A Case of Synchronous Squamous Cell Carcinoma in the Esophagus and Stomach

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Synchronous esophageal and gastric cancers with the pathologic features of a squamous cell carcinoma are extremely rare. A 57-year-old male visited our hospital with a history of hematemesis and was diagnosed with a synchronous cancer. He underwent a staging work-up, and the resectable lesion in the stomach was operated on following radiologic and endoscopic evaluations. The pathologic examination revealed a synchronous cancer consisting of squamous cell carcinoma in the distal esophagus and the cardia of the stomach. We report a case of a synchronous cancer that was successfully treated by surgical resection followed by concurrent chemoradiotherapy. We also discuss the hypothesis regarding the origin and presentation of the synchronous cancer and highlight the importance of careful surveillance by physicians at the time of diagnosis. (Gut Liver 2012;6:118-121)

Key Words: Synchronous; Esophageal neoplasms; Stomach neoplasms

INTRODUCTION

A synchronous cancer of squamous cell origin found in the esophagus and stomach is very rare among gastrointestinal cancers. Squamous cell carcinomas take up 38% of all esophageal cancers, and it is common in esophagus, but not in stomach.1,2 Less than 100 cases were reported until now.3 A synchronous presentation of squamous cell carcinoma in the esophagus and stomach is so rare that it has not been reported in Korea, yet. Therefore, making an accurate diagnosis is crucial in order to plan treatment for the synchronous cancer. We have experienced a squamous cell carcinoma of esophagus and stomach and herein report this case to demonstrate that the cancer can be treated through accurate diagnosis, effective surgery and combination of chemoradiation therapy.

CASE REPORT

A 57 year old male was admitted to the Department of Oncology complaining of dyspepsia for 2 months and sudden onset of hematemesis. He underwent endoscopy and computed tomography (CT) and was diagnosed with esophageal cancer and stomach cancer. He had a history of complete atrioventricular block and had a pacemaker implemented in 1992. He had diabetes mellitus and his social history was significant for drinking a bottle of alcohol daily and smoking one pack of cigarettes for 30 years. He had no significant family history.

He was chronic ill-looking, and alert. His blood pressure was 120/80 mm Hg, pulse 60/min, respiration 20/min, body temperature 36.5°C. His skin was dry and warm, with pale icterus and dry tongue. His lungs were clear to auscultation and his heart was regular without murmur or rubs. His bowel movement was normal without abdominal pain or tenderness. His liver and spleen were not palpable. The complete blood count showed white blood cell count 9,610/mm³, Hb 10.4 g/dL, Plt 284×10³/mm³. His blood chemistry was normal, with tumor markers carcinoembryonic antigen (CEA) 2.22 ng/mL and squamous cell carcinoma antigen (SCC Ag) 2.2 μg/L. The chest X-ray and simple abdomen showed no abnormality. On CT, there was an ulcerofungating mass from the pylorus of the stomach to lower esophagus. The stomach lesion was abutting the tail of the pancreas and the diaphragm on CT (Fig. 1). The positron emission tomography–computed tomography (PET-CT) showed no distant metastasis other than suspicious cancerous lesion in stomach and esophagus. He then underwent upper gastrointestinal endoscopy and endoscopic ultrasound with biopsy. The endoscopic finding revealed an irregular shaped lesion with...
decreased vascular marking from 31 to 39 cm from upper incisor. The main cancer lesion in the esophagus was 35 cm from UI with serosa invasion and local lymph node metastasis. It was poorly-differentiated squamous cell carcinoma (Fig. 2). The stomach lesion was Bormann III shaped, moderately-differentiated squamous cell carcinoma, with serosa exposure and local lymph node invasion by 9 mm (Fig. 3).

According to above findings, the stomach lesion was resectable and he underwent total gastrectomy and esophagoduodenostomy. The operative findings showed a 6×6 cm sized-ulcerofungating mass in the lesser curvature of the stomach that invaded soft tissue of the pancreas (Fig. 4). There was no distant metastasis to liver or rectum. Postoperative findings demonstrated a squamous cell carcinoma of the stomach, pT4N2M0 with serosa invasion, 4 out of 41 local lymph nodes metastasis with perineuromuscular invasion. The pathologic finding showed that the proximal resection margin of the gastric lesion was negative. This suggests the squamous cell carcinoma of the stomach was not a direct extension from squamous cell carcinoma of esophagus. They were indeed two separate cancers with different pathology.

The patient was in good condition after the surgery, and underwent combination chemoradiotherapy (5-Fluorouracil/Cisplatin: 5FU 1 g/m² per day on the first 4 days of weeks 1, 5, 8, and 11th weeks, Cisplatin 75 mg/m² on first days of 1, 5, 8, 11th weeks, Radiotherapy 2.0 Gy for 5 days a week). He is now in complete remission and regularly followed up in outpatient clinic.

**DISCUSSION**

There have been a few reports on the double primary cancers consisting of esophageal squamous cell carcinomas and gastric adenocarcinomas, but squamous cell carcinoma of stomach is a rare finding as described in this report. Recently, there has been increasing incidence of esophageal cancers associated with Bar-