

Case Report

Palliative oesophagogastrrectomy for dysphagia due to adenocarcinoma at the esophagogastric junction

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Abstract:

Dysphagia is the usual presenting feature of oesophageal cancer & is generally a sign of advanced disease. Palliation in this disease demands relief of dysphagia. Palliation of dysphagia can be achieved in a number of ways which includes surgical resection, stenting, laser ablation, photodynamic therapy, ethanol necrosis & bipolar coagulation. We report here a case of dysphagia due to lower oesophageal adenocarcinoma treated by palliative oesophagogastrrectomy.

Key words: *Dysphagia, Adenocarcinoma at oesophagogastric junction, Palliative oesophagogastrrectomy.*

Introduction:

There is an upward trend in the incidence of adenocarcinomas at the lower oesophagus. Surgery, radiotherapy & combination chemotherapy are effective in the early stages of lower oesophageal adenocarcinomas leading to tumour shrinkage & prolongation of life & even cure in some cases.¹ Surgical resection probably gives the best result for all forms of oesophageal cancer.² Unfortunately, in the majority of cases treatment is only palliative & it is relief of dysphagia.³

Deployment of stents can markedly improve symptoms of dysphagia & improve functional quality of life.^{4,5,6} Self expanding metal stents (SEMS) are commonly the standard for palliation of malignant dysphagia. The advent of retrievable stents & the development of self expanding plastic stents show promise to increase the possible applications for oesophageal stents. Non-stenting modalities (laser ablation, photodynamic therapy, ethanol necrosis & bipolar coagulation) have similar outcome in terms of morbidity & mortality compared with SEMS & at a comparable cost.⁷

In our country, non-stenting modalities as well as stenting is not widely available. The role of palliative resection is debatable & it should not be attempted if it is clear beforehand that palliation is all that can be achieved. However, palliative resection may be appropriate if incurable disease is found when an operation is already well underway.

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In this reported case, curative resection was the aim but during surgery it was found that the tumour has grossly involved the celiac & para-aortic groups of lymph nodes & the pancreas. So, palliative resection was performed.

Case report:

A male farmer aged about 70 years, presented with difficulty in swallowing for liquid & solid foods for 1 year and marked weight loss for 1 year. The patient was normotensive & non-diabetic. He did not have any chest problem. He had mild anaemia but no jaundice. His bowel habit was normal & Digital rectal examination revealed no abnormality.

Endoscopy of upper Gastro-intestinal tract shows polypoid growth with ulceration (**Figure-1**) at oesophago-gastric junction. Impression was malignant neoplasm at oesophagogastric junction. Histopathological diagnosis was well-differentiated adenocarcinoma.

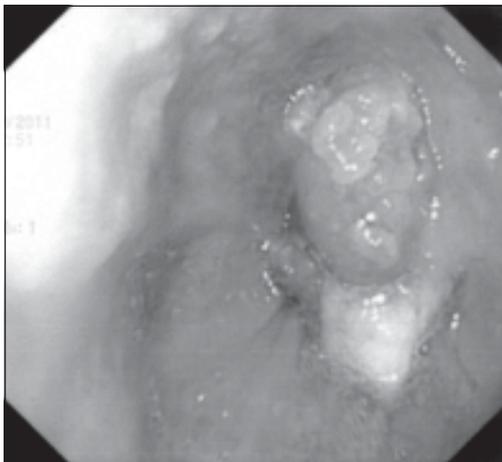


Figure 1: *polypoid growth with ulceration at oesophago-gastric junction.*

Full blood count, Liver function tests, Serum creatinine, Serum calcium, Fasting blood sugar, X-ray chest, ECG & Ultrasound Scan of whole abdomen was within normal limit.

Serum Carcino-embryonic Antigen was 10 ng/ml.

Curative resection was decided. Abdomen was opened by an oblique upper abdominal incision, parallel to right costal margin and directed to left 8th intercostal space. Initial survey of the abdomen was unremarkable. The left lobe of liver was mobilized by dividing the left triangular ligament. Examination of lower end of oesophagus and stomach revealed that growth has involved the pancreas, caeliac & para aortic lymph nodes. So curative resection was not possible and a palliative oesophago-gastrectomy followed by oesophago-gastrostomy was done. Ensuring haemostasis, wound was closed in layers after keeping a drain tube in situ.

On histopathology, section from the grossly found ulcerated area showed a malignant tumour composed of anaplastic epithelial cells arranged in grandular pattern. The tumour infiltrated through the whole thickness of muscle coat in the serosa at places. Sections from one of the grossly found five lymph nodes showed metastasis of same tumour. Sections from the proximal resected margins were involved by the tumour. However, the distal resected margins were free of lesion. Impression was adenocarcinoma, well differentiated, with lymph node metastasis.

Discussion:

Approximately 400,000 cases of oesophageal cancer are diagnosed annually world wide.⁸ The incidence of squamous cell carcinoma of oesophagus has decreased in the western hemisphere⁹ but the incidence of adenocarcinoma has shown dramatic increased.^{10,11} The prognosis of oesophageal cancer is dismal. Systemic metabolic disease is present in 50% of patients at the time of diagnosis.¹² Locally advanced disease can cause dysphagia, anaemia, weight loss, food sticking in oesophagus, regurgitation &

aspiration pneumonia.¹ In the reported case the patient had dysphagia & weight loss. Pre-operative survey did not reveal any regional or distant metastasis. Curative resection was decided but during surgery gross involvement of the tumour with pancreas & celiac & para-aortic groups of lymph nodes were detected, therefore palliative oesophago-gastrectomy was done. Peri-operative period was uneventful. The patient got relief of dysphagia & was referred to oncologist for further management.

Treatment options for advanced oesophageal cancer have changed considerably over the past two decades. Chemotherapy & radiotherapy in both pre & post operative phases have started to improve treatment outcome. Combined chemo-radiation as a definitive therapy has been demonstrated to be effective. A study¹³ including only adenocarcinoma patients, found a significant improvement in survival with use of neoadjuvant chemo-radiation & surgery versus surgery alone. For patients, metastatic diseases who are considered incurable by surgery, deployment of stents can markedly improve symptoms of dysphagia. Like surgical resection stents provide the most immediate relief from dysphagia but this procedure is not without risk. Early risks include perforation, haemorrhage, chest pain, stents migration, recurrent or unresolved dysphagia & recurrent stent obstruction.¹⁴⁻¹⁶

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