

## Esophageal Carcinoma in a Pregnant Woman Who Has Prior History of Gastric Cancer

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### ABSTRACT

Esophageal cancer in pregnancy is a very rare condition. Symptoms can be confused with pregnancy related complaints and diagnosis may delay. Mild gastrointestinal symptoms related to pregnancy are usually seen in first trimester, however, dysphagia must be considered as an important symptom. Upper gastrointestinal endoscopy can be performed safely during pregnancy but it should be delayed to the second trimester, if there is not an alarm symptom or urgent condition. Management of esophageal carcinoma in pregnancy can be difficult and a specific management has not been discussed. We report here a case of esophageal carcinoma, which diagnosed at the second trimester of pregnancy.

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**Key words:** Esophageal cancer; Pregnancy; Endoscopy

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### ESOPHAGEAL CARCINOMA IN A PREGNANT WOMAN WHO HAS PRIOR HISTORY OF GASTRIC CANCER

Esophageal cancer has been rarely reported during pregnancy and there are only two cases in the literature<sup>[1,2]</sup>. Symptoms can be masked by pregnancy related complaints and diagnosis may delay. We report a case of esophageal carcinoma, which diagnosed at the second trimester of pregnancy.

A 37-year-old woman at 18 weeks of gestation was referred to our clinic with complaints of nausea, vomiting, and dysphagia in the last six months. In history, she underwent a total gastrectomy and splenectomy followed by chemotherapy because of gastric carcinoma. She notify that, she was regularly controlled after treatment and recurrence or metastases were not detected in an eight years follow-up period. Physical examination was normal except the findings of mild dehydration and prior operation scars on abdomen. Laboratory investigations were normal. Esophagogastroduodenoscopy (EGD) was performed because of the persistent symptoms, dysphagia and weight loss. It showed yellow-white mucosal plaques at the proximal and middle part of esophagus and fragile and vegetative mass lesion from middle to distal part of esophagus which causing a partial obstruction. Pathologic examination was reported as candidiasis and squamous cell carcinoma. Termination of pregnancy and surgical treatment was planned, however, patient was rejected this decision. Patients complaints were mildly continue at this period. Because of worsening maternal condition and intrauterine growth retardation, a caesarean section was performed at 35 weeks of gestation and a 2.1 kg healthy male baby was delivered. EGD was repeated after the birth and lesion was seen as caused more obstruction. There were not metastases on thorax and abdomen computed tomography. Total esophagectomy and jejunal interposition was performed by the general surgeon. Multiple liver metastases were detected six months after the surgery and patient was remain uncontrolled after this period.

Gastrointestinal symptoms are very common during pregnancy

especially in first trimester, however, high risk conditions, such as refractory nausea and vomiting, dysphagia or odynophagia, gastrointestinal bleeding, family history of gastrointestinal cancer must be well described. EGD is generally safe during pregnancy but should be postponed to the second trimester whenever possible<sup>[3]</sup>. Esophageal cancer was diagnosed at advanced stage, inoperable and showed poor prognosis in reported pregnant cases<sup>[1, 2]</sup>. Gestational age of fetus, stage of tumor, maternal condition, and patients decision must be considered in management. Although a specific management has not been discussed for esophageal cancer in pregnancy, there are some informations about gastric cancer in the literature. In Sakamoto's review reported that, if diagnosis of gastric cancer was made prior the 24 weeks of gestation, patients were treated surgically following the termination of pregnancy. Most of the patients whom gastric cancer was diagnosed 28 weeks of gestation and beyond, successfully underwent cesarean section or vaginal delivery. Decision is difficult at 24 to 27 weeks of gestation<sup>[4]</sup>.

Another important point in our case is development of esophageal squamous cell carcinoma after gastrectomy. Some authors reported that it is only incidental<sup>[5]</sup>, however some experimental studies demonstrated that carcinogenic effects of the reflux of gastroduodenal contents on the esophagus is frequently observed after gastrectomy<sup>[6,7]</sup>. Kitayabashi et al reported that gastrectomy may precipitate chronic gastroesophageal reflux and it can induce the development of squamous dysplasia and carcinoma<sup>[8]</sup>. This effect may be considered for our patient.

In conclusion, diagnosis and management of esophageal cancer may be difficult in pregnancy because of the pregnancy related conditions. EGD should be performed in cases with high risk and persistent symptoms. Future studies are required to description of optimal management strategy in these patients.

## CONFLICT OF INTERESTS

The authors declare that they do not have conflict of interests.

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