

Acrometastasis: A Rare Entity. A Proximal Radius Case

Guijarro-Leo Sandra

Received: 14 December 2020 Accepted: 2 January 2021 Published: 15 January 2021

Abstract

Bone metastases under de knee and elbow (acrometastasis) are rare. We present the case of a patient diagnosed with lung adenocarcinoma, with a lesion in the right proximal radius. Radiological imaging through CT and MR suggested metastatic lesion, which anatomopathological results confirmed. As the presence of these markers provides a poor outlook, radiotherapy was initially considered. However, given the clinical stability of the patient and the limited amelioration observed, surgical treatment was finally conducted.

Index terms— acrometastasis, lung, radio, surgery.

1 Introduction

one metastatic disease is the most common malignant neoplasia of the bone. The term acrometastasis refers to the metastases produced in the distal extremities under knee and elbow.

They represent 0,1% of all bone metastases 1 having a greater incidence in males 2 .The metastases in these regions usually indicate a worse outlook. Most of these metastases are produced by bronchopulmonary and renal tumors, where pulmonary origin represents nearly half of these cases 3 , with greater incidence in the upper extremities.

Although most metastatic lesions appear during disease, occasionally they appear as the first symptom, in up to 10% of cases [4][5] .

Patients with distal bone metastasis have a poor outlook and, those in which these are the first signs of the disease have worse survival prospects, with a median of 3 to 9 months [5][6] II.

2 Case Report

We present the case of a 65 years old male with a pulmonary adenocarcinoma diagnosed, T4N2M0, IIIB stage, ROS1, and no ALK translocation, non-mutated EGFR, negative BRAF, PDL1 positive (1%). Ex-smoker for 14 years of a packet a day since age 15. The patient received chemotherapy (CBP/Alimta) + concomitant thoracic radiotherapy and is currently in maintenance treatment with Durvalumab.

The patient came to the emergency room of our hospital with pain in the proximal third of his right forearm, which had been ongoing for approximately one month and a half, with no record of previous trauma.

During the physical examination, he presented pain in the proximal third of the right radius and the anterolateral side of his forearm, accompanied by a loss of strength in the wrist. The supination ability was limited to 20°, with complete pronation and flexion and extension. Neurovascular distal exploration preserved.

In further tests, the following could be observed: Forearm RX: moth-eaten lytic lesion, poorly defined with cortical destruction of the proximal third with no evidence of associated fracture, compatible with bone metastasis. (Figure 1). Subsequently, the study is extended with an MRI (Figure 2) showing a lytic lesion with cortical invasion and soft-tissue mass in the proximal radius compatible with bone metastasis, invading the supine muscle and probably the extensor digitorum muscle as well as the distal insertion of the biceps tendon. With these findings, the medical oncology service requests a PET CT scan (figure 3) which shows the lesion in the right proximal radius and a partial improvement of the known pulmonary masses alongside a complete response of the bilateral hilar and mediastinal adenopathies. After surgery, a nerve paresis was observed of the radial nerve, which the patient has partially recovered with the help of rehabilitation. Clinically, the patient is no pain and has a mobility limitation of approximately 20° for supination and 10° for the extension.

3 III.

4 Discussion

Bone metastases can constitute the first symptom of a neoplastic process still unknown or appear concomitantly within an already diagnosed condition. The most important primary tumors of bone metastasis are prostate, breast, pulmonary, renal, and thyroid. Of these, prostate, breast, and lung constitute over 65% of all bone metastases 7 .

Clinically, the patient presents localized pain, progressive, which does not lessen at night nor improve with rest. Occasionally, it can be accompanied by soft tissue mass 8 , which depending on location and size, can require clinical practice due to the compression of neighboring structures.

Radiologically, we find lesions that are typically lytic, with a varying pattern of bone destruction but typically geographic with cortical affectation, without periosteal reaction in most cases, and occasionally with an associated element of soft-tissue mass. In fact, given its clinical and radiological characteristics, they can imitate those of an infection or other non-neoplastic processes such as inflammatory or rheumatoid arthritis 4 , producing a delay in obtaining a definite diagnosis, mainly in patients without a known primary tumour. As a result, inadequate treatment is likely to take place.

The process by which bone metastases appear is still not well defined, but it could be due to a diffusion system in the blood flow different from habitual lymphatic media, thus explaining the tumors cells' preference for distal regions which are richly vascularised 3 . Libson and col. show how the location of the metastasis depends on the venous system which different affected organs drain to. Hence, malignant neoplasm located at a supradiaphragmatic level such as the lung, tends to produce metastasis under the elbow, in contrast, subdiaphragmatic neoplasm as the colon, urothelial, uterus, and prostate tend to make metastasis under the knee 5,8,9 .

