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Salvage esophagectomy with pancreatectomy for local recurrence of thoracic esophageal cancer after definitive chemoradiotherapy: A case report

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ABSTRACT

INTRODUCTION: We encountered a case of advanced thoracic esophageal cancer in which R0 resection was achieved by salvage esophagectomy with pancreatectomy, but relapse occurred in the early postoperative phase.

PRESENTATION OF CASE: A 64-year-old man with lower intrathoracic esophageal cancer received chemoradiotherapy, and a complete response was achieved. Subsequently, however, lymph node relapse, with infiltration into the pancreas, was observed. Thus, subtotal esophageal resection, total gastrectomy, distal pancreatectomy, and splenectomy were performed. Hepatic relapse occurred 7 months after the surgery, and the patient died 18 months after the surgery.

DISCUSSION: The surgical risk of salvage surgery is considered to be extremely high, however selected patients may benefit from highly invasive procedures. In this case, despite R0 resection was achieved by salvage esophagectomy with pancreatectomy, a relapse occurred in the early postoperative phase. The treatment outcome of esophageal cancer patients with infiltration into the pancreas was not favorable.

CONCLUSIONS: Because the risk of postoperative complications and relapse is high in patients with advanced esophageal cancer undergoing esophagectomy with pancreatectomy, the applicability of surgery needs to be carefully considered.

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1. Introduction

The effectiveness of salvage surgery for local recurrence after definitive chemoradiotherapy (CRT) for esophageal cancer remains unclear. However, surgical excision is the only curative modality and several studies have reported the effectiveness of salvage surgery for local recurrence after definitive CRT [1–4].

Here, we describe a case of thoracic esophageal cancer in which a complete response (CR) was achieved after chemoradiotherapy, but lymph node recurrence, with infiltration into the pancreas occurred. Although R0 resection was accomplished by salvage esophagectomy with pancreatectomy, a relapse occurred in the early postoperative phase.

This work has been reported in line with the SCARE criteria [5].

2. Presentation of case

A 64-year-old man presented with a chief complaint of difficulty with swallowing. He had a history of prostate cancer. The patient's lifestyle included approximately 360 mL sake and 350 mL beer consumption per day, and 20 cigarettes per day for the past 20 years. Upper gastrointestinal endoscopy showed geographic esophageal 0-IIc lesions at 25 cm and 30 cm from the incisors; moreover, a type-2 lesion was observed 35–40 cm from the incisors (Fig. 1a–c). A biopsy confirmed squamous cell carcinoma. On contrast-enhanced computed tomography (CT), the primary lesion in the lower thoracic part of the esophagus demonstrated thickening of the wall all around it. Metastasis was observed in lymph nodes along the right recurrent nerve, left gastric artery, lesser curvature, and around the abdominal aorta. There was a possibility of lymph node infiltration into the pancreas at the lesser curvature lymph node (Fig. 2a). Fluorodeoxyglucose-positron emission tomography (FDG-PET) showed increased FDG uptake in the primary lesion and the lymph node along the left gastric artery (Fig. 2b). The patient was diagnosed with lower intrathoracic esophageal cancer T3N2M1 (LYM) Stage IV (seventh edition of the Union for International Cancer Control system).

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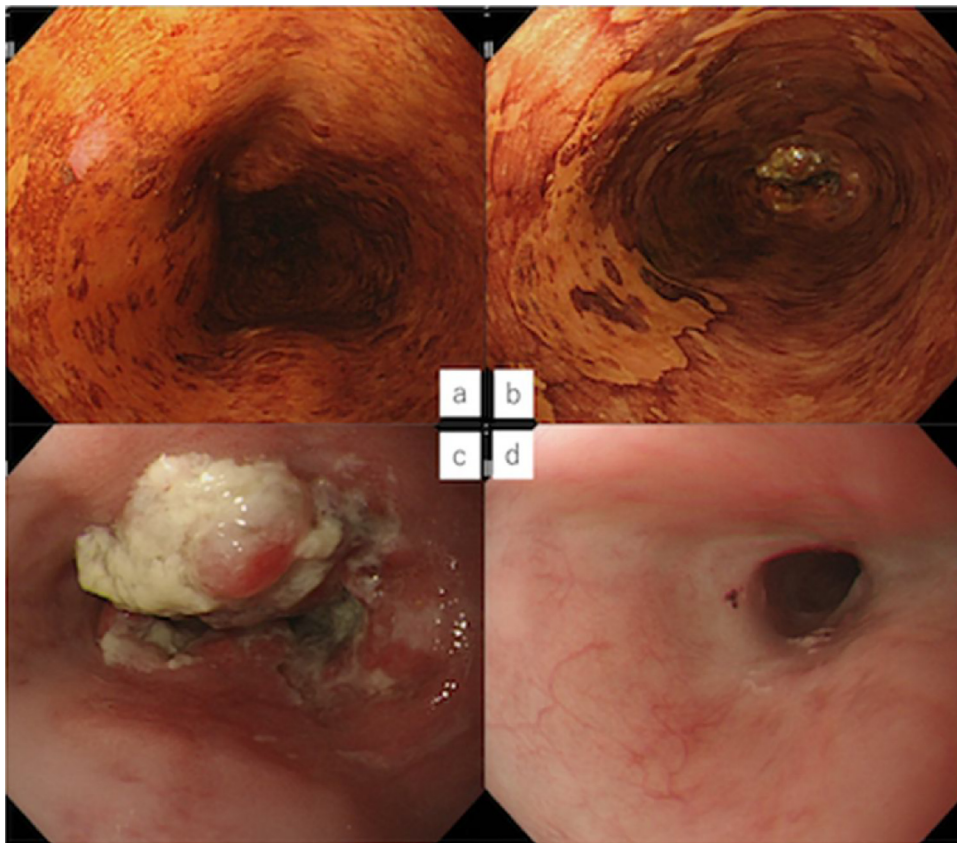


