



Contents lists available at ScienceDirect

International Journal of Surgery Case Reports

journal homepage: www.casereports.com

Curative two-stage resection for synchronous triple cancers of the esophagus, colon, and liver: Report of a case



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ARTICLE INFO

Article history:

Received 9 April 2015

Received in revised form 27 April 2015

Accepted 25 May 2015

Available online 30 May 2015

Keywords:

Esophageal cancer

Synchronous triple cancers

Two-stage operation

ABSTRACT

INTRODUCTION: Cases of synchronous triple cancers of the esophagus and other organs curatively resected are rare.

PRESENTATION OF CASE: A 73-year-old man was admitted to our hospital with bloody feces. He was diagnosed with synchronous triple cancers of the esophagus, colon, and liver. We selected a two-stage operation to safely achieve curative resection for all three cancers. The first stage of the operation comprised a laparoscopy-assisted sigmoidectomy and partial liver resection via open surgery. The patient was discharged without complications. Thirty days later, he was readmitted and thoracoscopic esophagectomy was performed. Although pneumonia-induced pulmonary aspiration occurred as a postoperative complication, it was treated conservatively. The patient was discharged on postoperative day 24.

DISCUSSION: Esophagectomy is a highly invasive procedure; thus, simultaneous surgery for plural organs, including the esophagus, may induce life-threatening, severe complications. Two-stage surgery is useful in reducing surgical stress in high-risk patients. For synchronous multiple cancers, the planning of two-stage surgery should be considered for each cancer to maintain organ function and reduce the stress and difficulty of each stage.

CONCLUSION: We successfully treated synchronous triple cancers, including esophageal cancer, by a two-stage operation.

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1. Introduction

Reports of synchronous multiple cancers have been increasing due to prolonged lifespan and improvements in diagnostic techniques [1,2]. The incidence of multiple cancers of the esophagus and other organs is reported to range from 9.5% to 20.7% [3–6]. Head and neck squamous cell carcinoma and gastric adenocarcinoma are most frequently observed as multiple primary cancers of other organs in esophageal cancer patients [7,8]. In Japan, the surgical procedure for thoracic esophageal cancer generally comprises subtotal esophagectomy with three-field lymphadenectomy; dissection of the mediastinal, abdominal, and cervical lymph nodes; and gastric tube reconstruction [9]. However, this is an extremely invasive procedure with a high mortality rate. Surgery for multiple cancers of other organs with esophagectomy is a highly complicated procedure. In addition to esophageal cancer surgery, for example, simultaneous total gastrectomy for synchronous gastric

cancer requires reconstruction of the colon with the addition of total pharyngolaryngoesophagectomy for synchronous head and neck cancer. It has been reported that two-stage surgery was both useful and safe for high-risk patients with esophageal cancer [10]. Therefore, a two-stage procedure may be suitable for complicated surgery for synchronous cancers of the esophagus and other organs. Cases of synchronous triple cancers of the esophagus and other organs are rare [1,7]. Here, we describe a case of synchronous triple cancers of the thoracic esophagus, sigmoid colon, and liver successfully treated with a two-stage operation.

2. Case report

A 73-year-old man was admitted to a local hospital with bloody feces. A barium enema revealed two tumors in the sigmoid colon (Fig. 1A). Endoscopic biopsy of both tumors revealed moderately differentiated adenocarcinoma. A screening esophagogastroscope to search for other gastrointestinal lesions showed a superficial elevated lesion with a surrounding Lugol-voiding lesion from 27 cm to 30 cm below the incisor (Fig. 2A). A diagnosis of poorly differentiated squamous cell carcinoma was histologically confirmed.

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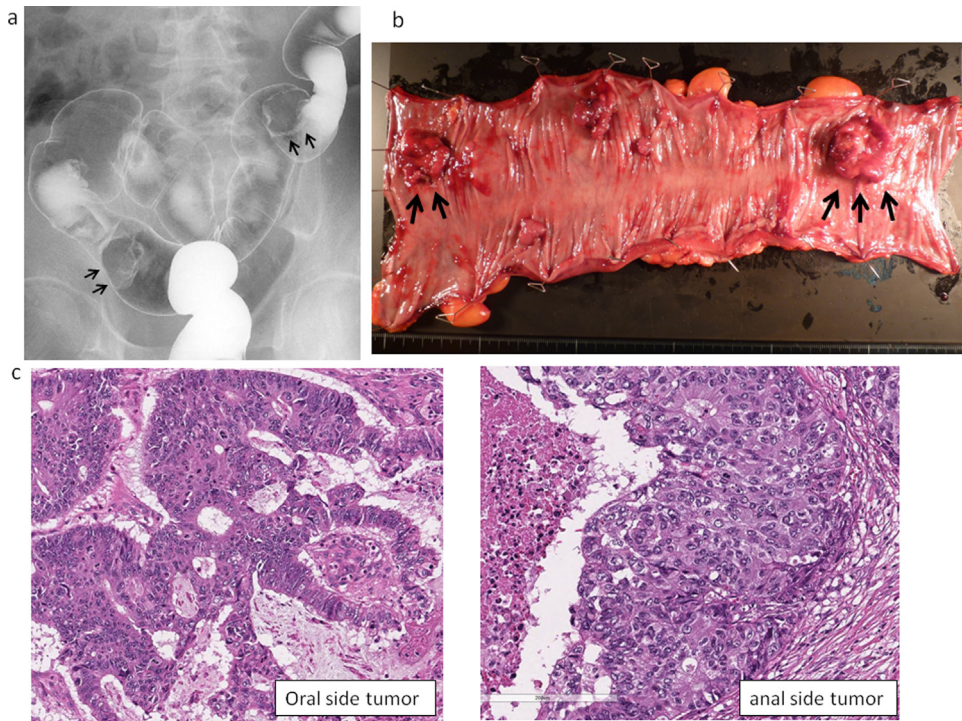


