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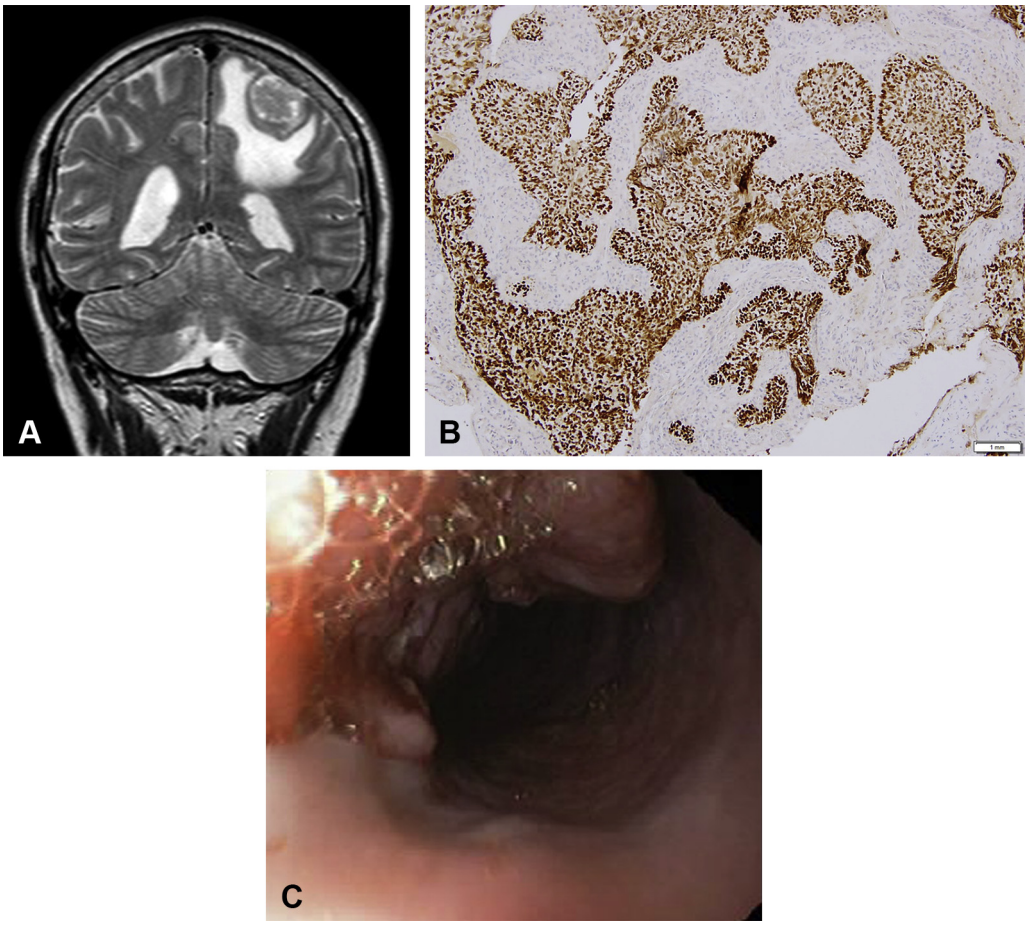
Frontal lobe lesion at brain CT as initial presentation of esophageal cancer



A 55-year-old man was admitted to the emergency department because of decreased strength in his right limbs for 2 days. The only relevant information regarding his personal history was his daily alcohol intake of 80 g. On neurologic examination, he had nystagmus in all directions of gaze, right hemiparesis (grade 4), and hemihypoasthesia. A brain CT scan showed a space-occupying lesion in the left frontal lobe with vasogenic edema, conditioning a right midline shift. A brain MRI favored the hypothesis of secondary brain tumor (**A**), although the thoracoabdominal-pelvic CT scan showed normal results. The patient underwent resection of the left frontal lobe lesion, with recovery of neurologic deficits. Histologic examination of the specimen revealed metastasis of squamous cell carcinoma, with immunocytochemistry showing expression of p63 in cancer cells (**B**). In the meantime, the patient developed dysphagia, and esophagogastroduodenoscopy revealed an irregular and ulcerated esophageal lesion between 30 and 35 cm from the incisors (**C**). Histologic examination of biopsy specimens revealed a squamous cell carcinoma. This is a rare case of brain metastasis/neurologic symptoms as the initial presentation of esophageal cancer.

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Commentary

Although esophageal cancer is one of the 10 most common types of cancer worldwide, it represents only 1.0% of all new cancer cases in the United States. Humphrey Bogart, the American screen actor of the iconic film *Casablanca*, was a victim of this neoplasia, which is highly lethal; in fact, the number of deaths almost matches the number of new cases. Diagnosis is challenging, given that dysphagia, the typical presenting symptom, occurs when two thirds of the lumen is occluded. This leads to a delayed diagnosis, which is usually made in stages III and IV, resulting in poor survival. Distant metastasis is the main cause of morbidity and mortality in cancer patients. Although esophageal cancer metastases occur mainly to regional lymph nodes, solid viscera such as liver, lungs, and bones can also be involved. Brain involvement is extremely rare. According to published reports in Japan, the incidence of central nervous system (CNS) metastasis from esophageal cancer is 1.5%. Its development has been found to be related to increased tumor size. Documented mechanisms include invasion through the lymphatics or the bloodstream, through the vertebral venous system. The clinical presentation depends on the location and size of the tumor within the CNS, as shown in this patient. This case reveals that esophageal cancer can be an asymptomatic condition from the GI standpoint. Clinicians should be aware of this unusual metastatic pattern of squamous cell esophageal carcinoma.

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Spontaneous intramural esophageal dissection successfully treated by endoscopic needle-knife incision

An 18-year-old man with no significant medical history presented with a week-long history of retrosternal chest pain and dysphagia. There was no history of dry retching, vomiting, or hematemesis. He had not recently undergone trauma or instrumentation. He had no relevant family history and denied the use of tobacco, alcohol, or illicit drugs. His physical examination, laboratory studies, electrocardiography, and chest radiograph revealed no abnormalities. A chest CT demonstrated 2 esophageal lumens with an intervening mucosal flap. There was no evidence of mediastinal free air to suggest an esophageal perforation. An upper GI series demonstrated the classic "double-barreled appearance" (**A**) of an intramural dissection extending from the cervical level to the level of the gastroesophageal junction with no extravasation of contrast medium. Upper endoscopy demonstrated a wide opening of a false lumen (**B**) 25 cm distal to the incisors and a pinhole defect shortly above the gastroesophageal junction. Because the patient had persistent dysphagia, an endoscopic incision (**C**) of the long septum between the 2 lumens was performed with a diathermy needle-knife papillotome. The patient had complete resolution of his symptoms and had no adverse events related to the procedure. He was subsequently discharged from the hospital and remained asymptomatic.

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