

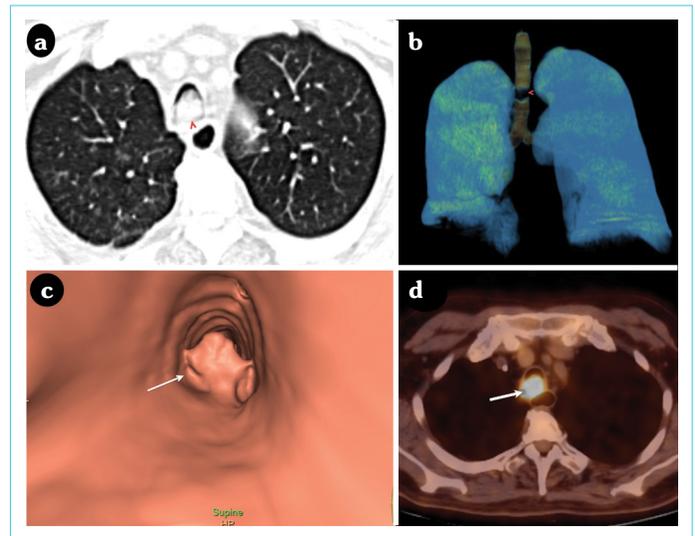


## Endotracheal Metastasis of Colon Cancer Presenting as Severe Dyspnea

IMAGE

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A 73-year-old male patient, who had a history of surgery for sigmoid adenocarcinoma 5 years earlier, presented at the emergency department with the complaint of progressive dyspnea. The most recent routine oncology control had been performed 3 months prior, and a chest computed tomography (CT) examination showed stable parenchymal nodules. A physical examination revealed a partial oxygen pressure of 84% in room air and stridor on auscultation. The laboratory test results were within normal limits, with the exception of an elevated white blood cell count (13.6 K/uL; reference range: 4–10 K/uL). The patient underwent an unenhanced chest CT, which revealed an ill-defined solid lesion within the trachea, 2x1.5 cm in size (Fig. 1). In addition, newly emerged solid nodules consistent with metastasis were observed in both lungs. For staging purposes, <sup>18</sup>F-fluorodeoxyglucose (FDG) positron emission tomography (PET)-CT was performed and revealed avid FDG uptake in the tracheal lesion (Fig. 1). The patient underwent a bronchoscopy and biopsy, and the diagnosis of colon adenocarcinoma metastasis was confirmed. The patient died due to aspiration pneumonia 2 days after the bronchoscopy.



**Figure 1.** (a) Axial chest computed tomography (CT) image shows a nodular lesion with irregular borders in the tracheal lumen, which is narrowing the air column (arrowhead); (b) Three-dimensional volume rendering CT image with lung opacity threshold shows interruption in the tracheal air column; (c) CT-generated virtual bronchoscopy image shows the ill-defined endoluminal nodular lesion, which is occluding almost the entire lumen (arrow); (d) Axial positron emission tomography-CT image shows avid <sup>18</sup>F-fluorodeoxyglucose uptake in the tracheal lesion (arrow)

Metastases from extrapulmonary solid tumors to the trachea are extremely rare (1). Cases of metastases from renal cell carcinoma, melanoma, breast cancer, thyroid carcinoma, and colorectal carcinoma to the trachea have been reported in the literature (2, 3). Although current treatment options have improved survival in patients with colorectal carcinoma, late complications and delayed metastases of colorectal carcinoma can occur, and patients should be followed closely for a long time. Early detection of subclinical tracheal metastasis is essential for survival (3). In patients with colorectal cancer, the trachea should be carefully evaluated in follow-up chest CT images, and newly emerged filling defects should be examined with the suspicion of metastasis. CT plays a guiding role in diagnosis, biopsy planning, and treatment.

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