Fig. 1. (a) Barium enema showed two tumors as defects in the sigmoid colon (arrows). (b) Surgical specimen of the sigmoid colon (arrows). (c) Pathological specimen from the sigmoid colon showed a moderately differentiated adenocarcinoma.

Computed tomography (CT) showed no evidence of lymph node involvement for the esophageal cancer, but revealed lymph node metastasis from the sigmoid colon cancer. A CT scan during hepatic arteriography showed a high-density area of 7 cm in diameter on subsegments 4 (S4) and 8 (S8), which was diagnosed as hepatocellular carcinoma (HCC) (Fig. 3A). The laboratory data were

as follows: WBC count, 6890/mm³; RBC count, 442 × 10⁴/mm³; hemoglobin, 13.9 g/dL; platelet count, 204 × 10³/mm³; prothrombin time, 97%; albumin, 4.2 g/dL; total bilirubin, 0.3 mg/dL; and indocyanine green retention rate at 15 min, 12%. The hepatitis markers were negative. The prothrombin induced by vitamin K absence or antagonist II level was 2016 mAU/mL, alpha-fetoprotein

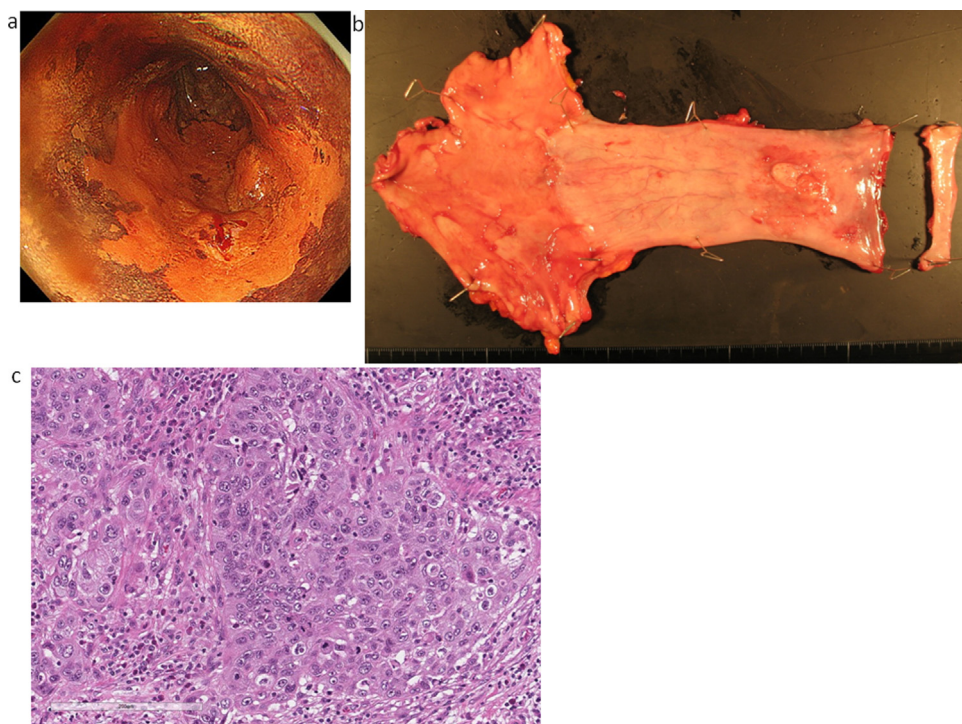


Fig. 2. (a) Esophagogastroscopy revealed a superficial elevated lesion with a surrounding Lugol-voiding lesion from 27 cm to 30 cm below the incisor. (b) Surgical specimen of the esophagus. (c) Pathological examination of a specimen from the esophagus showed poorly differentiated squamous cell carcinoma.

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