Female Gender in Esophageal Intramucosal Adenocarcinoma Treated with Endoscopic Mucosal Resection: A Case Series

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Female Gender in Esophageal Intramucosal Adenocarcinoma Treated with Endoscopic Mucosal Resection: A Case Series

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Background
• Barrett’s esophagus (BE) is a premalignant esophageal condition which may lead to dysplasia and esophageal adenocarcinoma (EAC).
• Incidence of BE is increasing.
• High-grade dysplasia (HGD) carries significant risk of progression to EAC.
• Patients with HGD and intramucosal adenocarcinoma (IMA) are treated with endoscopic mucosal resection (EMR) and radiofrequency ablation (RFA).
• Women have a lower risk of progression from BE to HGD or EAC.
• Females diagnosed with HGD are presumed to have an equal risk of progression to IMA or EAC.

Case Series Presentation

PATIENT 1:
• 68 year old female with a history of pancreatic cancer and Whipple procedure.
• EGD: Gastroesophageal junction (GEJ) nodularity with HGD on biopsy.
• EMR pathology: IMA with HGD.
• No endoscopic evidence of nodularity on repeat EGD with negative biopsies.
• Follow up EGD’s were done every 3 months with follow up EMR for GEJ subtle inflammatory changes with negative pathology.

PATIENT 2:
• 75 year old female with a prior history of non-dysplastic BE.
• Surveillance EGD showing HGD and IMA on biopsy.
• EGD/EUS: Para-esophageal lymph node (<1 cm) and esophageal nodularity treated with EMR.
  - Pathology: BE with HGD, low-grade dysplasia (LGD), possible IMA, and negative lymph node FNA.
• Repeat EGD: No evidence of nodularity; flat Barrett’s treated with RFA.
• EMR treatment at three separate occasions for short segment BE.
• Subsequent EGD with GEJ biopsy: Free of pathology.

PATIENT 3:
• 75 year old female with a history of reflux and gastritis.
• EGD: Irregular Z-line and esophagitis.
  - Pathology: Barrett’s mucosa with HGD, low-grade dysplasia (LGD), possible IMA, and negative lymph node FNA.
• Repeat EGD: GEJ nodularity treated with EMR.
  - Pathology: IMA with invasion into the muscularis mucosae with negative deep margins.
• Third EGD: No residual BE.

Discussion
• BE is found in 4% of patients undergoing EGD.
• BE has and estimated 20-fold increased risk of developing EAC.
• Visable nodules with HGD suggest a more advanced lesion; EMR upsstages the diagnosis to cancer in up to 40% of cases.
• EMR/RFA is the standard of care for BE with HGD or IMA.
• Female patients with esophageal HGD and/or IMA undergo EMR/RFA, but no data suggests their response is the same as male patients.
• Further investigation of gender differences may reveal distinct incidence and response to EMR/RFA.
• Such differences would affect prognosis, timing of surveillance, and treatment.
• Our case opens a discussion to examine gender differences in esophageal HGD and IMA with further studies.

References:

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