-519)</td>
</tr>
<tr>
<td>Diffuse panbronchiolitis</td>
<td>Paranasal sinuses X-ray</td>
<td>No abnormality</td>
</tr>
<tr>
<td></td>
<td>Serum IgA, mg/dL</td>
<td>314 (100-350)</td>
</tr>
<tr>
<td></td>
<td>Cold hemagglutination, folds</td>
<td>32 (≤128)</td>
</tr>
<tr>
<td>Pulmonary lymphangitic carcinomatosis</td>
<td>Tumor markers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serum CEA, ng/mL</td>
<td>277.2 (≤5)</td>
</tr>
<tr>
<td></td>
<td>Serum CA19-9, U/mL</td>
<td>8,500 (≤37)</td>
</tr>
</tbody>
</table>

tive staining for CK20 and CDX2 and negative staining for CK7, napsin A, and TTF-1 (Fig. 2), suggesting a cancer of gastrointestinal tract origin. Positron emission tomography (PET) showed a diffuse uptake of 2-deoxy-2-[fluorine-18] fluoro-D-glucose (18F-FDG) in both lungs along with an increased uptake in the intraperitoneal lymph nodes, mediastinal lymph nodes, and rectum (Fig. 3). Colonoscopy confirmed a definitive diagnosis of primary rectum cancer. The biopsy of the rectum tumor showed consistent result with those of lung biopsy including immunohistochemical analyses (Fig. 4). We therefore regarded pulmonary lymphangitic carcinomatosis as the primary manifestation of rectum carcinoma, which solely presented with chronic cough.

Discussion

Reportedly, from 8%-75% of patients with lung cancer present with cough as a symptom (1). While lung cancer as the cause of isolated cough lasting for eight weeks or longer is uncommon, we believe pulmonary lymphangitic carcinomatosis is an important cause of chronic cough. Breast, stomach, and lung are the most frequent primary organs of pulmonary lymphangitic carcinomatosis, while the prevalence of rectum as the primary site is only 2% (3). In clinical practice, pulmonary lymphangitic carcinomatosis is often misdiagnosed as other diseases, such as sarcoidosis (5), miliary tuberculosis (6), and interstitial lung disease (7), particularly when patients are younger than 40 years of age, as was our case.
Although a transbronchial biopsy is required for a definitive diagnosis of pulmonary lymphangitic carcinomatosis, characteristic findings on chest X-rays can be suggestive (5, 8). Thickened bronchovascular shadows, diffuse reticulonodular shadows, Kerley lines, hilar lymphadenopathy, and pleural effusion are observed in 20% to 50% of cases (5). However, chest X-rays show no abnormality in 30% to 50% of cases, as was a reported case by Jinnur et al (4). They reported a patient with occult pulmonary lymphangitic carcinomatosis solely presenting with chronic cough in whom chest X-ray and high-resolution CT showed no remarkable findings (4). Body weight loss, decreased appetite, and worsening cough developed 11 weeks after initial chest CT. Follow-up chest CT four months later revealed diffused pulmonary nodules with thickening of the bronchovascular bundle in both lungs (4). This suggests that cough may be the earliest sign of occult pulmonary lymphangitic carcinomatosis among other respiratory symptoms, such as shortness of breath and hemoptysis. However, we were unable to determine whether or not cough due to pulmonary lymphangitic carcinomatosis occurred prior to the development of radiological findings, as definite interstitial patterns...
were found on chest X-ray at the initial consultation. Thomas et al. described a patient with metastases to the intraperitoneal lymph nodes, mediastinal lymph nodes, and both lungs but not to the liver (Fig. 3) (5). This presentation accounts for 9% of cases of rectum cancer (9). Vascular endothelial growth factor (VEGF)-C and its receptor VEGFR-3, which are both lymphangiogenesis factors for such tumors, are associated with lymph node metastases including lymphatic dissemination to the lung (10). Although we were unable to evaluate his condition because he was referred to another hospital to receive chemotherapy, an intensive chemotherapeutic regimen including VEGFR inhibitors may be effective for treating cough via the attenuation of lymphangitic dissemination.

Conclusion

Based on our observation, pulmonary lymphangitic carcinomatosis should be considered as a cause of isolated chronic cough along with common causes, including asthma, especially because of its potentially life-threatening outcome, despite the absence of other symptoms, such as dyspnea, hemoptysis, and body weight loss.

The authors state that they have no Conflict of Interest (COI).

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Author Contributions

M.N. drafted the manuscript. Y.K. examined patients, performed bronchoscopy, made the diagnosis, and drafted the manuscript. T.O., T.A., S.F., H.O., M.T., K.M., and Y.I. assessed the clinical management, and discussed treatment plan. A.N. assessed the clinical management, discussed treatment plan, and supervised the whole manuscript.

*M.O. and Y.K. equally contributed to this work.

References


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