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Case Report
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A Case Report on Gastroesophageal Junction Tumor with Scalp Metastasis

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Introduction

Primary tumors that metastasize to the skin are in descending order of frequency, lung, breast, and rectal cancer. Metastases from esophageal malignancy to the skin are considered to be even rarer. However, cases of cutaneous metastases in their majority from squamous cell carcinoma of the esophagus have been reported [1,2]. They mostly affect patients aged over 60 years old appearing with asymptomatic nodules [2]. The skin lesions may be observed in different locations of the human body [3].

Cancer of the stomach and Gastroesophageal Junction (GEJ) constitutes a major health problem worldwide. Esophageal carcinoma accounts for approximately 6% of all gastrointestinal malignancies.

Peak age is between 60 and 80 years. Whereas distal gastric cancers account for the overall decrease in gastric cancer, tumors in the proximal stomach (cardia and GEJ) are on the rise [4,5].

For lower esophageal and gastroesophageal junctional adenocarcinomas, approximately 70% of patients will have nodal metastases at presentation.

The most common pattern of esophageal cancer metastases is to the lymph nodes, lung, liver, bones, adrenal glands, and brain. On the other hand, unexpected metastasis spread to uncommon sites has increasingly reported and consequently affected the pathway of diagnosis, staging, and management. Metastases were disseminated toward five main anatomical sites: The head and neck (42%), thoracic (17%), abdomen and pelvis (25%), extremities (9%), and multiple skin and muscle metastases (7%). The esophageal metastases were found to be synchronous 42% and metachronous 58%, isolated in 53.5% and multiple in 46.5% [3].

Cutaneous metastasis of esophageal cancer, in particular esophageal adenocarcinoma, cutaneous manifestations occur in less than 1% [6].

We presenting a case of carcinoma esophagus lower one third involving gastroesophageal junction with metastasis to scalp (frontoparietal region) which is proved histologically.

Case Presentation

A 52-years old male resident of Ranchi, married with 3 children's farmer by occupation, known tobacco chewer for 10 years. No any significant family history, non-hypertensive and non-diabetic., no any history of blood transfusion as of now patient takes liquid diet with difficulty associated with chest pain during deglutition after one month of this complaint patient started complaint of a swelling over frontoparietal region of head initially the size of the swelling 3 cm × 2 cm in a span of 20 days size of the swelling increased and also there is a pus discharging sinus with multiple tiny nodules surrounding the lesion. Patient had complaints of loss of appetite and loss weight. Upper gastrointestinal tract endoscopy showed gastroesophageal neoplastic stenotic junction, biopsy-adenocarcinoma (Figure 1) CECT whole abdomen showed heterogeneously enhancing asymmetrical circumferential thickening (max - 14 mm) is seen involving gastroesophageal junction, cardia and fundus of stomach. Air fluid level is noted in proximal esophagus. Few necrotic lymph nodes are seen in peri-gastric, periportal and splenic hilum region. Multiple enlarged hypo enhancing retroperitoneal and aortocaval lymph nodes are seen largest – 14.0 mm. Peripherally enhancing soft tissue is seen in right psoas muscle? deposits. Mild ascites seen with omental stranding's in right iliac region? Deposits few serosal and nodular peritoneal deposits are also seen (Figure 2). FNAC (Figure 3) from scalp lesion positive for malignancy – metastatic adenocarcinoma.

Hence a diagnosis of CA esophagus (lower one third with GE junction involvement, sievert

