Esophageal Cancer Associated With Pregnancy

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Abstract

Background: Esophageal cancer concomitant with pregnancy is very rare and the prognosis is poor. The main concern in diagnosis is that the clinical presentations of esophageal cancer in pregnant woman are often not considered serious and are misinterpreted as pregnancy-related symptoms.

Case: A 29-year-old woman presented at 29 weeks' gestation with dysphagia, weight loss, and a single episode of hematemesis. Esophageal carcinoma was diagnosed on endoscopy, and local spread confirmed by MRI. A Caesarean section was performed at 32 weeks' gestation, and shortly afterwards the patient underwent thoracotomy, but resection of the tumour could not be performed. Palliative treatment was begun and she was discharged from hospital.

Conclusion: Clinicians must be aware and include the probability of esophageal cancer in the differential diagnosis of gastrointestinal symptoms during pregnancy.

Résumé

Contexte : Il est très rare de constater un cancer de l'œsophage pendant la grossesse; une telle constatation donne lieu à un pronostic peu reluisant. Les présentations cliniques du cancer de l'œsophage chez les femmes enceintes sont souvent considérées comme étant bénignes et sont interprétées à tort comme étant des symptômes liés à la grossesse, ce qui constitue la principale préoccupation en matière de diagnostic.

Cas : Une femme enceinte de 29 ans en étant rendue à la 29^{e} semaine de gestation présentait une dysphagie, une perte pondérale et un épisode unique d'hématémèse. Un carcinome de l'œsophage a été diagnostiqué par endoscopie et une propagation locale a été confirmée par IRM. Une césarienne a été effectuée à la 32^{e} semaine de gestation; peu après, une thoracotomie a été menée, mais la tumeur n'a pu être réséquée. Un traitement palliatif a été mis en œuvre et la patiente a obtenu son congé de l'hôpital.

Conclusion : Les cliniciens doivent être sensibilisés et doivent inclure la probabilité d'un cancer de l'œsophage dans le diagnostic différentiel des symptômes gastro-intestinaux constatés pendant la grossesse.

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INTRODUCTION

Esophageal cancer presenting during pregnancy is extremely rare and was first described in 2008.[1] Presented here are the clinical features of another woman presenting in the third trimester of pregnancy with an advanced tumour.

THE CASE

The patient was a 29-year-old multigravid, non-smoking woman at 29 weeks of gestation. She had a history of difficulty in swallowing with weight loss. She had had one episode of hematemesis with no melena.

The physical examination was unremarkable except for cachexia; the patient had a BMI of 16. She had a single fetus with fundal height corresponding to 29 weeks' gestation. Upper gastrointestinal endoscopy revealed a fungating mass in the esophagus, starting at 25 cm from the upper incisors and extending to the cardia of the stomach (Figure 1). Magnetic resonance imaging of the chest and upper abdomen showed a circumferential esophageal wall thickening that extended into the gastric cardia. In addition, two small (5 mm) nodules were identified in the liver.

Biopsy of the esophageal mass confirmed the diagnosis of moderately differentiated squamous cell carcinoma (Figure 2).

At 32 weeks' gestation, after steroid therapy (dexamethasone 12 mg IM at 12 hour intervals for 48 hours), a premature baby was delivered by Caesarean section. Because the patient was severely malnourished, she was given total parenteral nutrition via a central intravenous line.

Ten days after delivery, intraoperative flexible bronchoscopy and diagnostic laparoscopy were performed. There was no identified endobronchial extension of the tumour, and no liver metastases or peritoneal disseminations were seen. Right thoracotomy was then performed. Advanced esophageal carcinoma invading the left main stem bronchus was found, with involvement of the posterior basal segment of the lower lobe of the right lung. Surgical resection was judged not possible, and the procedure was then abandoned.

The patient's immediate postoperative recovery was uneventful.