Currently the survival of cancer patients has increased to a great extent because of the improvement of oncological treatment, enabling the survival of patients with metastatic disease. This improvement in survival, at times, makes us reconsider, as surgeons, our therapeutic performance.

This increase in survival means pain control is frequently the main goal when treating these patients. The general state, the location of the lesion, and the type of primary cancer help establish the treatment which the surgeon must use 10 .

Due to the fact that acrometastases constitute a rare entity, no treatment protocol has been established. Each case must be examined separately in order to establish the best treatment according to the needs of each patient. In general terms, treatment tends to be palliative, including an adequate resection of the tumor, enabling pain relief and allowing fast recovery while preserving the maximal functional performance of the affected extremities.

Within the different treatments used, we mainly find radiotherapy, the tumor resection, and the combination of both 3,11 .

IV.

5 Conclusion

In conclusion, acrometastasis is an infrequent entity. However, due to the advance in the medical treatment of cancer, hence higher life expectancy of patients, there also exists a significant increase in the diagnoses of metastatic bone lesions.

In patients with a history of cancer, those with unusual symptoms, or those who do not respond to certain standard treatments, a differential diagnosis must be established, which includes bone metastasis diagnosis. ^{1 2}

¹© 2021 Global Journals

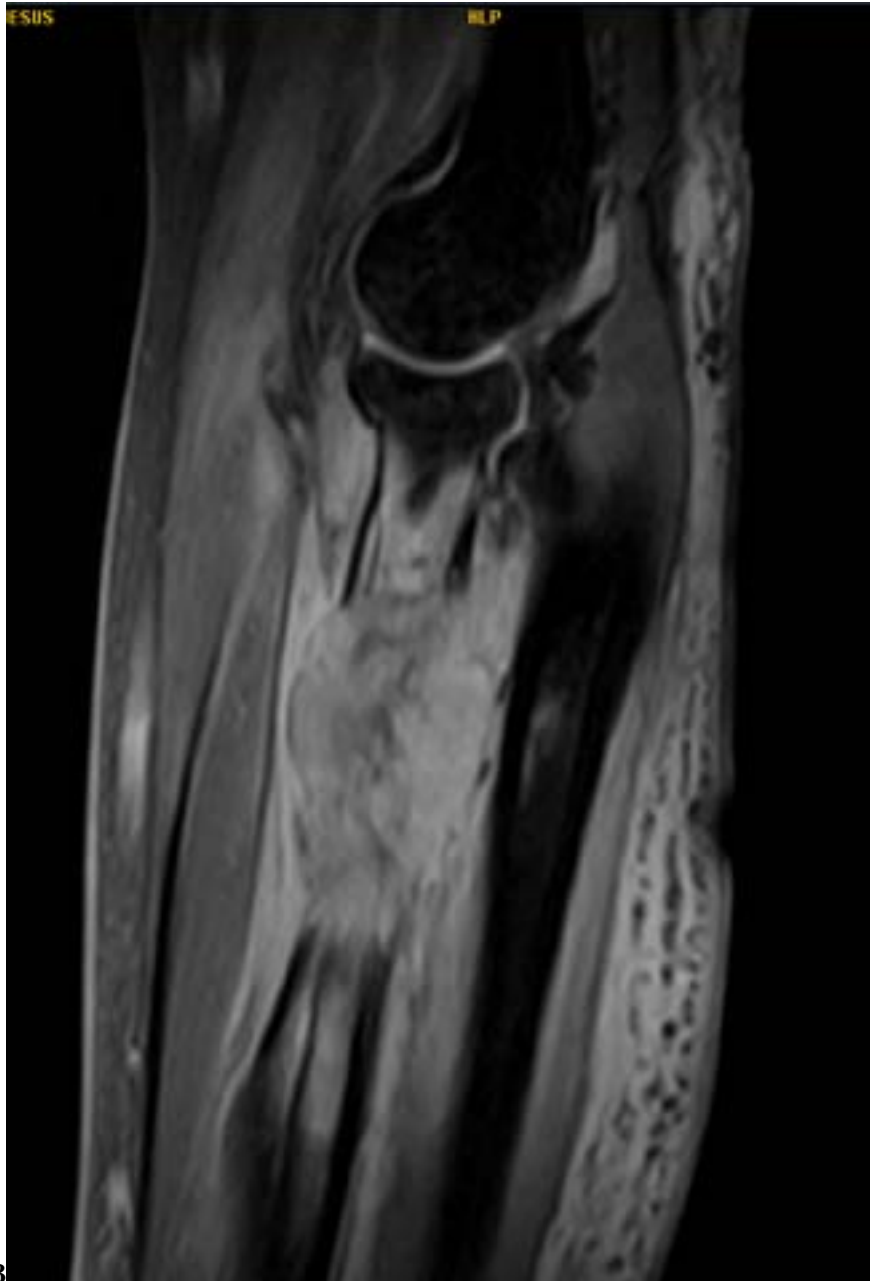
²© 2021 Global Journals Acrometastasis: A Rare Entity. A Proximal Radius Case



