

Laparoscopic Adrenalectomy Formetastatic Adrenal Mass as Diagnosis of Suspected Lung Tumor: A Case Report

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Introduction

Adrenal metastases at time of initial diagnosis occur in less than 10% patients with non small cell lung cancer. To an adrenal mass and a pulmonary nodule, adrenal ectomy should be performed in suspected adrenal metástasis from a primary lung tumor.

Case Report

A 60-years old male, ex-smoker since seven month ago, COPD, and colonic polyps, presents fever of unknown origin. A computed tomography scan of the thorax and abdomen demonstrated a pulmonary node of 15 mm in the upper right lobe (Figure 1) and a left adrenal mass of 8x9x8 cm with out defined fat planes of the left kidney upper pole and the left renal vein pedicle (Figure 2). Bronchial biopsy was no posible with Flexible bronchoscopy. The core needle biopsy showed the tumoral in filtration. Were sected the left adrenal mass after ligation of the left adrenal vein by laparoscopic approach with four trocars and with out complications. The tumor was totally resected with the spleen and the left kidney because they seemed in filtrates; we left a drain at the upper left quadrant. The operating time was 200 minutes. The resected specimen include a metastatic mass of 12x10x8 cm, the spleen of 10x6 cm and the left kidney of 9x6x4 cm (Figure 3 & 4). Microscopic examination confirmed metastatic adenocarcinoma originating from the lung. The spleen and the left kidney had not tumor in filtration. Post operatively the patient did well and was discharged on the third day.

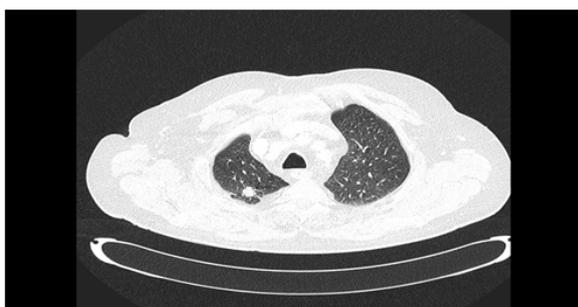


Figure 1: Upper right lobe.



Figure 2: Left adrenal mass.



Figure 3: Spleen.



Figure 4: Left Kidney.

Conclusion

Uncommonly the adrenal metastases may first appear as a single synchronous or metachronous metastasis. In patients with one

single synchronous metastase with a un certain tumoral diagnosis, we believe that the metastase resection with a laparoscopic approach is use full together diagnosis and improve the survival.



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