



Images

Lymphangitic carcinomatosis

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ARTICLE INFO

Article history:

Received 18 April 2019

Received in revised form

13 May 2019

Accepted 14 May 2019

Available online 21 May 2019

1. Clinical history

For a 71-year-old male presented with progressive breathlessness, a chest radiograph was obtained (Fig. 1).

2. Radiologic findings

The chest radiograph (Fig. 1) shows reticulonodular opacities in bilateral mid and lower zones with mild bilateral pleural effusions. Multiple sclerotic foci are seen in bilateral humeral heads, bilateral clavicles, few ribs, and dorsolumbar vertebral bodies (marked with dashed arrows).

3. Diagnosis

In view of the coarse reticulonodular pattern of lung opacities and osteoblastic bony metastases, it was diagnosed as lymphangitic carcinomatosis (LC) with bony metastases. The patient was proven to be a case of prostatic carcinoma on histopathology.

4. Differential diagnosis

The differential diagnosis of interstitial opacities in bilateral lungs includes

1. interstitial lung disease
2. sarcoidosis
3. LC

4. silicosis
5. coal workers' pneumoconiosis
6. extrinsic allergic alveolitis (hypersensitivity pneumonitis)
7. pulmonary edema
8. lymphoma and Kaposi sarcoma

5. Discussion

LC refers to the diffuse infiltration and obstruction of pulmonary parenchymal lymphatic channels by a tumor. It occurs in 6–8% of patients with pulmonary metastases. The spread of tumor cells to the pulmonary lymphatic system or the adjacent interstitial tissue results in thickening of the bronchovascular bundles and septa. Various neoplasms can cause LC, but 80% are adenocarcinomas. The most common primary sites are the breasts, lungs, colon, and stomach.^{1d}

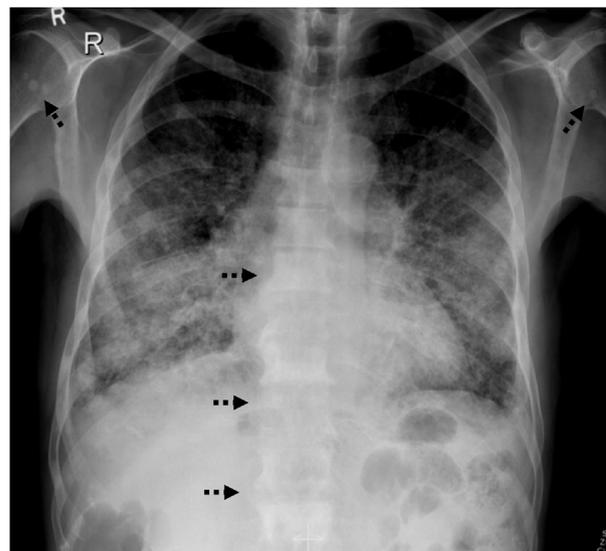


Fig. 1. Chest radiograph postero-anterior positioning (PA) view shows reticulonodular opacities are seen in bilateral mid and lower zones with pleural effusions. Multiple sclerotic foci are seen in bilateral humeral heads, bilateral clavicles, few ribs, and dorsolumbar vertebral bodies (shown with dashed arrows).

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The prostate cancer accounts for only a small fraction as a primary organ of LC. The radiologic findings of pulmonary metastasis from prostate carcinoma according to past investigations include pleural effusions (22%), followed by nodular lesions (8%), lymphadenopathy (4.5%), and reticulonodular lesions (3.5%).² The prostate is generally ignored as a cause of LC. It is necessary that the potential of the prostate as a primary organ is considered when an image suspicious of a carcinomatous metastasis is detected in the lungs of a male patient of elderly age group. In general, LC is a form of the terminal phase of carcinoma and leads to a poor prognosis. However, only for prostate carcinoma, some studies have reported remarkably effective use of maximum androgen blockade therapy for its treatment.³

Conflict of interest

None.

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