Paraneoplastic Limbic Encephalitis in a Human Epidermal Growth Factor Receptor-2-positive Gastric Cancer Patient Treated with Trastuzumab-combined Chemotherapy: A Case Report and Literature Review

Yu Uneno¹, Akira Yokoyama¹, Yoshitaka Nishikawa¹, Taro Funakoshi¹, Yoshinao Ozaki¹, Ikuo Aoyama¹, Kiichiro Baba¹, Daisuke Yamaguchi², Shuko Morita¹, Yukiko Mori¹, Masashi Kanai¹, Hisanori Kinoshita¹, Takeshi Inoue⁴, Nobukatsu Sawamoto⁴, Riki Matsumoto⁵, Shigemi Matsumoto¹ and Manabu Muto¹

Abstract

Paraneoplastic neurological syndromes (PNSs) are rare nervous system dysfunctions in cancer patients, which are primarily observed with small-cell lung cancer, gynecological cancer, and thymoma. We herein present an uncommon case of PNS in an anti-Hu antibody-positive patient with human epidermal growth factor receptor (HER)-2-positive gastric cancer (GC), who developed limbic encephalitis and a worsening cognitive function. Trastuzumab-combined chemotherapy was initiated and appeared to be partially effective for controlling the neurological symptoms and tumor volume. Chemotherapy failure eventually led to uncontrollable neurological symptoms. This is the first case demonstrating that trastuzumab-combined chemotherapy may be effective for controlling neurological symptoms of PNS in HER2-positive GC patients.

Key words: gastric cancer, trastuzumab, HER-2, paraneoplastic limbic encephalitis, anti-Hu antibody

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Introduction

Paraneoplastic neurological syndromes (PNSs) are rare neurological disorders of unknown cause that are often observed in association with cancer (1). The identification of several antibodies against neural antigens in primary tumors (onconeural antibodies) has suggested that the development of PNSs is immune-mediated. As specific onconeural antibodies are associated with several different cancers and neurological syndromes, the detection of onconeural antibodies may contribute to the identification of the primary site of cancers (1). However, the scientific literature on PNSs in gastric cancer (GC) is scarce; hence, detailed information on specific onconeural antibodies and neurological syndromes associated with GC remains unknown. We herein report the rare case of a patient with human epidermal growth factor receptor (HER)-2-positive GC who developed limbic encephalitis and was positive for anti-Hu antibodies and provide a literature review of PNSs accompanying GC. Our case is the first report to demonstrate that trastuzumab-combined chemotherapy may contribute to the management of PNS-associated neurological symptoms in HER2-positive GC patients.

Case Report

A 71-year-old Japanese man had no history of dementia and had been healthy until approximately 2 weeks prior to his first visit at a community hospital. However, his family
had consulted the hospital because of a rapid deterioration in cognitive function, general malaise, and an attack of unconsciousness. Magnetic resonance imaging (MRI; T2-weighted fluid-attenuated inversion-recovery images) of the brain revealed hyperintensity in the bilateral mesial temporal regions (Fig. 1a, b). Therefore, he was referred to our hospital for further assessment and treatment.

A neurological examination performed at our hospital showed cognitive dysfunction; in particular, we observed disorientation, acalculia, and memory disturbance [Minimal Mental State Examination score (MMSE) 18/30; Wechsler Memory Scale-Revised (WMS-R): verbal memory, 69; visual memory, 70; general memory, 67; attention/concentration, 93; and delayed recall, 59]. Frequent complex partial seizures were observed, resulting in unresponsiveness. A routine electroencephalography (EEG) examination revealed frequent EEG seizure patterns originating from the left temporal area.

Laboratory tests showed normal levels of vitamin B₁₂, folate acid, antinuclear antibody, and thyroid hormones. An elevated erythrocyte sedimentation rate (26 mm/h) and elevated levels of carcinoembryonic antigen (5.2 ng/mL) were detected. A cerebrospinal fluid analysis revealed a white blood cell count of 10/μL and a protein level of 48.4 mg/dL, without malignant cells.

Positron emission tomography (PET)/computed tomography (CT) of the brain showed increased ¹⁸F-fluorodeoxyglucose (FDG) avidity in the left mesial temporal region [maximum standardized uptake value (SUVmax), 13.2; Fig. 1c]. CT of the abdomen showed several low-density areas in the liver. Suspecting PNS, we performed PET/CT in order to detect the primary site of the cancer; stomach and liver lesions showed increased FDG avidity (SUVmax liver, 5.5; SUVmax stomach, 6.9; Fig. 2).

