CARDIAC METASTASIS FROM A SQUAMOUS CELL CARCINOMA OF THE TONGUE IN THE ABSENCE OF LOCAL RECURRENCE.

Editor,

A 77-year-old man presented to hospital following two episodes of collapse. Past medical history was significant for stable angina, osteoarthritis and squamous cell carcinoma of the tongue. On examination, he appeared frail with evidence of weight loss. Pulse was recorded at 108 beats per minute and was irregular. He was pyrexial with a temperature of 38.3°C. Auscultation of the chest revealed crackles at the left base. The remainder of the physical examination was unremarkable. In particular there was no evidence of lymphadenopathy or local recurrence of tongue cancer. An electrocardiogram confirmed atrial fibrillation. A chest X-ray displayed widespread pleural plaques and consolidation at the left base. Blood work was significant for an elevated white cell count, serum high sensitivity troponin T concentration and serum C-reactive protein concentration.

The patient was commenced on digoxin and received treatment for a lower respiratory tract infection. A computed tomography (CT) scan of brain was unremarkable. A transthoracic echocardiogram demonstrated a large mass in the right atrium (RA) and prolapsing through the tricuspid valve (TV) into the right ventricle (RV), during the cardiac cycle, with evidence of intramural invasion (I).

The appearances were felt to be in keeping with invasive malignancy. No definite evidence of lymph node or metastatic disease was observed on a CT scan of chest. The patient’s condition deteriorated acutely on day 28 of the admission; he was managed conservatively and died the following day.

On post-mortem examination, a tumour was observed arising...
from the medial border of the right atrium, extending through the tricuspid valve and into the right ventricle with infiltration of the myocardium (Figure 3). Histology demonstrated squamous cell carcinoma infiltrating the myocardium. The histological appearances were similar to those of the patient’s previous tongue tumour (Figure 4), confirming a diagnosis of a cardiac metastasis from a squamous cell carcinoma of the tongue.

Post-mortem studies show cardiac metastases in up to 25% of patients who have died from malignancy, however, ante-mortem presentation is rare. The most common tumours metastasising to the heart are carcinomas of the lung, breast and oesophagus, malignant lymphoma, leukaemia and malignant melanoma. Cardiac metastases usually present in patients with advanced widespread tumour disease. Treatment is therefore usually palliative and the prognosis is poor. In the present case an extensive cardiac metastasis was observed in the absence of clinically detectable local recurrence, lymphadenopathy or metastases elsewhere. Although such cases of cardiac metastasis are uncommon, similar cases have been described in the literature.

The authors have no conflict of interest.

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Some of the SOQ (Likert scale) data from the cohort was suitable for statistical analysis. Eight separate questions from the abbreviated SOQ formed a domain which measured belief about a right-to-die (Cronbach’s Alpha 0.79). The strength of belief in a right-to-die was then correlated against strength of religious belief (0-10 scale). This showed a moderately negative correlation i.e. a strong belief in a powerful deity that can influence what happens in one’s daily life tended to be associated with a belief that one does not have a right-to-die (p value <0.0001, R = -0.43).

We can therefore see that this cohort of 2002-2003 fourth year medical students in Belfast had slightly more females than males with nearly 90% indicating affiliation to the Roman Catholic or Protestant churches. A majority engaged in religious activity of some kind. Of particular contemporary interest is a moderate correlation between a belief in a powerful deity and the belief that one does not have the right to end one’s own life.

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J.C. Nelson, Specialist Registrar in Psychiatry, A. Collins, Consultant Psychiatrist, T. Foster, Consultant Psychiatrist, S.J. Cooper, Emeritus Professor of Psychiatry.

Table 1.

| Age range | 21-25 (mean 22) |
|-----------|-----------------|
| Gender    | Male 43%        |
|           | Female 57%      |
| Religion  | Religious and/or spiritual 93% |
|           | Neither religious nor spiritual 7% |
|           | Roman Catholic 44% |
|           | Protestant 43% |
|           | Muslim 4%       |
|           | Buddhist 3%     |
| Religious Activity | Prays alone 80% |
|           | Attendance at religious ceremony 57% |
|           | Religious study alone 53% |

RELIGIOUS BELIEFS AND ATTITUDES TOWARDS SUICIDE IN A COHORT OF MEDICAL STUDENTS AT QUEEN’S UNIVERSITY BELFAST.

Editor,

In 2002-2003 fourth year medical students at Queen’s University Belfast were invited to participate in a study of their religious beliefs and attitudes toward suicide. The study proposal was approved by the local Research Ethics Committee. Data was collected using the Royal Free Questionnaire for Spiritual and Religious Beliefs (Self-Report Version) and an abbreviated form of the Suicide Opinion Questionnaire (8 factor model). The questionnaires were offered to all 4th year medical students at a lecture during their undergraduate psychiatric placement; 152 were returned out of a year group of 180. Our statistical analysis of the results from the Suicide Opinion Questionnaire showed a lack of internal consistency and therefore much of the data was unusable. Further review of the literature showed that other authors have raised questions about the statistical reliability of the Suicide Opinion Questionnaire (SOQ), particularly regarding factor stability. However, some of the data is of relevance to factors influencing an important aspect of clinical practice. Demographic and spiritual information about the cohort are listed in Table 1.

REVIEWERS:

C. Page, Dr. L. Hayman and Dr. J. M. Stevenson.