

ONS Publishing Division Policy Regarding Letters to the Editor: Selection of letters to be published in Letters to the Editor is the decision of the editor. For acceptance, letters must be signed. A letter can appear anonymously if requested by the author. All letters are subject to editing.

A letter that questions, criticizes, or responds to a previously published *Clinical Journal of Oncology Nursing* article automatically will be sent to the author of that article for a reply. This type of collegial exchange is encouraged. Letters that question, criticize, or respond to an Oncology Nursing Society (ONS) policy, product, or activity will appear in *ONS Connect* and automatically will be sent to the ONS Board of Directors for a reply. Send letters to CJONeditor@ons.org.

Metastatic Polyps in the Hepatic Flexura of the Colon

Metastatic tumors of the gastrointestinal (GI) tract are uncommon. Lung cancer very rarely metastasizes to the GI tract, but when it does, the small intestine is the most frequent site (Kim et al., 2009). Among lung cancer subtypes, large and squamous cell carcinomas are the most common to metastasize to the GI tract (Antler, Ough, Pitchumoni, Davidian, & Thelmo, 1982; Kim et al., 2009). Small cell lung cancer metastasis to the GI tract has been reported only rarely. Herein we present a case report of metastatic involvement of the GI tract. To our knowledge, this is the first report of small cell lung cancer metastasis to the stomach and colon.

A 72-year-old woman was admitted with complaints of fatigue, weight loss, and progressive numbness of her extremities. She was a 15 pack-year smoker. Physical examination revealed mild weakness of distal extremities. Laboratory tests showed elevated levels of alkaline phosphatase (810 IU/L), gamma glutamyl transferase (334 IU/L), aspartate amino transferase (102 IU/L), alanine transaminase (124 IU/L), creatine kinase (600 IU/L), CA 15-3 (483 U/ml), and CA 19-9 (1,504 U/ml). A chest radiogram was normal. Ultrasonography revealed multiple metastatic lesions in the liver. To detect the origin of the metastasis, upper and lower GI tract endoscopies were performed. The upper GI endoscopy showed atrophic gastritis, so biopsies were taken from the corpus. At colonoscopy, two masses with a diameter of 30 mm at the proximal and distal part of hepatic flexura were detected (see Figure 1). Sometimes polyps may not be seen, but when colonoscopy is performed by nurses experienced with polyp detection, the



Note. The mass was about 30 mm in diameter and erosion was present at the top.

Figure 1. Mass in the Distal Portion of Hepatic Flexura at Colonoscopy

rate increases. Histopathologic examination of the gastric and colonic samples revealed metastasis of small cell lung cancer. Computed tomography of the thorax showed infiltration at the right lower lobe of the lung. Bone scintigraphy showed vertebral metastases. Electromyography revealed sensory motor peripheral neuropathy. Chemotherapy with cisplatin and etoposid was initiated. Although the patient had completed five sessions of her chemotherapy regimen, she died of brain metastasis four months after being diagnosed with lung cancer.

The most common metastatic region of lung cancer is the bone, liver, adrenal gland, bone marrow, and brain. Although GI tract metastasis of lung cancer has been reported at about 10%, the reported incidence of symptomatic GI metastasis is less than 0.5% (Berger et al., 1999).

Clinical presentation of colonic metastasis includes obstruction, bleeding, intussusceptions, perforation, and fistula. In this case study, the patient was free of any GI complaints and lung cancer was diagnosed after sampling from gastric and colonic lesions.

The authors take full responsibility for the content of the article. The authors did not receive honoraria for this work. No financial relationships relevant to the content of this article have been disclosed by the authors or editorial staff.

Digital Object Identifier: 10.1188/10.CJON.683-684