Case Report

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Medical case reports

2016
Vol.2 No.1:11

Elderly Man Presenting with Dysphagia and Weight Loss: A Case Report

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Received: Dec 19, 2015; **Accepted:** Jan 21, 2016; **Published:** Feb 01, 2016

Abstract

Introduction: This case report demonstrated an unexpected event in the course of observing or treating a patient presented with dysphagia.

Case presentation: An 89-year-old gentleman was admitted for esophageal dysphagia, vomiting and weight loss. Despite presenting with typical symptoms of an esophageal carcinoma, he was not offered upper endoscopy, but rather, barium swallow and then acid suppression therapy was given. The diagnosis was only reached 3 months after initial symptom onset by a PET-CT showing a locally advanced esophageal carcinoma. The cancer was no longer amenable to surgery at the time of diagnosis.

Conclusion: This case report demonstrated the importance of a timely upper endoscopy when esophageal cancer was a likely diagnosis. It carries major impact on primary care physicians who serve as the first tier in managing patients with 'red flag' features.

Keywords: Carcinoma of esophagus; Dysphagia; Upper endoscopy; Barium swallow

Introduction

This case report describes an elderly man who had alarming symptoms of carcinoma of esophagus but the diagnosis was unfortunately delayed owing to false reassurance by a normal barium swallow.

Case Presentation

An 89-year-old gentleman was admitted for dysphagia, repeated vomiting and weight loss for 3 months. He has history of indolent carcinoma of prostate, benign prostatic hypertrophy, ischemic stroke with good recovery and hypertension. He had dysphagia and vomited undigested food every time immediately after meal. He lost 5 kg over the past months. He was investigated with barium swallow by a general practitioner, which showed no abnormality. He was diagnosed to have gastro-esophageal reflux disease but he failed to respond to proton pump inhibitor and Helicobacter pylori eradication therapy. He was admitted to hospital. Initial physical examination and computated tomography of brain were unremarkable. Blood tests were unremarkable apart from hypoalbuminaemia (albumin: 33 g/L, normal 39-50 g/L). Serum tumour markers including prostatic specific antigen were all normal. Positron emitted tomography (PET) CT showed a large circumferential midthoracic oesophageal malignancy (5.6 cm with SUV 29.4) with multiple regional lymphadenopathies (**Figure 1a and 1b**) without distant metastasis. Subsequently an upper endoscopy confirmed a 7 cm long mid esophageal necrotic growth (**Figure 1c**), and biopsy showed poorly differentiated carcinoma. Nasogastric tube was inserted during upper endoscopy for feeding in view of progressive dysphagia. The diagnosis of a locally advanced carcinoma of esophagus was reached more than 3 months since initial symptom onset. The tumour was unresectable and he was treated with radiotherapy.

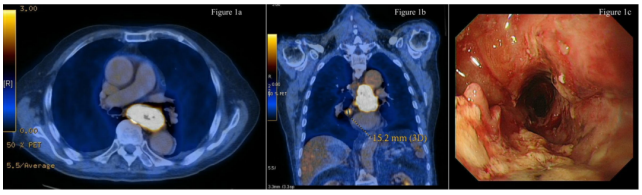

Figure 1 (a) PET-CT (transverse section) showing uptake in mid-thoracic esophagus. (b) PET-CT (coronal reconstruction) showing regional lymphadenopathies. (c) upper endoscopy showing mid esophagus irregular growth occupying more than 50% of circumference.

Discussion

Carcinoma of esophagus carries poor survival if it is not surgically resectable. According to the American Cancer Society, the 5-year survival rate for regional carcinoma of esophagus was only 21% [1]. Dysphagia is common in older adults, affecting up to 15% of this population [2]. When facing a patient with dysphagia, one must always look for mechanical cause especially if alarm symptoms i.e. 'red flag' features are

present, which include anorexia with weight loss, progressive rather than intermittent dysphagia, vomiting and symptoms related to gastrointestinal tract blood loss. The first step in evaluating patients with dysphagia is careful history taking to determine if the symptoms are due to oropharyngeal or esophageal dysphagia [3]. Oropharyngeal or transfer dysphagia is characterized by difficulty initiating a swallow, while esophageal dysphagia is characterized by difficulty swallowing several seconds after initiating a swallow and a sensation of food getting stuck in the esophagus. A retrospective analysis in 2005 demonstrated that all patients with esophageal dysphagia should be referred for an upper endoscopy [4,5]. Barium swallow as the sole diagnostic test for dysphagia should only be considered when upper endoscopy is deemed dangerous to cause esophageal perforation, e.g. in patients with known stricture, prior radiotherapy to neck or chest region, or known Zenker's diverticulum. It could supplement diagnostic information after upper endoscopy, which was negative for anatomical lesion, or to further evaluate for mucosal lesions found at endoscopy. Performing a barium swallow prior to an upper endoscopy in such patients has not been demonstrated to decrease the rate of endoscopic complications or improve outcomes; moreover, biopsy of an esophageal lesion during endoscopy could not be achieved if he received barium swallow instead. The initial normal barium swallow resulted in a false reassurance, thus the general practitioner did not offer upper endoscopy to the patient and the diagnosis was then delayed.

Conclusion

This case presented with esophageal dysphagia together with 'red flags': advanced age and weight loss. These 'red flags' were alarming features of an underlying esophageal anatomical lesion. He should be promptly referred for an upper endoscopy upon initial presentation instead of performing barium swallow. Even if the barium swallow was normal, upper endoscopy should still be performed. Diagnosis could have been made earlier if upper endoscopy was done upon initial presentation. This case demonstrates the importance of choosing the correct investigation in a patient present with dysphagia.

Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images.

Competing Interests

The authors declare that they have no competing interests

Authors' Contributions

LY Mak was responsible for acquisition of patient's clinical details and writing of this case report. TC Chan was the treating doctor, who also contributed in writing of this case report. HW Chan was a contributor in writing this case report.

Acknowledgement

It is acknowledged that all authors have contributed significantly and that all authors are in agreement with the content of the manuscript.

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