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TO STAGE OR NOT TO STAGE

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LEARNING OBJECTIVE 1: The available diagnostic tools may not always give accurate staging of a gastroesophageal tumor. This poses a staging dilemma in GE tumors.

CASE: 59 yr old Caucasian Male with no significant medical history presented with 4 month history of worsening dysphagia initially to solids which later progressed to liquids. He denied any nausea, vomiting, diarrhea, melena or blood in stool. He had noticed a 20 pound weight loss in last 3 months.

Patient was afebrile with normal blood pressure and heart rate. Patient looked cachectic and didn't have pallor, icterus or palpable lymphadenopathy. His abdomen was soft, non tender, non distended with normoactive bowel sounds. His stool occult blood was negative.

His CT Chest revealed moderate distension of esophagus with irregular wall thickening of GE junction and proximal stomach. CT Abdomen/Pelvis did not demonstrate any other lesions. No intra-abdominal lymphadenopathy or adenexal masses were noted. Patient underwent an endoscopy with EUS which demonstrated a T3 lesion of the gastroesophageal junction. Pathology confirmed a well differentiated adenocarcinoma. Patient underwent a diagnostic laparoscopy and J-tube placement. Liver biopsy showed

inflammatory mesenchymal cells with normal hepatic parenchyma and peritoneal fluid sampling didn't reveal signs of metastasis. PET scan did not reveal other areas of increased uptake. Based on the information, patient was diagnosed with Stage IIb adenocarcinoma of GE junction and was treated with neoadjuvant chemotherapy and was awaiting surgical resection.

Three days after chemotherapy, patient developed abdominal pain and hypotension, CT Abdomen/Pelvis revealed free air in the abdomen requiring exploratory laparotomy during which an inflamed appendix was visualized. Pathology of resected appendix confirmed metastatic adenocarcinoma. These findings changed his staging to Stage IV adenocarcinoma.

DISCUSSION: Adenocarcinoma of upper GI tract has increased 400 percent in the last 25 years in US. They commonly present with intraperitoneal metastasis, often difficult to diagnose. The current NCCN guidelines state all patients with adenocarcinoma of GE junction should get CT of Chest/Abdomen/Pelvis, PET scan and endoscopy with biopsy for staging of the tumor. There is grade B evidence for need of laproscopic evaluation for GE tumors. Our case, despite appropriate imaging, was staged incorrectly. Appropriate staging may have saved the patient from surgical trauma and complications but the treatment received would not have been affected.