Esophagogastroduodenoscopy revealed multiple ulcerative lesions with giant folds in the body of the stomach (Fig. 3). The lesions were characterized as Type V according to the Borrmann classification and exhibited atypical macroscopic features similar to primary gastric adenocarcinoma. However, a histological examination of biopsy specimens from

Figure 1. a, b: MRI (T2-weighted FLAIR images) of the head revealed a high intensity signal in the bilateral limbic system. c: PET/CT of the brain showed increased FDG avidity in the left mesial temporal region (SUVmax, 13.2). CT: computed tomography, FDG: ¹⁸F-fluorodeoxyglucose, FLAIR: fluid-attenuated inversion recovery, MRI: magnetic resonance imaging, PET: positron emission tomography

Figure 2. PET/CT showed a tumor-specific uptake in the liver (SUVmax, 5.5) and stomach (SUVmax, 6.9). CT: computed tomography, FDG: ¹⁸F-fluorodeoxyglucose, PET: positron emission tomography, SUV: standardized uptake value

Figure 3. EGD revealed the presence of multiple type-5 tumors in the body of the stomach. EGD: esophagogastroduodenoscopy
each lesion divulged the presence of well-differentiated ade-
necarcinoma showing 3' HER2 expression, as assessed by
immunohistochemistry (Fig. 4). Moreover, in PET/CT, a
FDG uptake could not be recognized in any organs other
than the brain, stomach, and liver. We therefore speculated
that the stomach was most likely the primary cancer site.

According to these results, serum onconeural antibodies
(anti-Titlin, anti-SOX1, anti-Hu, anti-Yo, anti-Ma2/Ta, anti-
CV2, and anti-Amp antibodies) were tested, and the pres-
ence of anti-Hu antibody was identified; however, other anti-
bodies against synaptic or neuronal cell-surface antigens
(NMDA and GABA) were not tested. Under the provision
of the available diagnostic criteria (1), the patient was diag-
nosed with definite PNS with HER2-positive stage IV gas-
tric adenocarcinoma (cT3N0M1).

To treat the cancer and relieve the neurological symptoms,
capecitabine, cisplatin, and trastuzumab (XP+HER) therapy
was initiated. In conjunction with chemotherapy, two
courses of pulse corticosteroid therapy were administered.
However, both failed to improve the symptoms (MMSE, 18/
30). After the first course of chemotherapy, cisplatin-related
acute kidney dysfunction progressed, and we were forced to
alter the regimen to capecitabine and trastuzumab (X+HER).

As support and home medical care by the patient’s family
were available, X+HER therapy was continued at an outpa-
tient oncology unit. X+HER therapy appeared to be effective
in terms of stabilizing the tumor, considering that a slight
increase was noted in the stomach tumor size; moreover, the
liver metastases exhibited a significant reduction, as ob-
served on follow-up CT after the 7th course of chemother-
apy (approximately 8 months after the onset of symptoms).
The patient’s cognitive condition was also stable (MMSE,
22/30; WMS-R: verbal memory, 77; visual memory, 61;
general memory, 69; attention/concentration, 94; delayed re-
call, 56), and PET/CT of the brain showed a lower FDG up-
take (SUVmax, 5.8) in the mesial temporal regions. Because
we considered it to be a clinically stable disease, we contin-
ued X+HER therapy.

After 10 courses of chemotherapy (over a period of ap-
proximately 11 months after the onset of symptoms), the pa-
tient suffered a generalized tonic-clonic seizure and was
transferred to the emergency department of our hospital. CT
of the abdomen revealed multiple enlarged liver metastases
and thickening of the gastric wall (Fig. 5). Despite the addi-
tion of an antiepileptic drug to his regimen, the complex
partial seizures and cognitive dysfunction worsened and be-
came uncontrollable. Given the failure of chemotherapy and
the deterioration in the performance status and progressing
dementia, treatment was discontinued and best supportive
care was initiated. Approximately 14 months after the onset
of symptoms, the patient passed away.

