ESOPHAGEAL CANCER CASES

Esophageal Cancer Case1

Mr. B. is a 63-year-old male with a three month history of dysphagia for solids. He has a history of GERD and has been on a PPI for many years. Recently he has been feeling fatigued and has lost 7 kg.

His PMH is significant for hypertension and a 20 pack-year smoking history. He drinks five alcoholic beverages per week. His physical examination does not reveal any abnormalities.

1. How would you investigate this patient at this time?

He has a CBC, LFTs, and chemistry which are all normal. CXR is also normal. He is referred to a gastroenterologist who performs endoscopy and biopsy. A mass is visualized at 25cm extending for 6cm. The pathology is of a squamous cell carcinoma.

2. What further investigations are required at this time?

His CT scan of the chest and abdomen confirms a mass in the midthoracic esophagus. There is no obvious lymphadenopathy, and his chest and abdomen are negative for metastatic disease. He is referred to his local cancer centre's multidisciplinary team for assessment. He is seen in consultation by a thoracic surgeon, as well as radiation and medical oncology to discuss neoadjuvant combined modality therapy.

3. In this case scenario, would you recommend preoperative chemotherapy +/- radiation? If so, why? If not, why not?
4. Does pre-operative chemotherapy affect survival?
5. What, if any, role is there for brachytherapy?
6. This patient population has unique nutritional issues. How should they be addressed?

He proceeds with preoperative cisplatin-based chemotherapy and concurrent radiation. His treatment course is complicated by toxicity from CMT requiring dose reductions and delays in administration of chemotherapy. He is hospitalized for 1 week toward the end of treatment because of dehydration. His CT scan of the chest and abdomen post-treatment identifies response to treatment, and surgery is now recommended.

He proceeds to have a total esophagectomy. There are no post-operative complications. Pathology reveals a grade 3 squamous cell carcinoma with negative resection margins. Muscularis propria is involved with tumor. Lymph nodes are all negative.

7. What stage of disease does this patient have?
8. Does he warrant further therapy? If so, what would you offer him? How effective is it and how is it delivered?

At his clinic visit six months after completion of all therapies, he complains of a three-week history of worsening dysphagia for liquids and solids. He has lost 5 kgs in weight. Physical examination reveals palpable supraclavicular nodes. His chest is clear. He has some RUQ tenderness on examination, but no hepatomegaly.

9. How would you investigate this patient?

He undergoes endoscopy which shows a large mass almost completely obstructing the esophagus. An attempt is made to dilate his esophagus but is not successful. Biopsy confirms recurrent disease. Repeat CT scan of the chest and abdomen reveal two metastases in the periphery of the right lobe of the liver measuring 2 cm and 1.3 cm respectively. Multiple enlarged lymph nodes are seen in the upper abdomen. He returns to discuss the results of the investigations. He asks you to address his prognosis.

10. Are there any pathological tests that can assist in directing treatment?
11. What treatment options are available to this patient and how effective are they?
12. How would you address his nutritional status?
13. What is his prognosis at this time?
14. What non-chemotherapy options are available for symptom management?
15. When would you consider involving palliative care?

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Esophageal Cancer Case 2

A 52-year-old male with a five month history of dysphagia and 10 kg weight loss presents to his family doctor. He has been spending at least 50% of his day resting or sleeping. He can no longer do tasks around his home such as yard work, cleaning et cetera.

1. How would you investigate this patient?

He is referred to a gastroenterologist for endoscopy which shows a tumor at the GE junction. Pathology is of an adenocarcinoma, grade 3. CT chest and abdomen shows a small left pleural effusion and several 1 cm nodules at the base of the left lung. There are metastases to the mediastinal nodes. The CT abdomen questions metastases to the right adrenal. Liver and pancreas are normal. His blood work reveals that he is slightly anemic (Hg 105), renal function and calcium are normal. His protein and albumin are slightly low. Liver function tests are at the upper limit of normal.

2. Is this patient a surgical candidate? If not, why not?
3. What treatment options exist for this patient regarding systemic therapy?

A pathology review is requested, including Her2neu, MSI and MMR analysis. The tumor is Her2Neu positive.

4. How does this change treatment options?
5. How does this affect prognosis?
6. If this tumor is Her2neu negative, how effective would systemic therapy be in improving median survival?
7. How would his treatment options change if his tumour is MSI high and/or MMR deficient?
8. Is there a role for radiation? If so, how would that be determined?
9. If this patient were to have an excellent response to treatment (i.e. post chemotherapy imaging were to show complete resolution of his previously noted disease), would he then be an appropriate surgical candidate?
10. Would you refer this patient to palliative care? If yes, why? If no, why not?

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