An usually disseminated advanced cancer presenting only as mild rheumatological symptoms

It is well known that several neoplasms produce signs and symptoms that mimic diseases of the musculoskeletal system [1]. These syndromes are known as paraneoplastic syndromes. In some cases, the symptoms and signs of the syndrome are the first detectable features of the neoplasm. In the majority of cases, the paraneoplastic syndrome develops in an advanced stage of the malignant disease. In such cases, there is no difficulty in diagnosis because the other features of the neoplastic disease are easily detectable.

The aim of the present letter is to report an unusual case of a patient with relatively mild musculoskeletal symptoms despite very advanced disseminated cancer.

A 78-year-old male was admitted to the hospital due to back pain, decrease in body mass (about 6 kg during half a year) and migrating pains of the joints of the lower extremities. He had no severe disorders in his history but 20 years before admission he had suffered from a myocardial infarction, and currently had slight symptoms of ischaemic heart disease. Seventeen years before admission, he had been operated on due to enlargement of the prostate. The pains appeared slowly and were detectable about 2 months before the admission. Physical examination revealed the following abnormalities: cutaneous changes on the front part of the thorax in the form of popular small, hard infiltrations. The liver was enlarged and hard at palpation. In the navel a small tumour mass was visible, which looked like a small umbilical hernia. The musculoskeletal system was typical for mild osteoarthrosis typical for the age of the patient, and no significant abnormalities were detected at rheumatological physical examination.

Imaging investigations, including computer tomography of the abdomen and thorax, revealed a tumour within the eighth segment of the left lung and massive dissemination of metastases. The metastases were detectable in the ribs, subcutaneous tissue of the chest, liver, spleen, periaortal nodes, suprarenal glands, and retroperitoneal space. Biopsy of the navel tumour revealed adenocarcinoma. The tumour in the lung was considered as the primary site of malignancy. It was consistent with the patient's smoking history. He was a heavy smoker for numerous years but he discontinued smoking after the myocardial infarction. Upon the request of the patient, he was discharged home. He died at home two weeks later after a two-day-long coma, probably due to the brain metastases.

The presented case is of interest from a few aspects. It remains unclear why the patients with full consciousness and cognitive functions had not sought medical help earlier. The rational explanation is that he had no pain or other symptoms. It is also possible that the patient had knowledge or rather suspicion of the nature of the morbid process. He was well educated and thus lack of understanding of the disease should be excluded. On the other hand, it is difficult to imagine such a degree of dissimulation and masking of pain despite the massive cancer dissemination. It can be speculated that in this case the pain perception was significantly diminished. For the rheumatologist, it remains interesting that even mild rheumatic symptoms may be associated with advanced malignant disorder.

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References

1. Kotulska A, Kucharz EJ. Zespoły paranowotworowe w chorobach reumatycznych. Lekarz 2008; 12: 75-79.