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## **Cell & Developmental Biology**

## NEOPLAASTIC METASTASES TO ENDOCRINE GLANDS



## ABSTRACT

Endocrine organs are metastatic targets for several primary cancers, either through direct extension from nearby tumour cells or dissemination via the venous, arterial and lymphatic routes. Although any endocrine tissue can be affected, most clinically relevant metastases involve the pituitary and adrenal glands with the commonest manifestations being diabetes insipidus and adrenal insufficiency respectively. The most common primary tumours metastasing to the adrenals include melanomas, breast and lung carcinomas, which may lead to adrenal insufficiency in the presence of bilateral adrenal involvement. Breast and lung cancers are the most common primaries metastasing to the pituitary, leading to pituitary dysfunction in approximately 30% of cases. The thyroid gland can be affected by renal, colorectal, lung and breast carcinomas, and melanomas, but has rarely been associated with thyroid dysfunction. Pancreatic metastasis can lead to exo-/endocrine insufficiency with renal carcinoma being the most common primary. Most parathyroid metastases originate from breast and lung carcinomas and melanoma. Breast and colorectal cancers are the most frequent ovarian metastases; prostate cancer commonly affects the testes. In the presence of endocrine deficiencies, glucocorticoid replacement for adrenal and pituitary involvement can be life saving. As most metastases to endocrine organs develop in the context of disseminated disease, surgical resection or other local therapies should only be considered to ameliorate symptoms and reduce tumour volume. Although few consensus statements can be made regarding the management of metastases to endocrine tissues because of the heterogeneity of the variable therapies, it is important that clinicians are aware of their presence in diagnosis.



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