A Unique Case of Simultaneous Anal Squamous Cell Carcinoma and Esophageal Squamous Cell Carcinoma

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Introduction

Anal cancer (AC) is uncommon and comprises only 3% of all digestive system malignancies. It is associated with HPV, tobacco use, and HIV. Esophageal cancer (EC) is the 8th most common cancer and 6th most common cause of death worldwide. Among other associations, HPV and tobacco use has been strongly linked to development of esophageal SCC. Though they have similar risk factors, the literature is limited when it comes to cases of simultaneous anal SCC and esophageal SCC.

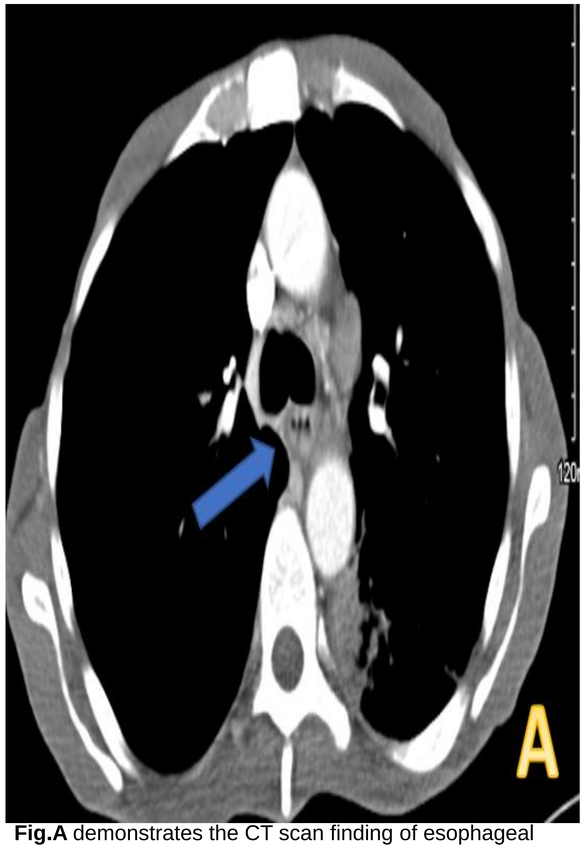

Fig.A demonstrates the CT scan finding of esophageal wall thickening

Case Description

A 50-year-old male with history of tobacco use presented with dysphagia, dyspnea, and weight loss. His symptoms were progressive with 20 lbs. of weight loss in 3 months. He initially had solid food dysphagia which progressed to liquids and constant regurgitation of food. His cough and dyspnea were acute and worsened 1 week prior to his presentation. He endorsed a bulging growth around his anus that grew over several months.

He was found to have a left lower lobe necrotizing pneumonia (NP) on CT scan as well as thickening of the esophagus with liver lesions suspicious for metastatic disease. Labs showed leukocytosis, macrocytic anemia, and a mild transaminitis. He was tested for tuberculosis and HIV which was negative. He underwent an EGD which showed a large, friable, fungating esophageal mass whose biopsies showed SCC. For his anal lesion, he underwent an excisional biopsy which was positive for SCC as well.

The patient was treated with antibiotics for his NP with a plan of 6 weeks of therapy followed by repeat imaging to determine if any surgical interventions would be needed. Oncology planned for palliative chemoimmunotherapy once his NP resolved. To improve his dysphagia, a palliative esophageal stent was placed.

