Dysphagia: An Unusual Presentation of Metastatic Uterine Cervical Carcinoma

Anam Hameed1, Alexander A. Dekovich2, Phillip J. Lum2 and Mehnaz A. Shafi2

ABSTRACT
Worldwide, cervical cancer is the third most common cancer among women and the fourth leading cause of death from cancer. The most common sites of metastasis are the pelvic lymph nodes, vagina, and the pelvic sidewalls. Distant metastases are uncommon but can involve the bone, lung, and liver. Characteristics associated with increased rate of distant metastasis include bulky tumor, endometrial extension, lymph node involvement, and advanced disease. We report the case of a woman with stage II cervical carcinoma, who presented with dysphagia due to cervical cancer metastases to the mediastinum.

Key Words: Dysphagia. Distant metastasis. Cervical carcinoma.

INTRODUCTION
Worldwide, cervical cancer is the third most common cancer among women and the fourth leading cause of death from cancer.1 The most common sites of metastasis are the pelvic lymph nodes, vagina, and the pelvic sidewalls. Distant metastases are uncommon but can involve the bone, lung, and liver. Characteristics associated with increased rate of distant metastasis include bulky tumor, endometrial extension, lymph node involvement, and advanced disease.2

We report the case of a woman with stage II cervical carcinoma, who presented with dysphagia due to cervical cancer metastases to the mediastinum.

CASE REPORT
A 36-year Hispanic woman presented to the Gastroenterology Clinic with complaints of bloating, abdominal pain, constipation, and slowly progressive dysphagia for solids for the past 6 months. She complained of decreased bowel frequency to every 4 - 5 days associated with abdominal bloating. She did not have heartburn, odynophagia or hematochezia and was tolerating a soft diet. The patient had undergone two upper endoscopies and a colonoscopy at an outside hospital within the year. The first endoscopy (EGD) was reported to be normal. The second endoscopy noted an inlet patch in the esophagus and a hiatal hernia. Empirical esophageal dilatation was performed during this procedure without improvement in the patient’s symptoms. The colonoscopy was unremarkable. The patient, however, complained of progressive constipation with less than two bowel movements a week. She was, therefore, scheduled to undergo a gastrointestinal motility study by a wireless capsule (SmartPill) study. After swallowing the capsule, the patient developed acute dysphagia symptoms from impaction of the capsule in the esophagus. On emergent EGD, luminal narrowing with retained capsule was seen in the proximal esophagus. The capsule was removed endoscopically with a Roth net basket. After the removal of the capsule, the endoscope was reintroduced into the esophagus. Resistance to the passage of the endoscope was noted due to extrinsic compression in the proximal esophagus from 20 to 25 cm from the incisors. No intrinsic esophageal stricture or mass was present. A CT scan of chest was performed which showed thickening of the proximal esophagus with blurring of the mediastinal fat extending into the inferior portion of the neck (Figure 1). Barium swallow showed a

Figure 1: A CT chest showing thickening of the proximal esophagus with blurring of the mediastinal fat extending into the inferior portion of the neck.
narrowing involving the upper (T1-T3) and mid (T5-T7) thoracic esophagus (Figure 2). A small marshmallow became stuck in the esophagus at the level of T5-6 that was subsequently swallowed. No esophageal mass was seen.

The patient’s past medical history was significant for a stage IIA moderately differentiated squamous cell carcinoma of the uterine cervix, diagnosed 3 years earlier. She had received 5 cycles of cisplatin chemotherapy, 25 cycles of 45 Gray (Gy) radiation and 2 treatments of intra-cavitary brachytherapy. Subsequent follow-up investigations (pap smears, PET/CT scan for disease recurrence or metastasis and HPV assays for high risk HPV types) were negative. She had no evidence of disease for the past 2 years.

The patient underwent an ultrasound-guided biopsy of the mediastinal lymph nodes. Biopsy results of the subcarinal and right intralobar lymph nodes were positive for metastatic squamous cell carcinoma, consistent with a uterine cervical primary. The patient subsequently received 33 fractions of 60 Gray (Gy) intensity-modulated radiation therapy (IMRT). Her disease, however, progressed rapidly; she developed pancreatic and liver metastases, peritoneal disease and small bowel obstruction. She was transferred to hospice care and expired 3 months later.

DISCUSSION

Cervical cancer is the third most common cancer in women worldwide and the fourth leading cause of death from cancer.1 Risk factors include untreated HPV infections (HPV-16 and HPV-18 being the most common), a high number of live childbirths, long-term use of oral contraceptive pills, and cigarette smoking. None of these risk factors were present in this patient.

Disease recurrences occur mostly within 5 years after the initial diagnosis. Metastasis usually occurs in the pelvis via local extension or lymphatic dissemination. Most common sites for metastasis are the pelvic lymph nodes, vagina, and the pelvic side walls. Hematogenous route is rare and can affect the lung, liver, and the bone. In a study by Fagundes et al., the most common sites of distant metastasis were lung (21%), the para-aortic lymph nodes (11%), and the abdominal cavity (8%).3

Mediastinal metastases appear to be extremely rare. On review of literature, only a handful of cases have been reported with metastatic mediastinal lymphadenopathy from a primary cervical carcinoma.4-6 Paris et al. in 2010 documented a case similar to this patient. A 37-year-old female presented with complaints of epigastric pain and dysphagia for solids and liquids, vomiting, and weight loss. Upper endoscopy was consistent with stenosis at 34 cm from the dental arch. CT chest showed contrast enhancement in the middle and distal third of the esophagus. The lesion caused tight stenosis with dilatation of the upper proximal tract. Biopsy of the retrocarinal lymph node revealed metastatic squamous cell carcinoma consistent with primary cervix.4

In conclusion, a very rare manifestation of metastatic uterine cervical carcinoma is hereby reported, which presented with progressive dysphagia due to extrinsic compression of the esophagus from mediastinal metastases.

REFERENCES