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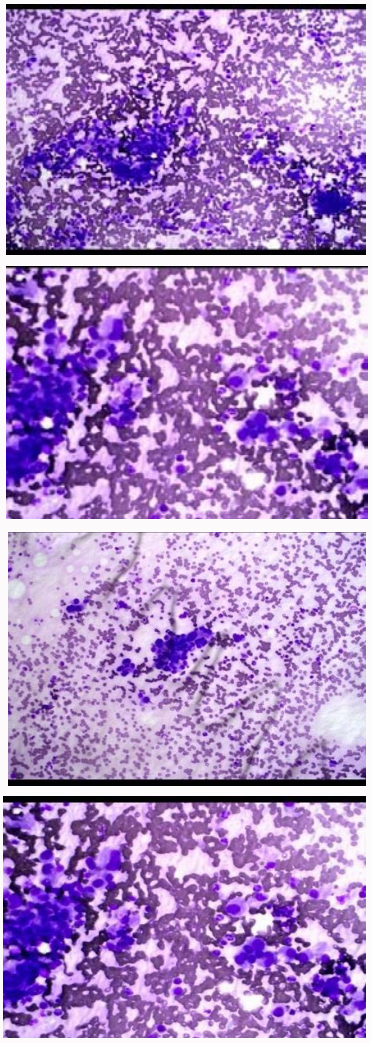

Figure 1: FNAC: Smears from scalp lesion are cellular and show few clusters, sheets and acini as well as singly scattered atypical cells on a hemorrhagic background. These atypical cells are moderately to markedly pleomorphic showing nucleomegaly with coarse chromatin and inconspicuous to conspicuous nucleoli with moderate amount of cytoplasm showing vacuolation at places. Few binucleated and multinucleated cells seen along with interspersed scattered few benign squamous epithelial cells.

type -2) was made and patient has been started on chemotherapy (Tab. Capecitabine and Inj. Oxaliplatin). He received 2 cycles of chemotherapy (last in Nov), further treatment didn't continue due to some financial crisis, and the patient died after 4 months of last chemotherapy cycle in march 2021).

Discussion

Cutaneous metastases are rare. They consist of 0.5% to 9% of metastatic tumors in total [7]. Incidence of all cutaneous metastases originated from esophageal carcinomas, including adenocarcinomas and squamous cell carcinomas of the esophagus, was 1% [8]. In most cases, metastases to the skin are considered to be a poor prognostic factor due to the aggressiveness of the disease. As a result, median survival has been reported to be 4.7 months [9]. According to literature, the average time of occurrence of the metastatic disease was estimated to be approximately 2.9 years after the onset of the primary tumor [7].

Esophageal adenocarcinoma may metastasize to various tissues

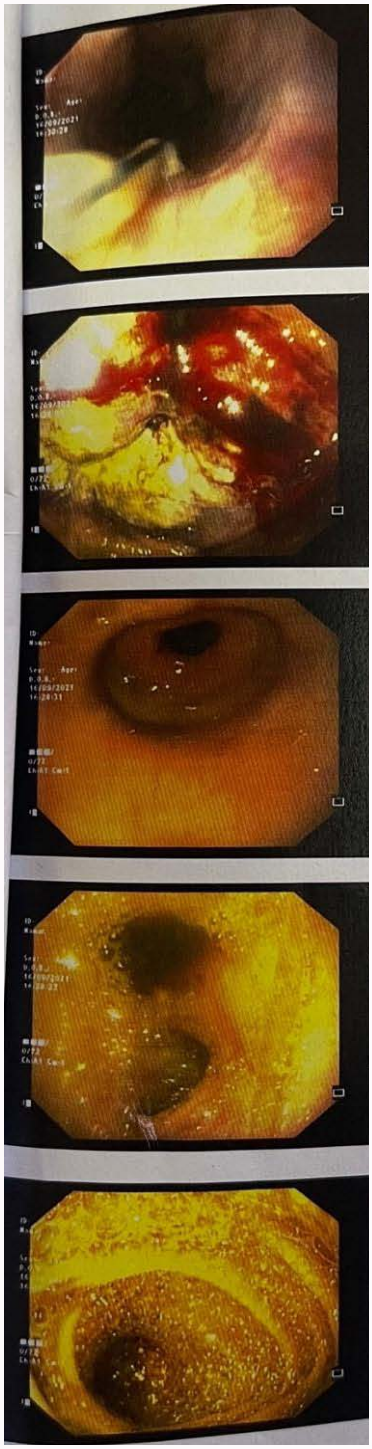

Figure 2: UGIE:
Esophagus: GE junction at 40cm-An exophytic ulceroproliferative mass lesion seen extending from GE junction further into the funds of stomach.
Stomach: Funds: An exophytic ulceroproliferative mass lesion with overlying slough and overhanging edges (approx. 2.5 cm × 2 cm) noted in funds. Mild ooze was seen from lesion.

