Somerset NHS Foundation Trust
Yeovil District Hospital

Assessment and Management of Patients with Suspected Lymphangitis Carcinomatosis

Protocol

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Applies to	Adult patients with a known or suspected cancer diagnosis	**Exclusions**	None

CONTENTS

1.0 INTRODUCTION

1.1 Lymphangitis carcinomatosis is the term given to tumour spread throughout the lymphatics of the lung.

1.2 It is most commonly seen secondary to breast, lung, gastro-intestinal and prostate cancers

1.3 The aim of this document is to set out the best practice, based on expert opinion, for the management of adult patients with a known or suspected cancer diagnosis, to guide the investigations and subsequent management of suspected or confirmed lymphangitis carcinomatosis

1.4 Lymphangitis carcinomatosis is difficult to diagnose, the clinical history and symptoms are key elements alongside radiological investigations

1.5 Differential diagnosis should also include sarcoidosis, viral pneumonia, pulmonary oedema, radiation pneumonitis

1.6 The median life expectancy is short, often measured in months, without systemic anti-cancer treatment. Patients should be referred to palliative care (community +/or hospital) if lymphangitis is confirmed

2.0 CLINICAL PRESENTATION

2.1 This can be very variable with some patients being symptomatic with abnormal lung function tests early in the course of disease and well before any radiographic abnormalities are evident, whereas others remain asymptomatic until much later

2.2 Symptoms include: progressive exertional dyspnoea, breathlessness at rest, dry cough, haemoptysis

3.0 INVESTIGATIONS

3.1 **Plain film-** unfortunately, up to a quarter of patients with subsequently established lymphangitis carcinomatosis have normal chest x-rays. When abnormal, the most common finding is of a reticulonodular pattern, with thickening of the interlobular septae which may resemble Kerley B lines

3.2 **CT-** excellent at demonstrating both peripheral and central changes. Typically appearances are of interlobular septal thickening, most often nodular and irregular, although smooth thickening may also be seen on occasions. This results in prominent definition of the secondary pulmonary nodules, manifesting as tessellating polygons. Thickening broncho-vascular interstitium is usually irregular and nodular, with changes seen extending towards the hilum

4.0 IMMEDIATE MANAGEMENT

4.1 Treatment is determined by the histology of the primary tumour, but in general relies on systemic chemotherapy

4.2 Significant symptomatic benefits can be achieved with steroids- dexamethasone 4mg bd (08:00 and 12:00 with PPI cover) which can be tried for a week and if there is no improvement should be stopped. If there is a response, the steroid dose should be titrated down to the lowest possible dose

4.3 Medication for cough should also be prescribed- simple linctus +/- opioids

5.0 REFERENCES

Royal Marsden NHS Foundation Trust (2011) “Acute Oncology- Clinical Problems and their Management”

British National Formulary

Marshall E., Young A., Clark P.I., Selby P. (2013) “Problem Solving in Acute Oncology”

British National Formulary

Palliative Care Formulary

6.0 KEY CONTACTS

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Respiratory team via secretaries at either SFT or YDH site

Out of hours – please page the on-call Haematologist or Oncologist via switchboard