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Clinical Image

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Esophageal Squamous Cell Carcinoma in Achalasia Cardia

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66-year-old white male was admitted with history of nonproductive cough and hematemesis, consisting of fresh blood and clots. Past medical history was notable for superficial transitional cell cancer of the bladder, rheumatoid arthritis treated with immunosuppressive therapy and achalasia correction 20 years earlier. He had scant smoking history and no alcohol use. CT scan revealed a large mass in the middle third of a dilated esophagus (Figure 1). Esophagogastroduodenoscopy confirmed a large mass in the middle third of the esophagus and biopsy confirmed squamous cell carcinoma (Figure 2). Radiation therapy with concurrent chemotherapy was administered.

Achalasia is a rare primary esophageal motor disorder characterized by loss of esophageal peristalsis and insufficient lower esophageal sphincter relaxation in response to deglutition. This results from loss of inhibitory myenteric neurons due to loss of ganglions in myenteric plexus. Achalasia is a well-established risk factor for esophageal cancer, especially squamous cell cancer [1]. Chronic inflammation from food stasis predisposes esophageal mucosa to dysplastic changes and cancer. These cancers are delayed in onset (mean of 11.3 years from myotomy or dilatation), more often involves middle third of esophagus and often locally advanced at the time of diagnosis and associated with poor survival [2]. Surveillance for esophageal cancer is not recommended presently. Cost effectiveness and utility of surveillance program are still not established. Increased need for intervention and age have been identified as risk factors for development of esophageal cancer [3].

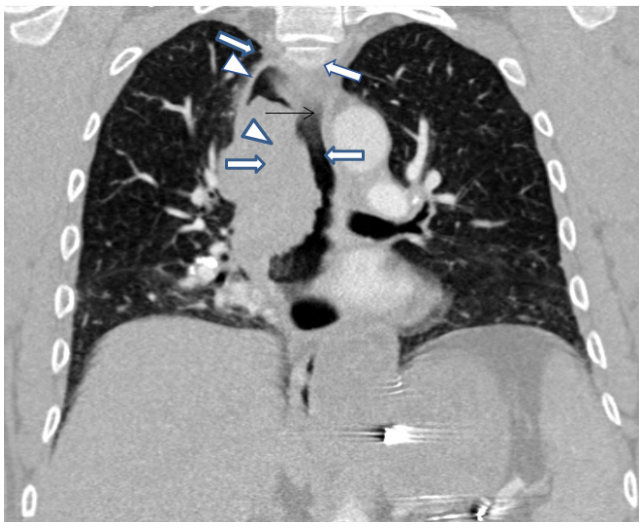

Figure 1: Coronal reformatted image from contrast enhanced chest CT. Esophageal mass is demonstrated with superior and inferior extent indicated by white arrowheads. Dilated esophageal lumen is shown both proximal and distal to the mass (white arrows). Lumen remains patent at the level of the mass (thin black arrow), despite the large size of the mass.

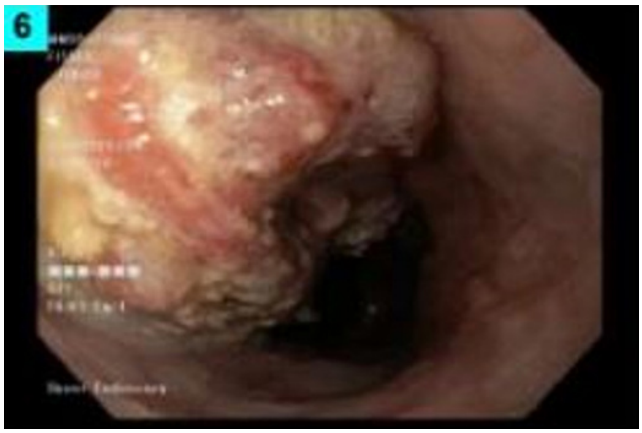

Figure 2: EGD revealing large malignant appearing mass without active bleed.

Patients with symptom recurrence should be carefully evaluated for development of esophageal cancer.

Conflict of Interest

The authors declare no competing interests.

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References

1. Torres-Aguilera M, Remes Troche JM. 2018. Achalasia and esophageal cancer: risks and links. *Clin Exp Gastroenterol* 11: 309-316. https://doi.org/10.2147/CEG.S141642
2. Streitz JM, Ellis FH, Gibb SP, Heatley GM. 1995. Achalasia and squamous cell carcinoma of the esophagus: analysis of 241 patients. *Ann Thorac Surg* 59(6): 1604-1609. https://doi.org/10.1016/0003-4975(94)00997-l
3. Markar SR, Wiggins T, MacKenzie H, Faiz O, Zaninotto G, et al. 2019. Incidence and risk factors for esophageal cancer following achalasia treatment: national population-based case-control study. *Dis Esophagus* 32(5): 106. https://doi.org/10.1093/dote/doy106