of the human body. Most frequently esophageal adenocarcinoma metastasizes to the liver, lungs, and brain. On the other hand, metastases to the skin from esophageal primary tumors are less common. Cases of patients with metastases to the skull, the upper lip, the scalp, neck, chest, and abdominal wall have been reported [10]. Metastatic skin lesions are often asymptomatic.

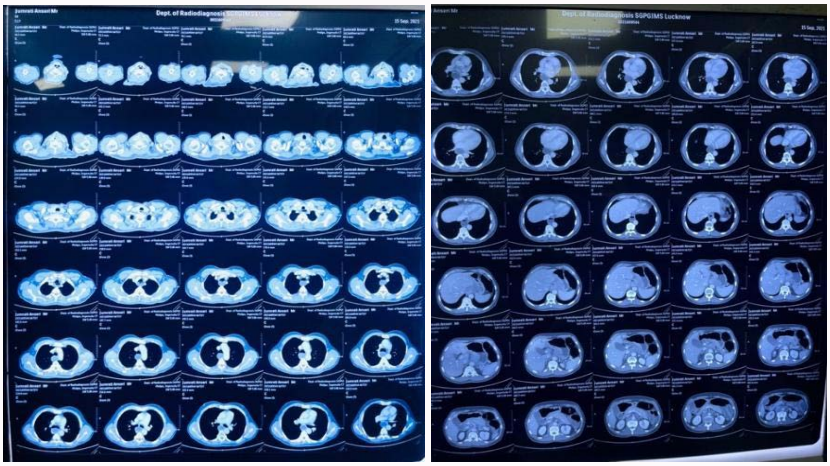

Figure 3: CECT images.

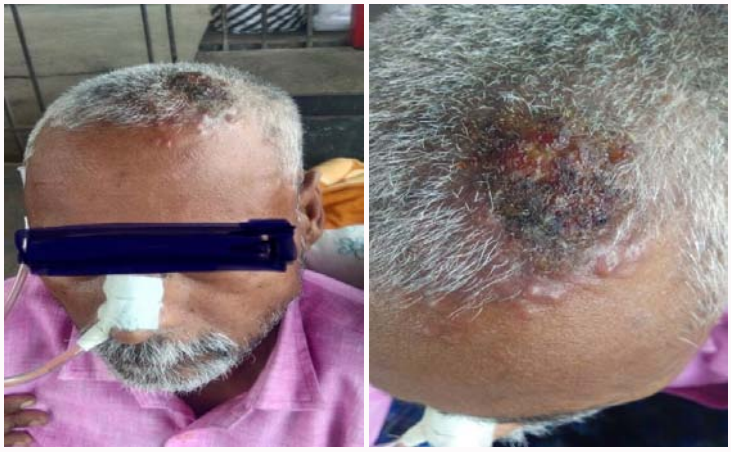

Figure 4: Image of the metastatic lesion over the scalp.

Table 1: Published case reports of esophageal carcinoma metastasized to skin.

Case report	Age	Histology	Site	Treatment
Iwanski et al. [11]	51	Adenocarcinoma	Disseminated skin nodules	Palliative chemotherapy
Stamatina et al.	60	Adenocarcinoma	Rt arm	Sx, adj. CTRT
Riley [12]	81	Adenocarcinoma	back	Sx only
Smith et al. [13]	61	Adenocarcinoma	trunk	NACT, RT, SX
Silfn et al. [14]	75	scc	Scalp and trunk	CT only

Furthermore, the majority of the cases concern cutaneous metastases from primary tumors located in the lower third of the esophagus. More precisely, most of the primary tumors that develop at or near the gastroesophageal junction arise from Barrett's esophagus, as a complication of chronic gastro-esophageal reflux disease [1,14] (Table 1).

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