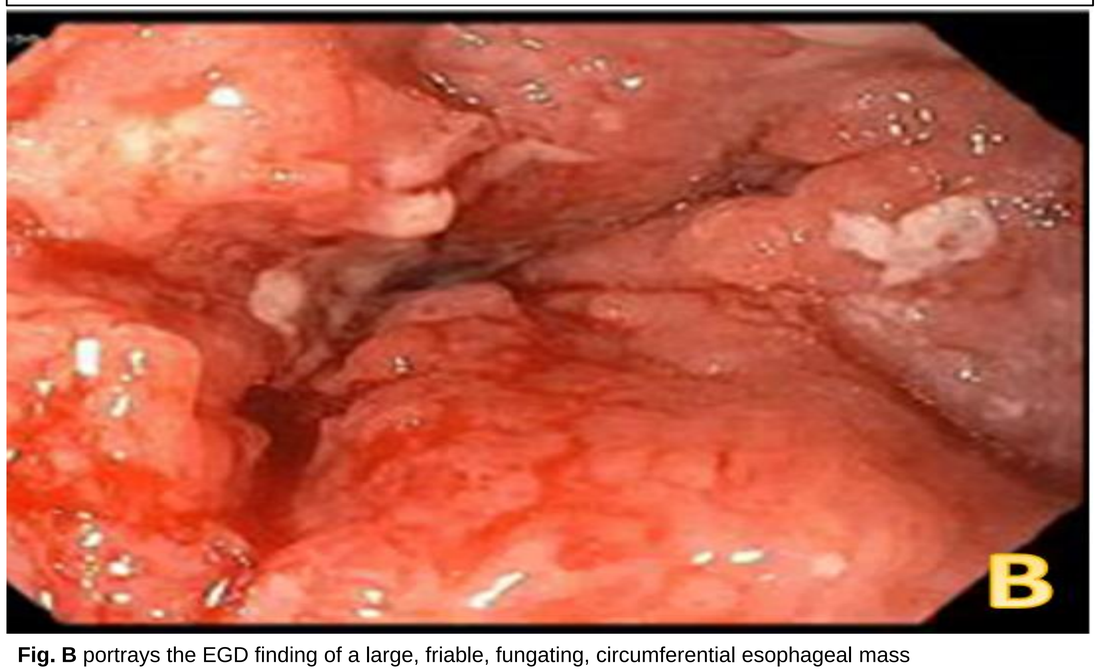

Fig. B portrays the EGD finding of a large, friable, fungating, circumferential esophageal mass

Discussion

This patient had both a primary anal SCC and esophageal SCC with his only risk factor being tobacco use. Though both AC and EC commonly metastasizes to the liver, EC is more likely to metastasize. For esophageal SCC, local lymph node invasion typically occurs early since the lymphatics are in the lamina propria rather than beneath the muscularis mucosa. In this case, the patient presented with a NP and though no definitive fistula was noted on imaging, local invasion of esophageal SCC can present with fistulizing disease. Unfortunately, Stage 4 esophageal SCC is uncurable though systemic therapies may provide a palliative effect and survival benefit. In this case, an endoscopic esophageal stent was placed for palliation of his dysphagia while awaiting chemoimmunotherapy.

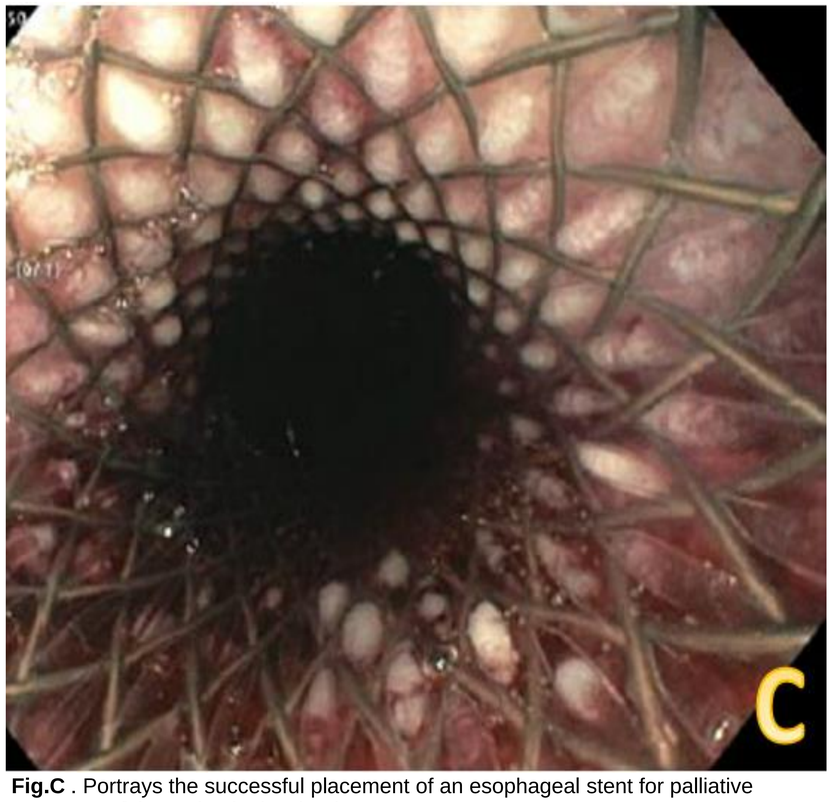

Fig.C . Portrays the successful placement of an esophageal stent for palliative treatment of the patient's dysphagia. .