# Simultaneous oesophageal and gastric carcinoma in an elderly man

## A case report

W. F. C. VAN GELDEREN


## Summary

A patient with radiological evidence of both oesophageal and gastric carcinoma is presented. Histological examination revealed squamous cell carcinoma of the mid-oesophagus and adenocarcinoma of the stomach. This is a most unusual combination. A short review of the literature is presented.


*S Afr Med J* 1983; **64:** 455-456.

## Case report

An emaciated 61-year-old Coloured man presented in October 1981 with a 2-week history of dysphagia, vomiting and postprandial pain; a 2-month history of loss of weight, malaise and persistent coughing was also obtained.

On examination marked cachexia was a striking feature. No abnormality of the cardiovascular or respiratory systems was detected and his blood pressure and pulse rate were within normal limits. Apart from minimal hepatomegaly no other abdominal abnormality was in evidence. No jaundice or anaemia was noted. A clinical diagnosis of carcinoma of the stomach or oesophagus was entertained, and the patient was referred for radiological examination of the chest and a barium swallow and barium meal examination.

Chest radiography showed no abnormality. Barium studies revealed a large filling defect, measuring 4 cm in length and with an irregular outline, involving the anterior wall of the oesophagus at the level of the carina, and with a small anterior soft-tissue component (Fig. 1).

A large, fairly well circumscribed, rounded polypoid-type lesion involving the cardia along the lesser curvature of the stomach close to the oesophagogastric junction was also demonstrated (Fig. 2). The remainder of the stomach and the duodenum were normal.

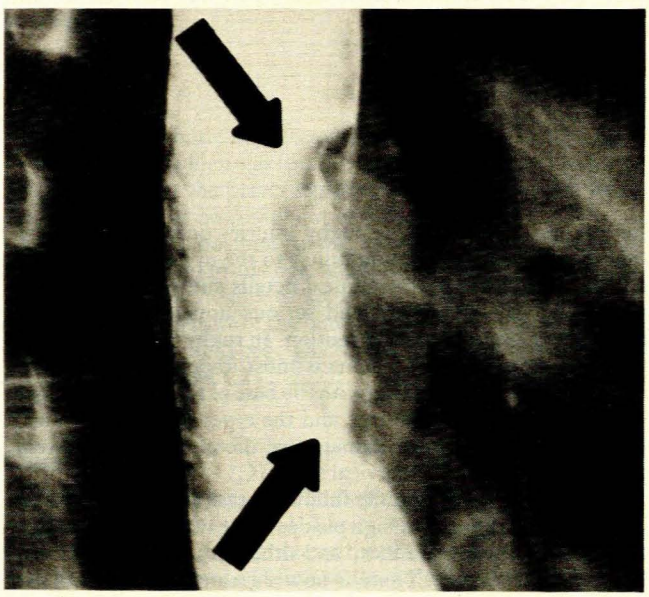

**Fig. 1. Filling defect involving the anterior wall of the mid-oesophagus at the level of the carina, with a small anterior soft-tissue component.**

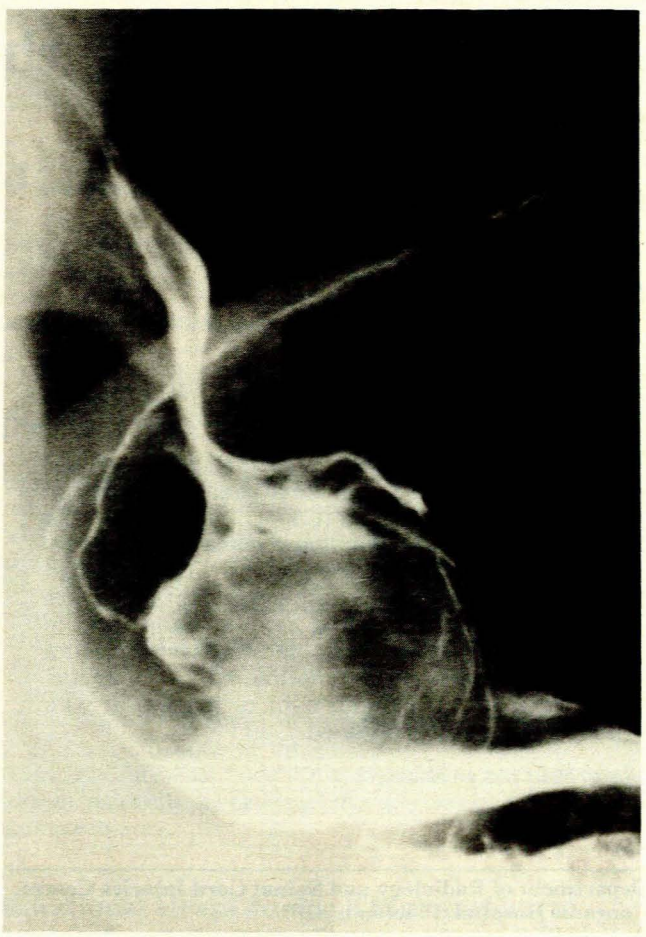

**Fig. 2. Large, rounded polypoid-type lesion involving the cardia along the lesser curvature of the stomach close to the oesophagogastric junction.**

**Department of Radiology, Tygerberg Hospital, Parowvallei, CP**
W. F. C. VAN GELDEREN, M.B. CH.B., F.F. RAD. (D.) (S.A.)

