

Atypical Esophageal Metastasis in the Thoracic Wall

Metastização Esofágica Atípica na Parede Torácica

Keywords: Esophageal Neoplasms; Thoracic Neoplasms/secondary; Thoracic Wall

Palavras-chave: Neoplasias Esofágicas; Neoplasias Torácicas/secundárias; Parede Torácica

Dear Editor,

Esophageal adenocarcinoma (ADC) carries a particularly poor prognosis, with nearly half of the cases presenting with metastasis at the time of diagnosis.¹ While subcutaneous metastases originating from esophageal cancer (EC) are relatively rare, occurring in only 0.7% to 9% of cases, reports of such occurrences,¹⁻⁵ especially involving the chest wall, remain sparse.

The authors present the case of a 57-year-old man, a non-smoker with a history of bariatric surgery performed 14 years prior. He presented to the emergency department with a two-month history of progressive swelling in the right infra-axillary region, accompanied by anorexia, asthenia, and unspecified weight loss. Additionally, he reported dyspnea with minimal exertion and thoracic pain in an upright position. Physical examination revealed a sizable, indurated mass in the right thoracic wall, adherent to deep tissue planes (Fig. 1A). Laboratory investigations showed normocytic normochromic anemia, elevated lactate dehydrogenase, C-reactive protein, and type 1 respiratory failure.

The patient was admitted to the Pulmonology Department with a suspected diagnosis of thoracic neoplasia, possibly a sarcoma. The thoracoabdominal computed tomography (CT) scan confirmed a soft tissue large mass, 18 cm in diameter, heterogeneous, with intra- and extra-thoracic components, causing destruction of rib arches and right lung collapse (Fig. 1B). Additionally, there was a thickening of the wall in the distal portion of the esophagus, prompting the performance of an upper gastrointestinal endoscopy. This test revealed an ulcerated invasive

neoplasm, occupying more than 75% of the lumen, in the distal esophagus and esophagogastric junction. The histopathology of the esophageal biopsies was consistent with ADC, with expression of AE1/AE3 and with negative p63, TTF-1, GATA-3. A percutaneous thoracic biopsy was also performed. The histopathological examination confirmed a metastasized esophageal ADC to the chest wall. Staging with FDG PET-CT and brain CT demonstrated a fluorodeoxyglucose (FDG) avid parietal thickening centered on the lower third of the thoracic esophagus (qSUVmax: 17.0) with extensive metastatic disease involving: bone (5th left rib, qSUVmax: 13.7), nodal (right paraesophageal adenopathy, qSUVmax: 5.9) and soft tissue sites (a large mass on the right thoracic wall, qSUVmax: 17.0).

Despite the multidisciplinary efforts and the initiation of palliative chemotherapy, the patient's clinical condition deteriorated rapidly, culminating in his death two weeks later.

This case underscores the rare occurrence of chest wall metastasis from EC, highlighting the importance of heightened clinical awareness and vigilance in diagnosis and management. However, it should be stressed that the risk of late diagnosis is real, especially when symptoms are atypical, which in the presented case made any effective treatment impossible in a relatively young patient.

AUTHOR CONTRIBUTIONS

SRL: Conception and writing of the manuscript.

MB, CG, IV, SV: Data analysis and critical review of the manuscript.

All authors approved the final version to be published.

PROTECTION OF HUMANS AND ANIMALS

The authors declare that the procedures were followed according to the regulations established by the Clinical Research and Ethics Committee and to the Helsinki Declaration of the World Medical Association updated in 2013.

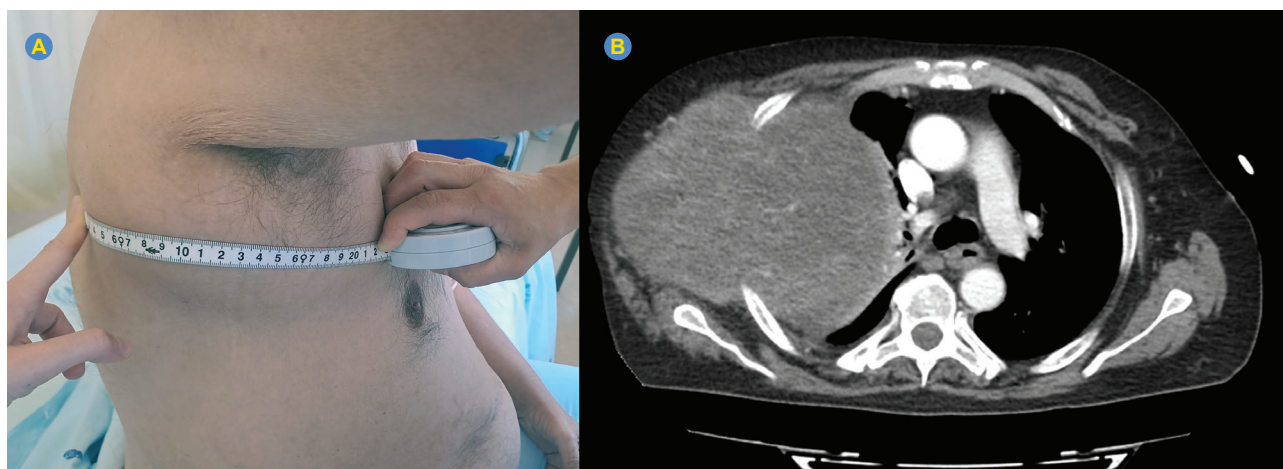


Figure 1 – Physical examination: large, indurated mass in the right thoracic wall, adherent to deep tissue planes (A). Thoracoabdominal CT scan: a large mass of soft tissues, 18 cm in size, heterogeneous, with intra and extra-thoracic components, causing destruction of rib arches and right lung collapse (B).

DATA CONFIDENTIALITY

The authors declare having followed the protocols in use at their working center regarding patients' data publication.

PATIENT CONSENT

Obtained.

COMPETING INTERESTS

The authors have declared that no competing interests exist.

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