Case Report

Esophageal carcinoma with acro-metastasis: a rare case report

Mohammad Saad Ahmed1, Hina Pathan1*, Sheeza Imtiaz1, Jawaid Mallick2, Shabbir Hussain2, Saifullah Ubaidullah1

INTRODUCTION

Esophageal cancer is one of the deadliest cancers with a lifetime risk of about 0.8% for men and 0.3% for women. Incidence of esophageal cancer is 13 cases per 1,00,000 population for black American men. On the whole it is the sixth commonest cause of cancer related deaths in the world.1 Two major risk factors for esophageal adenocarcinoma are gastro-esophageal reflux disease (GERD) and Barrett’s esophagus (BE). Cancer of the esophagus typically occurs in one of two forms, SCCs arising from the stratified squamous epithelial lining of the organ, and adenocarcinomas affecting columnar glandular cells that replace the squamous epithelium.2 SCC is the predominant histologic type of esophageal cancer worldwide. The incidence of squamous cell cancer of the esophagus increases with age as well and peaks in the seventh decade of life. The incidence of SCC of the esophagus has been found to dramatically increase in the presence of any factor that causes chronic irritation and inflammation, such as excessive alcohol intake, especially in combination with smoking.3,4

CASE REPORT

A 35 years old male, presented to our oncology department with the history of dysphagia for solids and liquids and weight loss for two and half months. He underwent surgical laparotomy, thoracotomy and esophagectomy. Histopathology was done, which revealed moderately differentiated squamous cell carcinoma with the size of 5.5×3.5 cm, tumor infiltrated muscularis propria and adventitia with the proximal margin of 1.6 cm and distal margin of 5 cm. Lymph nodes were 0/9. Tissue from bronchial wall was also positive for tumour. Staging was also done showing stage III-C. Radiation therapy was...
planned and 5800 cGy was given in one month. He then
developed pain in his right thumb with restricted
movements. X-ray of right hand was done, which showed
bony metastasis in head and distal shaft of first
metacarpal. CT-scan of chest was also done for
confirmation of lung metastasis.

DISCUSSION
Esophageal cancer is a devastating disease. Although some
patients can be cured, the treatment for esophageal cancer
is protracted, diminishes quality of life, and is lethal in a
significant number of cases. The principal histologic types
of esophageal cancer are squamous cell carcinoma and
adenocarcinoma. As squamous cells line the entire
esophagus, squamous cell carcinoma can occur in any part
of the esophagus; it often arises, however, in the upper half
of the esophagus. Adenocarcinoma typically develops in
specialized intestinal metaplasia (Barrett metaplasia) that
develops as a result of GERD; thus, adenocarcinoma
typically arises in the lower half of the distal esophagus.
The most common presenting symptom of esophageal
cancer is dysphagia. Esophagogastroduodenoscopy allows
direct visualization and biopsies of the tumor, while
endoscopic ultrasonography is the most sensitive test for
determining the depth of penetration of the tumor and the
presence of enlarged peri-esophageal lymph nodes. In
patients who appear to have localized esophageal cancer,
positron emission tomography (PET) scanning may be
useful as part of the baseline staging. Other imaging
studies may be valuable in selected patients.
The progression of Barrett metaplasia to adenocarcinoma is
associated with several changes in gene structure, gene
expression, and protein structure. The onco-suppressor
gene TP53 and various oncogenes, particularly Erb-b2,
have been studied as potential markers. Casson and
colleagues identified mutations in the TP53 gene in
patients with Barrett epithelium associated with
adenocarcinoma.

CONCLUSION
Survival in patients with esophageal cancer depends on the
stage of the disease. Squamous cell carcinoma and
adenocarcinoma, stage-by-stage, appear to have equivalent
survival rates, therefore, considering the rarity of
metastatic disease to the bone from adenocarcinoma of the
gastroesophageal junction, we emphasize the importance
of the follow-up of patients who have been treated for
primary esophageal malignancy. Constant awareness and
concern of the physician is required. Every high-risk skin
lesion has to be revealed and removed. Such specimens
should be biopsied and histo-pathologically evaluated.
Further knowledge is required in the field of the diagnosis
and the options of treatment of metastatic disease from
esophageal carcinomas.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES