Dysphagia to liver failure

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DESCRIPTION

A 54-year-old man presenting with dysphagia, weight loss, epigastric pain and cervical lymphadenopathy was referred directly to endoscopy. The medical history included hypertension and hypercholesterolaemia. Blood tests showed normal bilirubin, aspartate transaminase (AST) 490 iu/L, γ -glutamyl transferase (GGT) 535 iu/L, alkaline phosphatase (ALP) 829 iu/L and prothrombin time (PT) 13 s.

Gastroscopy showed a lower oesophageal lesion (figure 1) with biopsies showing high-grade dysplasia. A CT scan showed lower oesophageal wall thickening and multiple lymphadenopathy in the chest/abdomen but no liver metastases (figure 2). The local multidisciplinary team meeting outcome was for repeat oesophageal biopsies and supraclavicular lymph node biopsy to exclude a lymphoma.

The patient thereafter clinically deteriorated over a 4-week period, developing jaundice. On admission, he became overtly encephalopathic within 48 h, with a suggestion of acute liver failure. Bloods revealed: bilirubin 238 μ mol/L, AST 1034 iu/L, GGT 569 iu/L, ALP 887 iu/L, albumin 20 g/L, PT 27.2 s and lactate 4.7 mmol/L. Repeat imaging showed no signs of liver metastasis and acute liver screen was negative. Repeat oesophageal biopsies showed poorly differentiated adenocarcinoma. The patient rapidly deteriorated and died before a planned liver biopsy could be performed.

Post mortem revealed disseminated oesophageal adenocarcinoma, lymph node metastases, ascites and diffuse liver metastases replacing the majority of the liver parenchyma. The potential short life span of patients with fulminant liver failure means prompt assessment is essential, however the cause can often remain undiagnosed in some patients. There are reports of fulminant liver failure in patients with breast¹ and lung cancer,² and liver metastases in any cancers can cause deranged liver function tests, but this case highlights a clinical liver failure presentation in oesophageal adenocarcinoma.

Figure 1 Endoscopic picture of oesophageal tumour.

Figure 2 CT scan showing oesophageal cancer (red arrow) but no obvious liver lesions.

Learning points

- ▶ Liver metastases may not be apparent on CT or MRI modalities.
- ▶ Diffuse liver metastases can cause liver failure in oesophageal adenocarcinoma and if there is clinical suspicion, a liver biopsy may be helpful.
- ▶ While discrete liver metastases are common in different malignancies, diffuse infiltration and parenchymal replacement are relatively uncommon.

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Contributors VTFC drafted and finalised the manuscript and prepared figure 1. JS prepared the CT image in figure 2. NR and AM contributed to the writing and content of the manuscript.

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