Discussion

Although PNSs are tumor-associated, immune-mediated
syndromes, they are not caused by a local effect of the tu-
mor or its metastases. They potentially affect any level of
the nervous system and may result in motor neuron syn-
dromes, extrapyramidal symptoms, cerebellar degeneration,
myelitis, mononeuropathy, and limbic encephalitis (1). The
main pathogenic effect is most likely exerted by cytotoxic T
cells, resulting in neuronal cell death. The incidence of PNS
is far less than 1% for solid tumors, and commonly associ-
Onconeural antibodies have often been useful for identifying paraneoplastic syndromes (PNSs) that precede the diagnosis of cancer. The detection of antibodies against intracellular antigens, whereas anti-VGKC and NMDAR antibodies target neuronal cell-surface antigens, showing a better treatment response than that seen in diseases associated with antibodies against intracellular antigens (4). The detection of onconeural antibodies has often been useful for identifying the primary site of cancer, as several antibodies have a strong association with specific tumors and neurological symptoms (1). Anti-Ma antibodies are almost always associated with testicular germ-cell tumors. The anti-Hu antibody is highly associated with small-cell lung cancer and often results in neurological symptoms, including encephalomyelitis, encephalitis, cerebellar degeneration, and/or sensory neuropathy, that precede the diagnosis of cancer.

Moreover, Molinuevo et al. reported that the anti-Hu antibody has a high diagnostic value, with a specificity of 99% and a sensitivity of 82% (5). Aiming to identify specific onconeural antibodies and neurological symptoms in patients with GC, we performed a literature review (Table). Only 11 cases of GC patients with PNSs have been reported, and well-characterized onconeural antibodies were recognized in eight of these cases (73%). A histological confirmation of GC was obtained in nine of the 11 patients. Notably, the incidence of neuroendocrine carcinoma was striking in those patients. To the best of our knowledge, our case is the first case of anti-Hu antibody-positive limbic encephalitis in a patient with HER2-positive GC. The correlation among HER2, anti-Hu antibody, and limbic encephalitis in our case is unknown. However, in previous studies on breast cancer, HER2 overexpression was mentioned as an important requirement for developing anti-Yo-associated paraneoplastic cerebellar degeneration (6). Hence, such a correlation may be possible.

The symptoms of PNSs can be dramatic. A rapid worsening of neurological symptoms is sometimes critical in the diagnosis of PNSs. The management of PNS symptoms has been challenging, as various immunosuppressive treatments have proved to be ineffective for syndromes with onconeural antibodies. Previous studies suggest that surgical tumor removal could stabilize and even improve the clinical picture of these patients (7, 8). In the present case, the response to trastuzumab-combined chemotherapy was clinically stable disease, including stable neurological symptoms, and the SUVmax of the mesial temporal regions was 5.8 by PET/CT; however, chemotherapy eventually failed, and the patient’s symptoms deteriorated, with the SUVmax of the mesial temporal regions rising to 10.8. This presentation suggests that the tumor volume corresponds to the amount of antibody and neurological symptoms. Graus et al. reported that in patients with PNS associated with the anti-Hu antibody, antineoplastic therapy was associated with recovery or stabilization, with an odds ratio of 4.56 (95% confidence interval, 1.62-12.86) (3). Thus, prompt tumor volume control

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age (years)/Sex</th>
<th>Pathological Diagnosis</th>
<th>Neurological Syndrome</th>
<th>Onconeural Antibody</th>
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<tr>
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<td>Adenocarcinoma</td>
<td>Subacute sensory neuropathy</td>
<td>Anti-Hu antibody</td>
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<td>Subacute cerebellar degeneration</td>
<td>Anti-Yo antibody</td>
</tr>
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<td>Limbic and brainstem encephalitis</td>
<td>Anti-Ma antibody</td>
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<tr>
<td>11</td>
<td>63/male</td>
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<td>Subacute cerebellar degeneration</td>
<td>Anti-Ri antibody</td>
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<td>NA</td>
<td>Encephalomyelitis</td>
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<tr>
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<tr>
<td>16</td>
<td>58/male</td>
<td>Neuroendocrine carcinoma</td>
<td>Subacute cerebellar degeneration</td>
<td>Negative</td>
</tr>
</tbody>
</table>

Our case: 71/male, Adenocarcinoma, Limbic encephalitis, Anti-Hu antibody

NA: information not available
may contribute to improving symptom management, and our case suggested that molecularly-targeted, combined-drug chemotherapy could potentially be effective for the management of PNS.

In conclusion, we presented a rare case of PNS with HER2-positive GC that developed limbic encephalitis and carried anti-Hu antibodies. This case brought to our attention the fact that a prompt diagnosis and treatment are essential, as optimal chemotherapy may lead to the improvement of PNSs.

The authors state that they have no Conflict of Interest (COI).

References


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