Date received: 1 June 1983.
Reprint requests to: Dr W. F. C. van Gelderen, Dept of Radiology, Tygerberg Hospital, PO Box 63, Tygerberg, 7505 RSA.

At oesophagoscopy a fungating mass, 4 cm in length, was demonstrated at 28 cm. Various biopsy specimens were taken from this mass; it was possible to advance the oesophagoscope beyond the mass and to dilate the oesophagus. Subsequent laparotomy demonstrated the gastric mass, and a biopsy specimen was taken from this. Diffuse metastatic spread in the abdomen and hepatic metastatic deposits were noted. Unfortunately no biopsy material was obtained from the latter sites. A gastrostomy feeding tube was inserted.

Histological examination of biopsy material revealed squamous cell carcinoma of the mid-oesophagus and adenocarcinoma of the cardia of the stomach. The patient was subsequently discharged on palliative management.

## Discussion

The simultaneous occurrence of more than one primary malignant tumour, once regarded as a rare medical curiosity, is now recognized as a common medical problem.[1,2]

The common association of intra-oral and oesophageal malignant lesions is well known.[3] There have been sporadic reports of cases of multiple primary neoplasms of the oesophagus.[4,5] In 1944 Slaughter[6] reported on 1018 cases of multiple primary malignant tumours in various parts of the body, and of these 26 were cases of simultaneous involvement of the oesophagus and stomach.[6]

The occurrence of an oesophageal and a gastric carcinoma with different histological features presenting at the same time is rare, and prompted me to publish this short case report and review.

Grateful thanks are extended to Professor J. A. Beyers and Dr A. D. Keet for helpful suggestions.

REFERENCES

1. Moertel CG, Dockerty MB, Baggenstoss AH. Multiple primary malignant neoplasms. *Cancer* 1961; **14**: 221-247.
2. Einhorn J, Jakobson P. Multiple primary malignant tumours. *Cancer* 1964; **17**: 1437-1444.
3. Goodner JT, Watson WL. Cancer of the oesophagus: its association with other primary tumours. *Cancer* 1956; **9**: 1248-1252.
4. Suri RK. Double primary malignant lesions of the oesophagus. *Indian J Cancer* 1974; **11**: 444-447.
5. Rosengren JE, Goldstein HM. Radiologic demonstration of multiple foci of malignancy in the oesophagus. *Gastrointest Radiol* 1978; **3**: 11-13.
6. Slaughter DP. The multiplicity of origin of malignant tumours: a collective review. *Int Abstr Surg* 1944; **79**: 89-98.

# Rugby injuries of the upper cervical spine

## Case reports

A. T. SCHER

### Summary

Fractures and dislocations of the upper cervical spine (atlas and axis) differ markedly from those of the lower cervical spine (C3 - C7) because of the unique anatomy and function of these two vertebrae. Case reports of 4 rugby players who sustained serious injuries of the upper cervical spine are presented. The role of the high tackle in causing these injuries is described and the association of head and upper cervical spinal trauma is emphasized. The radiological management of the player with suspected injury is outlined.

*S Afr Med J* 1983; **64**: 456-458.

**Department of Radiology and Spinal Cord Injuries Centre, Conradie Hospital, Pinelands, CP**
A. T. SCHER, M.B. CH.B., D.M.R.D. (Present appointment: Professor of Radiology, University of the Witwatersrand, Johannesburg)

Date received: 3 December 1982.

Review of the literature on rugby injuries does not reveal any case reports or discussion on injury to the upper cervical spine (Cl and C2). Recently the clinical details and radiographs of 4 players, all of whom sustained serious upper cervical spinal injury, were brought to my attention. In rugby injuries consideration of upper cervical trauma is most important. The upper cervical spine in conjunction with the base of the skull is a unique segment of the spinal column, and the types of injury seen and potential for spinal cord damage are therefore very different from those of the lower cervical spine (C3 - C7).

A finding evident from the following case reports is that all 4 players were subjected to high tackles at the neck level. The high tackle is still common practice,[1] and although sometimes accidental is often deliberate. There is now a greater awareness of the dangers of this type of tackle, but avoidable and sometimes catastrophic injuries still occur. In 1978 I published a paper drawing attention to the dangers of the high tackle,[2] and it is not too soon to re-emphasize the hazards of such play.

## Case reports

### Case 1

A 28-year-old centre had possession of the ball when he was