Case Report

Superficial esophageal basaloid squamous cell carcinoma with rare form


Department of Surgery, Tokai University School of Medicine

Abstract

We report here a case of superficial esophageal basaloid squamous cell carcinoma (BSC) that presented with a rare form. The patient was a 64-year-old man with a two-month history of dysphagia. Barium esophagography showed a polypoid tumor in the middle esophagus, measuring 2.5 cm in diameter and esophagoscopy demonstrated the lesion as protruding tumor with peduncle. The case was diagnosed as poorly differentiated squamous cell carcinoma by analyzing the biopsy specimen and computed tomogram demonstrated one abdominal lymph node metastasis. The patient underwent thoracic esophagectomy with three-field lymph node dissection. In the resected specimen, the tumor shape was similar to a mushroom, and the histological diagnosis was BSC invading the submucosal layer.

Key Words: basaloid squamous cell carcinoma, esophageal carcinoma, pedunculated type

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Correspondence to: Hideo Shimada, Department of Surgery, Tokai University School of Medicine, Isehara, Kanagawa 259-1193, Japan. TEL: +81-463-93-1121, FAX: +81-463-95-6491, e-mail: seikai@is.icc.u-tokai.ac.jp

Introduction

Basaloid squamous cell carcinoma (BSC) of the esophagus is a rare and uncommon malignant disease. Only about 0.1% of esophageal carcinoma cases have been diagnosed as primary BSCs. Superficial esophageal BSCs mainly present as elevated or depressed lesions, but not as a polypoid elevation with peduncle. We present a case of superficial esophageal BSC, that presented with a rare form.

Case Report

A 64-year-old man without any smoking habit was admitted to our hospital with a two-month history of dysphagia. Physical examination did not demonstrate any abnormalities, and laboratory data were within normal limits. Barium esophagography demonstrated a polypoid type tumor in the middle esophagus, measuring 2.5 cm in diameter (Fig. 1). Esophagoscopy demonstrated a protruding tumor with a peduncle located approximately 35 cm from the incisor (Fig. 2a, b). Histopathological analysis of the biopsy specimen indicated poorly differentiated squamous cell carcinoma (SCC). Computed tomogram showed one metastatic lymph node near the esophagogastric junction. The case was then diagnosed as SCC with abdominal lymph node metastasis. The clinical stage was Stage IIB-T1N1M0 according to the TNM classification proposed by the UICC. The patient underwent thoracic esophagectomy with three-field lymph nodes dissection.

In the resected specimen, the tumor form appeared similar to a mushroom and was defined as 0-Ip type tumor, according to the endoscopic classification based on the guidelines for clinical and pathologic studies on carcinoma of the esophagus proposed by the Japan Esophageal Society (Fig. 3a, b, c). Although almost all of the tumor surface was covered with carcinoma cells, the peduncle of the tumor was covered with non-carcinomatous squamous epithelium (Fig. 3c). Histologically, the carcinoma invaded the submucosal layer of the esophagus (Fig. 4a). And lymphatic and venous permeation by the cancer cells was observed in the esophageal wall. The carcinoma was composed of solid nests of basaloid cells, that contained scanty cytoplasm and hyperchromatic nuclei, in lobular configuration with peripheral palisading (Fig. 4b). The histological type of the tumor was compatible with BSC. And the peduncle consisted of non-carcinomatous components, i.e. squamous epithelium and submucosal tissue. One abdominal lymph node was positive for metastatic BSC.

Two months post operatively, the patient was given two courses of postoperative chemotherapy (5-fluorouracil 750 mg/m², day 1-5 and cisplatin 75 mg/m², day1). He has remained well for more than 4 years without any evidence of recurrence.
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Discussion

BSC of the esophagus is a rare malignant disease, and an uncommon and distinct variant of SCC. A poor prognosis has been reported in patients with BSC of the esophagus and even if surgery is possible, this type of carcinoma is associated with a poor outcome. However, some recent clinicopathological and immunohistochemical studies have gradually clarified the features and behavior of this carcinoma. The growth pattern of the carcinoma is downward and expansive in the relatively early stage. Many superficial esophageal BSCs show a form similar to that of submucosal tumor. About the prognosis of patients with the carcinoma, Sarbia et al. reported that after potentially curative resection, it did not differ from that of patients with typical SCC.

Ohashi et al. studied 12 cases of superficial esophageal BSC in detail and reported that the tumor mainly presented as an elevated lesion in eight cases and one of these showed polypoid elevation with a conspicuous constriction at the base. However, almost all advanced esophageal BSC showed non-polypoid lesion, e.g. ulcerative, infiltrative or protuberant lesion. The present tumor was the superficial type and exhibited polypoid elevation with peduncle, and peduncle was covered with non-carcinomatous squamous epithelium. So, the present tumor appeared similar to a mushroom. Although the growth pattern of the present tumor was upward and not expansive, one abdominal lymph node was positive for metastatic carcinoma.

Systemic chemotherapy for patients with esophageal BSC has not yet been thoroughly discussed. Moreover, postoperative chemotherapy has not yet been established. The patient was given chemotherapy consisting of continuous infusion of 5-fluorouracil and cisplatin because one lymph node was positive for metastatic carcinoma.
Some case reports have indicated the effectiveness of continuous infusion of 5-fluorouracil and cisplatin for esophageal BSC\textsuperscript{4,5,7,10}. Especially, Bekavac \textit{et al.} reported postoperative chemotherapy for carcinoma with lymph node metastasis\textsuperscript{5}. An accumulation of cases is required to establish the role of this combination as therapy for esophageal BSC\textsuperscript{21}.

\textbf{Reference}