Fig. 1. Esophagoscopy prior to treatment, showing superficial esophageal tumors (a) 25 cm and (b) 30 cm from the incisors. (c) A 70-mm-long protruding lesion on the right wall of the esophagus, 36–43 cm from the incisors. (d) After docetaxel, CDDP, and 5-FU (DCF) therapy, and chemoradiotherapy (CRT), these lesions disappeared, and the outcome was rated as a complete response (CR).

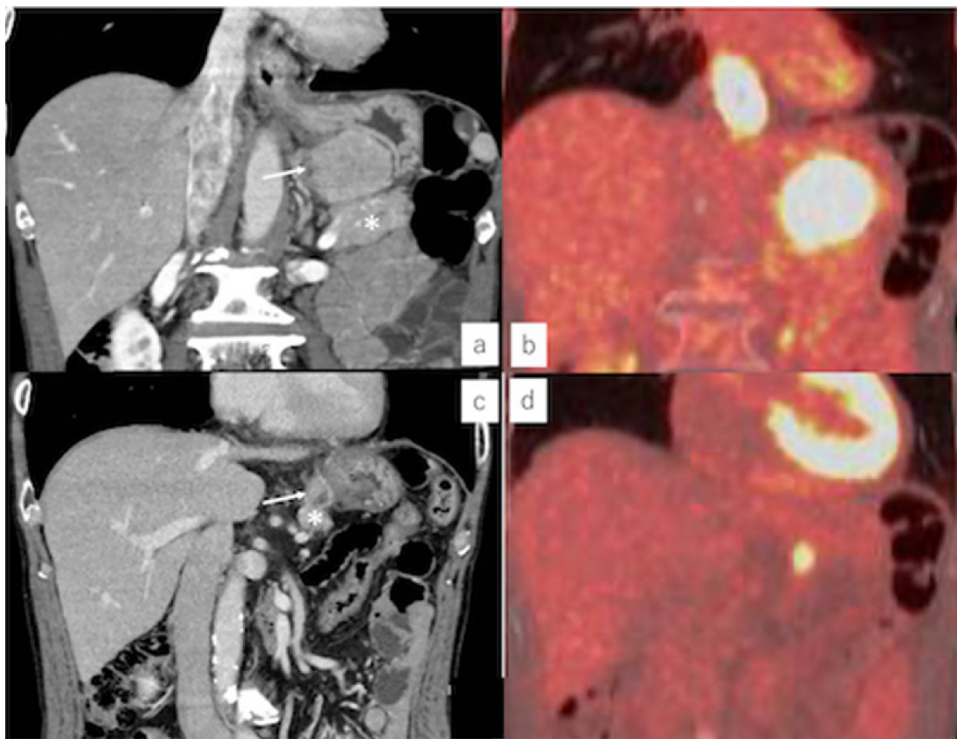


Fig. 2. (a) Computed tomography (CT) showed a 65 mm swollen lymph node invading the pancreas (*) and stomach at the lesser curvature of the stomach (indicated by an arrow). (b) Positron emission tomography (PET)-CT showing fluorodeoxyglucose (FDG) uptake by the lymph node. (c) After DCF and CRT, the invasion to the stomach and pancreas was unclear, (d) but the lymph node displays FDG uptake.

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