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Metastatic oesophageal adenocarcinoma

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Case

- 62 year old male
- Seen in private sector, in Johannesburg
- Background: Gout
  Dyslipidaemia
  Ex-smoker
- Presented with features of lower respiratory infection in May 2023
  - had been having chronic reflux, multiple PPI's
    - previous endoscopy + biopsy showed high grade dysplasia
  - no dysphagia
  - no loss of weight
- ECOG PS 0

Gastroscopy

- Had gastroscopy done: Barrett’s oesophagus 32 – 35cm, ulcerating

- Biopsy done:
  - Specimen 1, oesophagus, at 27cm:
    - well established Barrett's oesophagus, no dysplasia
  - Specimen 2, oesophagus, 36cm:
    - well established Barrett's oesophagus, no dysplasia
  - Specimen 3, ulcer, 34cm in the oesophagus:
    - invasive ulcerated low-grade adenocarcinoma (tubular-type).

Biopsy results

- Specimen 4, gastric antrum:
  - mild-to-moderate chronic gastritis
  - no evidence of H. pylori infection
- **Specimen 5, oesophageal ulcer at 33cm:**
  - **invasive low-grade (moderately differentiated) tubular-type adenocarcinoma**
- **Specimen 6, epithelium labelled "polypoid lesion 30cm":**
  - **glandular epithelium with high-grade dysplasia (at least adenocarcinoma in-situ from which tumour has probably arisen)**
- **Specimen 7, ulcer, 35cm:**
  - **invasive low-grade adenocarcinoma (moderately differentiated) tubular adenocarcinoma**

Biopsy – further testing

- Microsatellite stable by IHC

MLH1	Positive
PMS2	Positive
MSH2	Positive
MSH6	Positive

- PDL1 CPS <2
- Her2 3+ staining

Imaging

- CT staging was performed:
  - circumferential irregular mural thickening of mid-thoracic oesophagus
    - Adjacent mediastinal fat stranding
    - 69mm in length, extending to the gastro-oesophageal junction
    - Enlarged para-oesophageal lymph nodes
    - Superior mediastinal and left supraclavicular lymph nodes
    - Fissural pulmonary nodules in both lung fields
      - Largest LUL 7x6mm
  - Large coeliac axis lymph node 23x6mm
  - No liver lesions
  - No bony lesions

PET

- PET requested to assess if lung disease avid
  - LLL nodule 7x7mm, SUV 4.2
  - Sub 5mm scattered pulmonary nodules elsewhere
  - Avid supraclavicular and coeliac lymph nodes, as seen on CT

- Features in keeping with metastatic oesophageal carcinoma

Pre-treatment work-up

- Referred for baseline cardiac assessment
  - LV-EF: 77%
  - Normal pulmonary pressures
  - Structurally normally heart
- Baseline bloods: normocytic anaemia of 10.4
  - Normal renal and liver function
- Informed consent process carried out

Treatment

- Started on CAPOX + trastuzumab
  - Received 3 cycles
  - Toxicities included diarrhoea – up to grade 2
    - Dose of capecitabine adjusted
- Reimaged after 3rd cycle – partial response

in mm	30/6/23	19/9/23
Lt level 4	18 x 18	9 x 7
Rt para-oesophag.	13 x 12	11 x 7
Coeliac node	25 x 23	14 x 13
LLL perifissural	7 x 7	Scar

Surgical review

- Was seen by upper GI surgeon with above response
  - Confirmed that not for operative management
  - To continue with medical therapy

Continued CAPOX + trastuzumab

- Hb improved to 11.4 on therapy
- Interim events:
  - Histology was reviewed
    - CPS 1.8
    - Application done for pembrolizumab addition
      - Declined by patient's medical aid (funding scheme)
- Issued CAPOX + trastuzumab to 8 cycles total
  - Then changed to maintenance with capecitabine + trastuzumab

Post C8

- Ongoing partial response
  - Tolerating treatment very well

in mm	30/6/23	19/9/23	13/12/23
Lt level 4	18 x 18	9 x 7	8 x 6
Rt para-oesophag.	13 x 12	11 x 7	11 x 5
Coeliac node	25 x 23	14 x 13	12 x 11
LLL perifissural	7 x 7	Scar	Scar

MDT discussion

- To perform G-scope
  - Barrett’s like changes noted (from 27 to 37cm)
  - Sampled: invasive oesophageal adenocarcinoma

- Residual disease
  - For continued systemic therapy

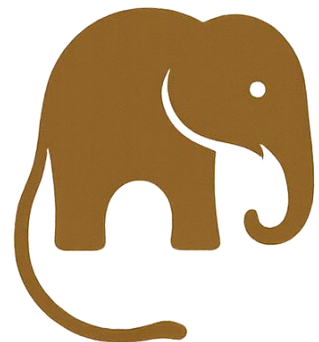
Case

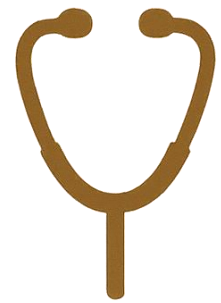
- On 24/04/2025: self-funded pembrolizumab
  - Added to capecitabine + trastuzumab
  - New LVEF assessment: 74%
  - Received 5 cycles of pembrolizumab [+ capecitabine + trastuzumab]
    - Then developed Grade 4 pneumonitis after C5
    - Required admission
    - Improved with corticosteroids
    - Pembrolizumab discontinued

Case

- As of 29 August 2025, new CT staging done
  - Mural thickening extends for a length of 39 mm (previously 30 mm).
  - Possible transmural extension into the adjacent posterior mediastinal fat at the 9 o'clock position
  - Oesophageal lesion marginally increased in size.
- Distant disease remains stable
- Due for regional MDT discussion
  - Points to consider: **local PD**
  - Role for RT/CCRT?
    - If we consider this oligoprogression
  - What other systemic options would we consider?
    - Ongoing Her2i?
    - Naïve to irinotecan, taxanes

Thank you





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