

Case Report

The acromet

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Introduction

Incidence of acrometastasis is rare and accounts for 0.1% of all metastatic lesions. Differential diagnosis includes osteomyelitis, avascular necrosis and inflammatory arthritis.

Case report

A 62 year-old woman who was diagnosed with metastatic squamous cell carcinoma of lung, involving both the lungs received four cycles of Gemcitabine and Carboplatin chemotherapy as standard first line treatment. She had a good response initially but relapsed quickly post-chemotherapy and was given second line treatment with Erlotinib. This was not tolerated due to grade 3 rashes, significantly affecting the quality of life. Though she was tried with decreased dose, it was stopped after three months due to progressive disease. She received palliative radiotherapy to the chest for her symptoms of increasing breathlessness and cough. On routine follow up appointment she presented with swelling and pain over the third metacarpal joint but X-ray of which did not reveal any gross abnormalities. She was treated with intraarticular steroids to relieve the pain at local clinic because inflammatory arthritis was the working hypothesis. Her pain improved initially but then worsened again as the swelling increased and gradually restricted the movements. Repeat X-ray in six weeks time was performed which showed a metastatic deposit eroding the proximal phalanx of left middle finger. Subsequent bone scan showed hot spots corresponding to the bone metastasis in the finger and a further deposit in the femur. Surgical options of dysarticulation or amputation were not thought appropriate in view of the poor



Fig 1. X-ray showed a metastatic deposit eroding the proximal phalanx of left middle finger.

prognosis. She received palliative radiotherapy to her Acromet, with which her pain was relieved completely, though the swelling was persistent.

Discussion

Acrometastasis accounts for only 0.1% of all metastasis. Lung cancer is the most common primary malignancy which metastasizes to hand (40 to 50% of acrometastasis) (2) and carries a very poor prognosis with a mean survival of less than six months (7). The most commonly histology is squamous cell carcinoma although a few cases of small cell carcinoma have been reported. The next commonest cancers to metastasis to the

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hand are breast cancer (15%) and renal cell cancer (10%).

Phalanges of the hand account for three quarter of metastasis to the hand, followed by the metacarpals and carpals. 10% of the patients experience lesions in both hands (1). The third finger was the digit most commonly affected by osseous metastases reported in the literature. Some reports suggest that 1 in 9 cases were initially treated for inflammatory condition because they present in a similar way. The treatment of choice for acrometastasis appears to be palliative radiotherapy with limited information on the efficacy of systemic therapy.

Conclusion

Our patient demonstrated many classical features for acrometastasis with presentation in the proximal phalanx of the third finger with a squamous cell lung cancer primary and was initially treated as an inflammatory arthritis. Patients presenting with such features need to be treated with a high degree of suspicion for metastatic disease so as to identify and treat quickly, which may be particularly important in terminal patients to maintain their quality of life.

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