Figure 1: Figure 1 :



Figure 2: Figure 2 :



3

Figure 3: Figure 3 :

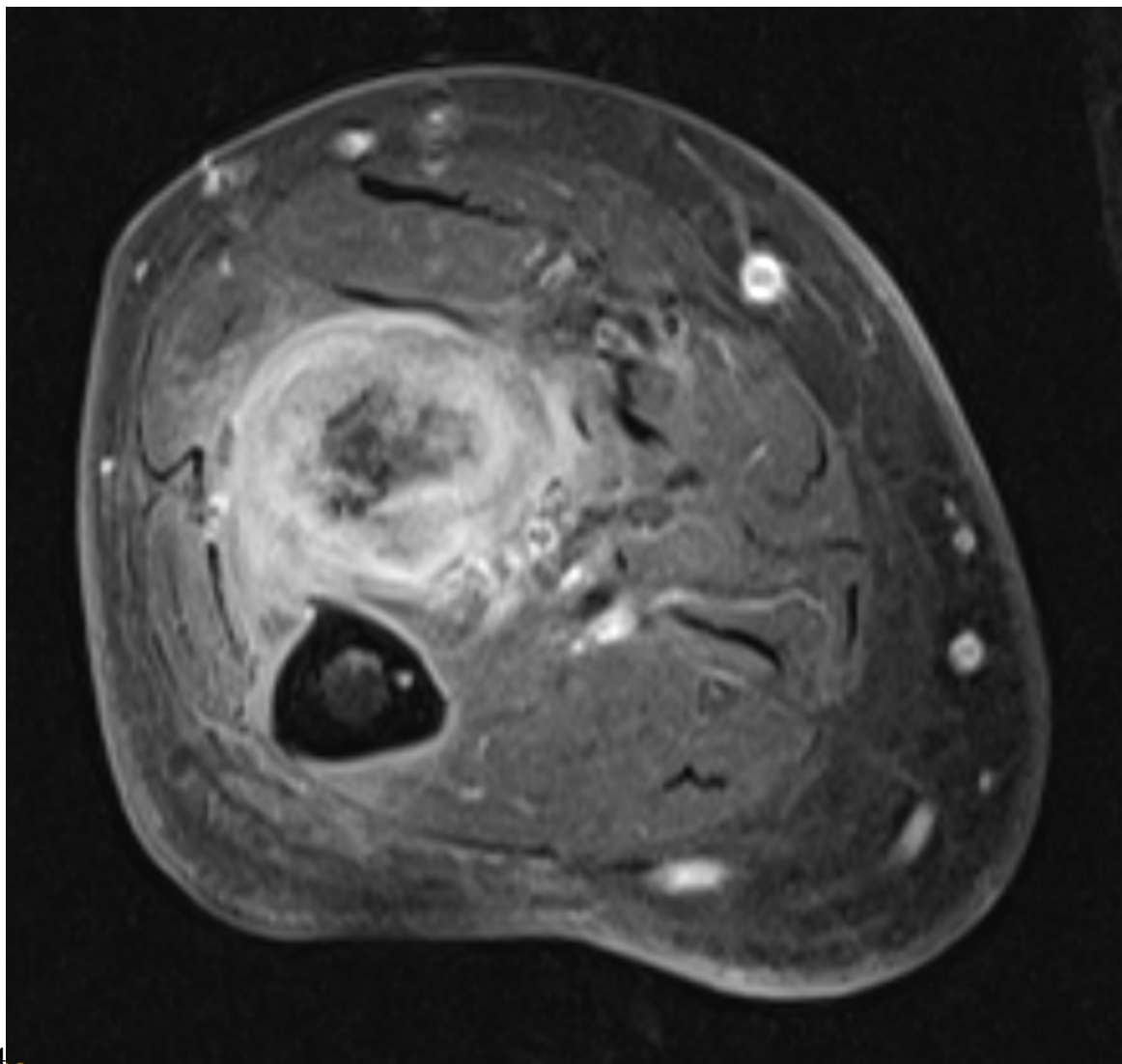


Figure 4: Figure 4 A

86 All authors have contributed significantly, and all authors are in agreement with the content of the manuscript.

87 .1 Funding

88 This research did not receive any specific grant from funding agencies in the public, commercial, or notfor-profit
89 sectors.

