



Need for Early evaluation in Carcinoma Esophagus

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Abstract

A 64-year-old male was referred for neo-adjuvant therapy by the surgical oncology team after complaining of semi-solid food swallowing difficulties for six months. Three rounds of Neoadjuvant chemotherapy were given to the patient. But despite numerous counseling sessions, the patient refused to have surgery. As a result, the case was discussed and the patient's concurrent chemoradiotherapy was scheduled. He received 50.4Gy/28# of chemoradiotherapy to his mediastinum and oesophagus using the 3DCRT technique on a 6MV LINAC. The patient experienced a painful ulcerated nodule across her scalp and left axilla three months after finishing chemotherapy and radiation treatment. Both nodules tested positive for squamous cell carcinoma. The patient was subsequently instructed to get a PET CT scan to check for any additional distant metastases, and an electron therapy course of action was then developed. However, the patient died on the day of PET CT scan. Hence the question that arises is, can distant metastasis be analyzed earlier? Or will early investigation after Concurrent chemoradiotherapy give false positive results?

Introduction

Cutaneous metastasis in esophageal cancer cases is uncommon, making up only 1% of distant metastatic sites, with the liver and lungs being the most frequent. So any instance of cutaneous metastasis indicates a disease that is aggressive. Direct, lymphatic, or haematogenous spread may occur to the skin. This is an intriguing example of esophageal cancer treated with concurrent chemoradiotherapy and neo adjuvant chemotherapy after the patient refused surgery. The patient developed cutaneous metastases and left axillary lymphadenopathy, both of which were positive for squamous cell carcinoma, three months after finishing chemoradiotherapy. The patient was scheduled to receive electron therapy to the cutaneous scalp; however, the patient passed away during the course of his treatment, leaving us to wonder whether our treatment planning was adequate and whether early disease evaluation following chemoradiotherapy is necessary to avoid false positive results and to prevent the death of patients with advanced carcinoma of the esophagus.

Case Report

The patient, a 63-year-old male heavy smoker, first complained of trouble swallowing semisolids six months prior (June 2020). An esophageal growth was visible during an upper GI endoscopy 30-35 cm from the central incisors. Squamous cell carcinoma with considerable differentiation was seen in an esophageal biopsy. An examination of the neck, thorax, and abdomen using CECT revealed that the lower third of the esophagus' circumferential wall had thickened by around 2.0 cm in the AP dimension across a length of about 8.5 cms. It is approximately 2.0cm away from the GE connection. It is obstructing the esophageal lumen partially. The surgical oncology team referred the patient for neo-adjuvant treatment. Following three cycles of treatment with Inj. Paclitaxel and Inj. Carboplatin, the patient underwent a PET CT scan, which revealed FDG avid (SUV max 12.6) heterogeneously enhancing

circumferential thickening in the distal third of the esophagus measuring 7mm in length. The lesion's cranial edge is 3.2cm distal to the carina. The patient was urged to have surgery, but the patient refused. The situation was discussed, and concurrent chemoradiotherapy was arranged for the patient. The patient got EBRT 50.4Gy/28# to the esophagus and mediastinum using 3DCRT on a 6MV LINAC, as well as concomitant chemotherapy Tablet Capecitabine and 4 cycles of weekly Inj. Cisplatin. The patient was on regular follow-up when, three months after finishing chemoradiotherapy, he developed a severe ulcerated lump across his head and left axilla, which tested positive for squamous cell carcinoma in both cases. The patient was subsequently advised to have a PET CT scan to rule out any more distant metastases, after which an electron treatment was planned. The patient, however, died on the day of the PET CT scan. As a result, the question that emerges is whether distant metastases may be investigated early. Will an early inquiry following concurrent chemoradiotherapy provide false positive results?

Discussion

Squamous cell carcinoma, in contrast to adenocarcinoma, is more likely to be found near the tracheal bifurcation, has a predisposition for quicker lymphatic spread, and is associated with a poorer prognosis. Squamous cell carcinoma is the most prevalent histology in Eastern Europe and Asia, while adenocarcinoma is the most common in North America and Western Europe.

According to Strickley et al's meta-analysis, the total incidence of cutaneous metastases is 5.3%. Melanoma and breast cancer are the most likely to spread to the skin and subcutaneous tissues. Other cancers, such as lung, colon, head and neck, and hematologic disorders, have also been described with some frequency. In addition, esophageal cancer cutaneous metastasis is uncommon, particularly in esophageal squamous cell carcinoma, and the chance of skin metastasis is reduced. However, esophageal adenocarcinoma is more likely to spread to the skin. The majority of the literature describes scattered nodules that are rarely painful as the presentation of skin metastases from esophageal cancer. According to Ferreira et al's retrospective study, adenocarcinoma is the histological type of lung cancer that is most prone to skin metastasis, similar to esophageal cancer. However, single nodules are the most common clinical manifestation of lung cancer skin metastases, and the most common place is the head. Typical ductal or lobular carcinoma, unlike esophageal and lung cancer, involves cutaneous metastases to the thorax and abdomen, occasionally with firm, erythematous plaques. Nonetheless, single or more skin-toned or pink nodules are the most prevalent clinical appearance.

Cutaneous metastasis from esophageal cancer is uncommon and usually occurs in advanced tumour stages. This implied a fast-moving illness. Fine-needle aspiration cytology is a quick and safe approach for diagnosing skin metastases. In some circumstances, a critical study of cytomorphological traits, together with relevant clinical facts, can aid in the location of unknown primary sites. Furthermore, a comprehensive examination of cell morphology and clinical characteristics can aid in determining the genesis of a cutaneous metastatic disease.

Chemotherapy is the main treatment for advanced esophageal cancer that has spread to other parts of the body. 5-fluorouracil, platinum agents, and taxanes are examples of commonly utilized agents. The objective response rate of platinum-containing dual-agent chemotherapy for esophageal squamous cell carcinoma, on the other hand, is low. Immunotherapy using antibodies targeting PD-1 immunological checkpoints has shown promising outcomes in the treatment of patients with esophageal squamous cell carcinoma. A 64-patient phase 2 clinical trial confirmed nivolumab monotherapy for advanced esophageal squamous cell cancer. The primary endpoint was the objective response rate, which was 17.7 percent. In conclusion, nivolumab demonstrated promising activity with a tolerable safety profile in patients with esophageal advanced squamous cell carcinoma who were refractory or intolerant to conventional treatments.

Conclusion

Despite the finest treatment choices for carcinoma esophagus, such as surgery and chemoradiotherapy, the development of distant metastases is a major worry. The need for early evaluation is required for optimal management of carcinoma esophagus



Figure 1. Showing cutaneous scalp lesion in 64 year old female, diagnosed and treated case of carcinoma esophagus