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Oncology

# AN UNUSUAL PRESENTATION OF ESOPHAGEAL CARCINOMA: A CASE REPORT

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**ABSTRACT** Esophageal cancer accounts for 6% of all gastrointestinal cancer, but presentation with cutaneous metastasis is a rare occurrence. The incidence of cutaneous metastasis is less than 1% of all cases of metastatic esophageal cancer. Less than 15% of the patients diagnosed with esophageal cancer are curable, with around half of the patients presenting in metastatic or unresectable stage. The paper reports a case of a 57-year-old male patient presenting with two swellings on the anterior thorax, one on left side above the nipple and other on the right side, along with dysphagia. FNAC from both the swellings showed metastatic squamous cell carcinoma.

**KEYWORDS :** esophageal cancer, swellings, metastatic, squamous.

## INTRODUCTION

Esophageal cancer is the eight most common cancer in the world and accounts for 6% of all gastrointestinal malignancies. It is more common in males with the male to female ratio being 4:1[1]. Its incidence varies with geography, with high incidence being at "esophageal cancer belt"[2]. Its incidence is very high in North Eastern India, accounting for 13.6% of all cancers occurring in males. Squamous cell carcinoma is the most common histological subtype followed by adenocarcinoma. It is associated with various risk factors like alcoholism, smoking and pan chewing, and diet low in vegetables, fruits and animal products. Most common presenting symptom is dysphagia and most common sites for metastasis are lymph nodes, lung and liver[3]. Cancers that are most commonly associated with cutaneous metastasis are breast in females and lung in males, with esophageal cancer presenting with cutaneous metastasis being a rare occurrence[4,5].

### Case Report

A 57-year-old male patient came to the Department of Radiation Oncology, RIMS with complain of swellings on the anterior thorax for last 45 days and dysphagia for last 20 days. The swellings were two in number, one on left side on anterior thorax just above the nipple which was approximately 7 × 8 cm in size, and second one on right side of anterior thorax below the nipple approximately 5 × 5 cm in size. The swellings were initially small and gradually increased in size over the course of 45 days. The patient also complained of dysphagia for the past 20 days which was more to solids as compared to liquids. There is no history of chest pain, cough, respiratory distress or bowel upset. There is no family history of cancer or similar illness in the past. The patient gives history of alcohol use for the past 30 years.

On examination, patient general condition was fair with body surface area being 1.6 $m^2$ and Karnofsky Performance Score (KPS) being 60% only. On palpation, a single large (8 × 11 cm in size) firm, vaguely tender, bony swelling, with smooth surface and margin was found on anterior thorax on the left side just above the nipple (fig. A). Another small swelling (5 × 5 cm in size) firm, non-tender, mobile, with smooth surface and margin was found on the anterior thorax on the right side below the nipple (fig. B). No peripheral lymph nodes were clinically palpable.

**Fig A: Bony swelling just above the nipple on the left side**

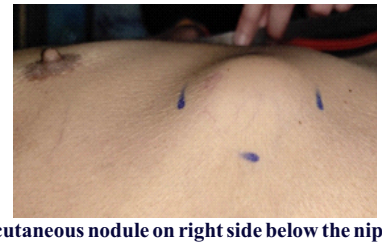

**Fig B: Subcutaneous nodule on right side below the nipple**

Routine baseline investigations were done and were within normal range. Chest X Ray showed mild left pleural effusion. CT scan of the thorax showed circumferential wall thickening of esophagus extending from sub carina to cardia of stomach with luminal narrowing and proximal dilatation of esophagus along with left anterior chest wall soft tissue enhancing mass with erosion of left rib costochondral junction (fig. C and D). Endoscopic guided biopsy of esophageal mass was not done due to unwillingness of the patients' family members.

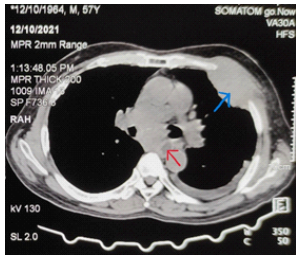


**Fig C: CT thorax (axial view) showing bony mass (blue arrow) on left side of thorax involving the chest wall and mass in esophagus lumen (red arrow)**

Fine Needle Aspiration Cytology (FNAC) from both the swellings showed metastatic squamous cell carcinoma (SCC). Metastatic work up of the patient was done and it showed no other sites of metastasis or organ involvement. The patient was planned for palliative radiation therapy but the patient general condition deteriorated over time and thus the patient was kept on best supportive care.

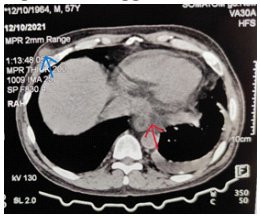

**Fig D: CT thorax (axial view) showing a subcutaneous nodule**

**(blue arrow) on right side of thorax and esophageal mass (red arrow)**

## DISCUSSION

Esophageal cancer is the sixth most common cause of cancer death in the world. The two most common histological types are squamous cell cancer and adenocarcinoma. Squamous cell type is characterized by extensive local growth and increased incidence of lymph node metastasis. Incidence of nodal metastasis with adenocarcinoma is related to depth of tumor invasion6. Symptoms usually start 3-4 months before the diagnosis and is influenced by the site of the primary tumor in the esophagus. More than 90% of patients presents with dysphagia, irrespective of tumor location and 50% presents with odynophagia[7].

It carries a poor prognosis with 5-year survival rate of 5-35% with lung and liver being the most common organs for metastasis via hematogenous route8. Subcutaneous metastasis is very rare, with incidence being less than 1% in metastatic esophageal cancer9. Skin metastasis is more common with adenocarcinoma variant10. Subcutaneous metastasis can be confused with skin infections also, thereby treated with antibiotics which can cause a delay in the diagnosis of metastasis or recurrence. Cutaneous manifestations are usually painless and can present as indurated or erythematous nodules, papules or rapidly growing subcutaneous nodules.

Squamous cell carcinoma is the most common type but in recent years, there has been an increase in the incidence of adenocarcinoma variant in the western countries11,12. The presence of cutaneous metastasis in esophageal cancer or any gastrointestinal cancer is a sign of aggressive and advanced disease with a survival time of 4-20 months after diagnosis[13].

Diagnostic workup for esophageal cancer includes a detailed history and physical examination, along with upper gastrointestinal biopsy, imaging and histopathological analysis. Treatment for esophageal carcinoma is either curative or palliative. Only around 20% of patients presents with tumor localized to the esophagus, while as the remaining 80% presents with either locally advanced or metastatic disease at the time of diagnosis14. A multimodality approach is used in the treatment of esophageal cancer which includes surgery, radiation therapy (both EBRT and brachytherapy) and chemotherapy (monotherapy or combination).

## CONCLUSION

Esophageal cancer presenting as a cutaneous manifestation as the primary symptom is a very rare occurrence. Detailed history and physical examination along with FNAC of any cutaneous lesion helps in fast diagnosis and staging of the disease. This study showed a case of a 57-year-old male patient who was diagnosed as case of esophageal carcinoma with subcutaneous manifestation after imaging and FNAC from skin lesion, and has been kept on best supportive care due to his deteriorating general condition.

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