Major Cerebral Infarction from Tumor Embolus

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SUMMARY A major right hemispheric infarct developed in a 31-year-old man within forty-eight hours of lung resection for metastatic synovial-cell sarcoma. Post mortem exam revealed tumorous occlusion of the right internal carotid artery. Major stroke from cerebral tumor embolus should be seriously considered in patients with primary or metastatic lung cancer who have had a very recent pneumonectomy, especially when there are symptoms and signs of multi-organ or extremity ischemia.

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MAJOR CEREBRAL INFARCTION in patients with malignant solid tumors is usually secondary to a hypercoagulable state or emboli from infectious or nonbacterial thrombotic endocarditis.1-4 Tumor emboli that occlude major cerebral vessels are rare and, except for atrial myxoma, are often not emphasized in the differential diagnosis of nonatherosclerotic stroke.5-7 or of CNS vascular disease in cancer patients.2,4 Occasionally, tumor mucin can embolize to cerebral vessels8-9 and multiple microscopic tumor emboli to smaller vessels may present as an encephalopathy.3,10 Here, we present a case of synovial-cell sarcoma with a tumor embolus resulting in total internal carotid occlusion shortly after a partial pneumonectomy.

Report of a Case

This 31 year old black man developed swelling under his right toe in March of the year of admission. In mid-June, biopsy of the lesion revealed “clear-cell sarcoma of the tendon”. At that time there was no evidence of metastatic disease on bone and gallium scans, or on chest x-ray.

Three weeks later, chest x-ray revealed two large nodular densities in the left lower lobe. He underwent a right below the knee amputation, and 12 days later, a left lower lobectomy with five wedge resections of the left upper lobe. Pathologic examination of the lung tissue confirmed metastatic synovial sarcoma with extensive vascular invasion. On the same day, he had a bone marrow storage procedure in preparation for intensive chemotherapy.

Two days after the pneumonectomy, he developed a dense left hemiplegia, hemianesthesia, and hemianopsia with left sided hyperreflexia and an extensor plantar response, but remained alert. There was no clinical evidence of emboli to viscera, skin or limbs. On the day of this event, head CT with and without contrast was normal; however, repeat scan, four days later, revealed a non-enhancing low-density lesion in the distribution of the right middle cerebral artery. The patient did not improve neurologically.

Subsequently, he developed melena and his hematocrit fell from 33 to 27. Radiological studies revealed partial small bowel obstruction by metastatic nodules just distal to the duodeno-jejunal junction. He became febrile and died one month after his pneumonectomy.

Postmortem Examination

The patient had extensive spread of synovial-cell sarcoma. A metastatic deposit in the jejunum had perforated, with resulting peritonitis and abscess formation. Additional metastases were present in other bowel areas, lungs, spleen, both kidneys and adrenal glands. No major visceral or limb arteries were occluded by tumor emboli.

Neuropathologic examination showed the intradural portion of the right internal carotid artery to be completely occluded by firm, yellowish-white tissue (fig. 1). The occlusion extended into the first three centimeters of the right middle cerebral artery. Microscopic examination of the occluding material showed that it consisted of synovial-cell sarcoma (fig. 2). The anterior portion of the right temporal lobe, basal ganglia, and internal capsule showed infarction with early liquefaction necrosis. In addition, two hemorrhagic metastatic lesions, 3 cm² in size, were present in both frontal lobes; there was one smaller non-hemorrhagic metastasis in the right occipital lobe.

Comment

Fifteen prior cases of major cerebral infarction from malignant tumor emboli were reviewed (table 1).3,11-23
Fourteen patients had involvement of lung from primary or metastatic tumor. As in our patient, the stroke occurred within two days post-pneumonectomy for tumor excision in eight. In the majority of the remaining cases, there was obvious pulmonary venous or left atrial invasion on postmortem exam. Several of the patients with tumorous cerebral infarction, also had concurrent signs of emboli to other organs or the extremities. Surgical manipulation of the lung undoubtedly promotes release of emboli, especially when there is vascular tumor invasion in the lung. The single case free of lung

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involvement was a patient who had paradoxical tumor embolism via a patent foramen ovale.11
Lung and lymph nodes are the most common sites of metastases of synovial-cell sarcoma; brain metastases have been rare.14-20 Our patient had a normal CT two days after his pneumonectomy. However, upon his death four weeks later, autopsy revealed bilateral frontal and right occipital metastases. It is quite possible that these metastases began as micro-emboli released at pneumonectomy which grew to macroscopic site prior to the patient's death.

Major vessel tumorous cerebral infarction is rare. In Graus et al's21 review of 256 patients with known systemic cancer and major cerebral infarction, only two had tumor embolus as the etiology. Despite its rarity, major tumor embolus should be suspected when a patient, with primary or metastatic lung tumor, develops a stroke within the period immediately following pneumonectomy. In addition, other signs and symptoms of multi-organ infarction should serve to raise the index of suspicion. We conclude that major cerebral artery tumor embolus should be considered in the differential diagnosis of nonatherosclerotic forms of stroke, especially in the appropriate clinical setting.

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