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**Commentary Article**

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# Lung Metastasis and Multiple Micro Nodular Lung Diseases in Women with Gynecologic Malignancies

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## DESCRIPTION

In women with gynaecologic malignancies, multiple micro nodular lung diseases are the biggest challenge, regardless of whether they are found at the initial stage or discovered during the follow-up after complete treatment. Because the aetiology varies greatly, ranging from various infectious, inflammatory or immunological diseases to malignant and metastatic diseases. Making a precise diagnosis of gynecologic cancers that have spread to the lung is challenging, and it can be challenging to distinguish between the following malignant states, such as Pulmonary Lymphangitic Carcinomatosis (PLC), Pulmonary Tumour Thrombotic Microangiopathy (PTTM), and Multiple Lung Metastases (MLM). In actuality, all of the aforementioned symptoms are considered for gynecologic cancer patients in their advanced stages. Physician must first be aware with the clinical symptoms of pulmonary lymphangitic carcinomatosis (PLC), which has a primary pathologic finding that is mostly contained to the pulmonary interstitial tissue and lacks tumour cells in the pulmonary arteries and/or capillaries. In actuality, dyspnea, sputum, or coughing were completely absent in 60% of patients (16/27) that completed the test. Moreover, it is difficult to differentiate between PLC and PTTM due to the clinical symptoms and signs of both being highly similar and frequently overlapping. Compared to PTTM patients, PLC patients do not exhibit as many clinical signs of pulmonary hypertension and cor pulmonale, according to some experts.

The earliest feature of PLC is typically smooth or nodular thickening, and occasionally peri-lymphatic nodules may be present along with thickening of the bronchial wall extending from the hilum. More than half of patients did not exhibit any clinical symptoms or signs, such as dyspnoea, cough, or sputum, as demonstrated. This may make it harder to detect PLC in patients with end-stage gynecologic cancer. Therefore, even on the basis of observation, imaging systems may only be useful to rule out other causes rather than to diagnose PLC in gynecologic cancer patients who exhibit dyspnoea and cardio-respiratory symptoms. Second, the fact that gynecologic cancer patients with PLC have the most adverse outcomes, as demonstrated and suggests that there is still no effective therapeutic approach. It is challenging to determine how to diagnose PLC because half of the patients show no symptoms or warning indications, and only a high degree of suspicion is used. Therefore, it is extremely difficult to make an earlier diagnosis when image systems lack appropriate sensitivity and specificity.

In reality, the more effective interceptive measures should be used to diagnose PLC. Although this technique is quite invasive and disruptive, it is reported to achieve this goal and provide a conclusive histologic/cytological diagnosis. Additionally, only 6-8% of MLM patients are reported to have PLC, and the frequency of PLC in stage IV patients is relatively low. The decision to utilise and select these extremely invasive procedures are not advised, and the use of invasive and aggressive techniques to confirm the diagnosis of PLC should be based on an assessment of risks

and benefits. If physicians didn't consider the general condition of the patients, the proposed procedure's safety, the stage and significant long-life expectancy, as well as the availability of effective therapy and shared decision making. Third, many patients (78%, 21/27) were initially diagnosed, implying that their outcomes would be poor. However, nearly one-third (30%, 8/27) of the reported patients had a time interval of less than 6 months between the initial diagnosis of diseases and the final diagnosis of PLC. Although the exact reason is unknown, people believe that some of them were overlooked for PLC diagnosis in their original diseases.