Figure 1. Fungating mass at gastric cardia

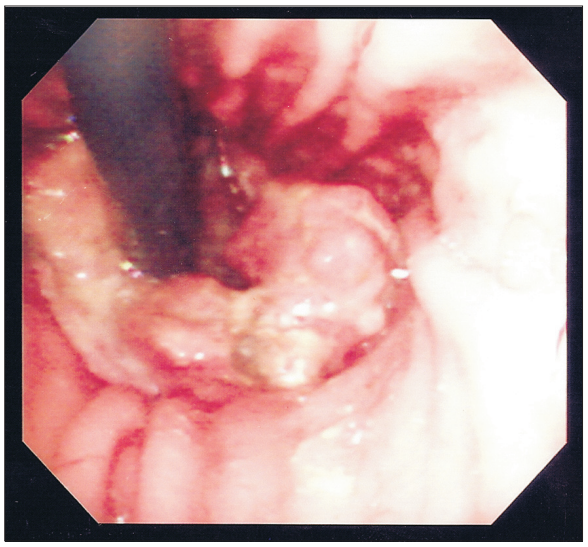
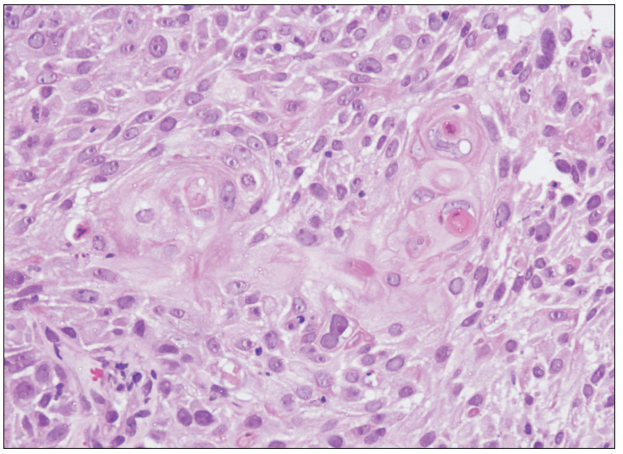


Figure 2. Biopsy specimen from gastric cardia shows infiltration with atypical squamous cells, highly pleomorphic with eosinophilic cytoplasm and prominent mitotic figures. Hematoxylin and Eosin stain



Plans were made for palliative chemotherapy and radiation therapy, and the patient was discharged and died four months later.

DISCUSSION

Esophageal cancer identified during pregnancy is extremely rare. It was reported for the first time by Sharma and colleagues in 2008.[1] Practical guidelines are available for the management of gastric[2] and colorectal cancer[3] during pregnancy, but very limited information is available for esophageal cancer.

The major concern in diagnosis is that the symptoms of esophageal cancer may be misinterpreted as pregnancy-related symptoms. Consequently, diagnosis is delayed and as a result esophageal cancer is advanced at the time of diagnosis.

Practical guidelines for the treatment of esophageal cancer during pregnancy are similar to those for gastric cancer during pregnancy.[2] The management is determined by the gestational age of the pregnancy and the stage of the tumour.

Ueo et al. developed treatment guidelines for gastric cancer during pregnancy.[2] For gastric cancer diagnosed before 24 weeks' gestation, the recommendation is for surgical treatment. The treatment for gastric cancer diagnosed at between 25 and 29 weeks depends on the stage of the cancer. If it is advanced and resectable, immediate resection is recommended despite the risk for the fetus. If the gastric cancer is at an early stage, treatment may be postponed to the 30th week of gestation to provide a greater probability of survival of the neonate. If gastric cancer is diagnosed after the 30th week of gestation, the recommended approach is delivery when the infant is viable, followed by radical surgery for the tumour.

The prognosis for women with gastric cancer during pregnancy is poor.[4] Overall, 88% of patients die within one year. Of 61 Japanese patients reviewed by Ueo et al.,[2] 96.7% had advanced stage cancer at the time of diagnosis. Similarly, of 92 cases of gastric cancer during pregnancy reported by Jaspers et al.,[4] nearly all tumours were advanced, 82% were poorly differentiated, and only 51% were resectable at the time of diagnosis.

The average five-year survival rate of 6.2% in young patients[5] does not differ from the overall average five-year survival rate of 7.3% in major series.[6]

In view of the unfavourable outcomes of these reported cases, it is important for clinicians to consider early upper gastrointestinal endoscopy for all pregnant women with persistent epigastric complaints, particularly if associated with hematemesis or weight loss.

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