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## Reply to Letter "Skeletal Muscle Metastasis: An Uncommon Finding in Lung Cancer"☆

### *Réplica a la Carta «Metástasis musculoesqueléticas: hallazgo infrecuente asociado al cáncer de pulmón»*

*Dear Editor,*

We read with interest the letter of De Vega Sánchez et al.,[1] which describes 3 patients with musculoskeletal metastases (MSM) secondary to primary lung cancer. The first case was a 57-year-old woman who consulted due to constitutional symptoms and a deep adherent mass in the right flank. Further study revealed a right hilar lesion with a mass on the left abdominal oblique muscle. The second case was an 83-year-old man who consulted due to a painful mass on the flexor digitorum superficialis muscle of the fingers. The extension study revealed 2 masses consistent with lung adenocarcinoma.

The MSMs described by the authors fall under the heading of undetected primary lung cancers. In this setting, the authors contend that the initial diagnostic process usually begins with a chest computed tomography (CT).

Surov et al.[2] determined that the tumors that most frequently cause MSM are gastrointestinal tumors (21.3%), followed by urological tumors (16.4%), and malignant melanoma (13.1%). Bronchial tumors, like cancers of unknown origin, account for 8.2%.

While it is true that the reported cases do not fall under the definition of the Spanish Society of Medical Oncology (SEOM) of cancer of unknown primary site,[3] the referenced literature on MSM leads us to believe that a systematic approach to the detection of the primary tumor is essential.

The study of patients who develop MSM in the absence of a known primary tumor must start with a detailed clinical history, followed by a complete physical examination, including an anorectal examination, with a gynecological exploration in women and testicular in men. Additional tests must include basic clinical laboratory tests (complete blood count, kidney and liver function, electrolytes, calcium, and urine tests) and fecal occult blood. Endoscopy must be requested on the basis of indicative signs and symptoms, and finally a chest-abdominal-pelvic CT may be performed.[4]

One example of a systematic approach is the third case published by Martin Asenjo et al. in this journal.[5] This was a 73-year-old patient who presented with constitutional symptoms and cough. Clinical laboratory tests showed iron-deficiency anemia and an altered chest X-ray. The study of the patient began with a complete clinical history, followed by a request for a gastrointestinal endoscopy, in view of the iron-deficiency anemia. Given the documented *Mycobacterium xenopi* infection and the abnormality in the chest X-ray, chest CT, fiberoptic bronchoscopy, and finally PET/CT were requested.

Only a systematic approach, taking into account all possible signs and symptoms of the primary tumor causing MSM, will lead to a more accurate diagnosis, while avoiding multiple unnecessary tests.

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