90 .2 Ethicalapproval

91 Written informed consent was obtained from the patient for publication of this case report and accompanying
92 images. A copy of the written consent is available for review from the Editor-in-Chief of this journal on request.

93 .3 Conflict of interest

94 All authors disclose any financial and personal relationships with other people or organizations that could
95 inappropriately influence our work.

96 [Mavrogenis et al. (2013)] , A F Mavrogenis , G Mimidis , Z T Kokkalis , E S Karampi , I Karampela , P J
97 Papagelopoulos , Armaganidis A Acrometastases . 10.1007/s00590-013-1311-1. 24013815. *Eur J Orthop Surg*
98 *Traumatol* 2014 Apr. 2013 Sep 8. 24 (3) p. .

99 [Credit authorship contribution statement] *Credit authorship contribution statement*,

100 [Fraguas A et al.] *Diagnóstico y tratamiento de las metástasis óseas*, Fraguas A , F Portabella , J Minguell , E
101 Guerra . Panamericana. 2021.

102 [Bahrabadi et al. (2021)] ‘Foot Metastasis: Review of 38 Cases’. M Bahrabadi , B Otoukesh , M Moghtadaei ,
103 S Hoseinzadeh , S Amiri . 10.22038/abjs.2020.49792.2474. 33778125. PMC7957098. *Arch Bone Jt Surg* 2021
104 Jan. 9 (1) p. .

105 [Ratasvuori et al. (2013)] ‘Insight opinion to surgically treated metastatic bone disease: Scandinavian Sarcoma
106 Group Skeletal Metastasis Registry report of 1195 operated skeletal metastasis’. M Ratasvuori , R Wedin
107 , J Keller , M Nottrott , O Zaikova , P Bergh , A Kalen , J Nilsson , H Jonsson , M Laitinen .
108 10.1016/j.suronc.2013.02.008. 23562148. *Surg Oncol* 2013 Jun. 2013 Apr 4. 22 (2) p. .

109 [Long et al. ()] *Lung cancer presenting as acrometastasis to the finger: a case report. Case Rep Med*, L S Long ,
110 L Brickner , L Helfend , T Wong , D Kubota . 10.1155/2010/234289. 2010. 2010. p. 234289.

111 [Leeson et al. (1986)] ‘Metastatic skeletal disease distal to the elbow and knee’. M C Leeson , J T Makley , J R
112 Carter . 3708998. *Clin OrthopRelat Res* 1986 May; (206. p. .

113 [Kerin (1983)] ‘Metastatic tumors of the hand. A review of the literature’. R Kerin . 6654944. *J Bone Joint Surg*
114 *Am* 1983 Dec. 65 (9) p. .

115 [Libson et al. ()] ‘Metastatic tumours of bones of the hand and foot. A comparative review and report of 43
116 additional cases’. E Libson , R A Bloom , J E Husband , D J Stoker . 10.1007/BF00350965. 3306939. *Skeletal*
117 *Radiol* 1987. 16 (5) p. .

118 [Abrahams (1995)] ‘Occult malignancy presenting as metastatic disease to the hand and wrist’. T G Abrahams
119 . 7747180. *Skeletal Radiol* 1995 Feb. 24 (2) p. .

120 [Asencio et al. ()] ‘Osseous metastases in the hand. A general review of three cases’. G Asencio , C Hafdi , H
121 Pujol , Y Allieu . 10.1016/s0753-9053(82)80069-0. 6927376. *Ann Chir Main* 1982. 1 (2) p. .

122 [Flynn et al. (2008)] ‘Two cases of acrometastasis to the hands and review of the literature’. C J Flynn , C
123 Danjoux , J Wong , M Christakis , J Rubenstein , A Yee , D Yip , E Chow . 10.3747/co.v15i5.189. 19008991.
124 PMC2582515. *Curr Oncol* 2008 Oct. 15 (5) p. .