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# Dysphagia Revealing Mediastinal Small Cell Lung Carcinoma: A Case Report

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## Abstract

Dysphagia is an uncommon presenting symptom of lung cancer, occurring in a minority of patients and often leading clinicians to pursue gastrointestinal etiologies first. However, thoracic malignancies, particularly small cell lung carcinoma (SCLC), may occasionally present with esophageal symptoms due to mediastinal involvement. Upper endoscopy and upper endoscopic ultrasound play a role in patients with esophageal extrinsic compression and/or local invasion. Herein, we describe a case of a 29-year-old man with no history of tobacco use who presented with progressive dysphagia and significant weight loss and was diagnosed with small-cell lung cancer.

**Categories:** Gastroenterology
**Keywords:** atypical cancer presentation, lung cancer (lc), malignant dysphagia, mediastinal mass, small cell lung cancer (sclc)

## Introduction

Lung cancer remains one of the most common malignancies worldwide and is the leading cause of cancer-related mortality. While typical symptoms include cough, dyspnea, hemoptysis, and chest pain, less common presentations such as dysphagia can be diagnostically challenging and may delay timely identification of the underlying malignancy [1,2]. Dysphagia is rarely the initial manifestation of lung cancer and is more often attributed to gastrointestinal or oropharyngeal pathology. However, in rare cases, extrinsic compression or direct invasion of the esophagus by mediastinal tumors or lymphadenopathy from lung cancer may be the primary cause [3,4].

It is estimated that only 1-2% of patients with lung cancer present with dysphagia at the time of diagnosis, and approximately 6-7% develop it during the disease course [5]. The mechanism is most often related to subcarinal or peri-esophageal lymphadenopathy, leading to extrinsic compression, although direct invasion, treatment-related changes, or paraneoplastic syndromes may also contribute [6]. Small cell lung carcinoma (SCLC) is an aggressive neuroendocrine tumor that is characterized by rapid doubling time, early metastasis, and frequent mediastinal involvement. Because of its central location and propensity for nodal spread, SCLC can present atypically with compressive symptoms [7]. Upper endoscopy is commonly the initial modality for dysphagia assessment, with endoscopic ultrasound (EUS) being performed in cases of suspected malignant dysphagia for staging purposes. This case describes a young male presenting with progressive dysphagia as the initial symptom of SCLC.

## Case Presentation

A 29-year-old man with a past medical history of type 2 diabetes mellitus, hypertension, hyperlipidemia, and obesity presented to the emergency department with progressive dysphagia over two months. Dysphagia initially affected solids and subsequently progressed to liquids. Symptoms associated with nausea, vomiting, and weight loss of approximately 50 pounds. There was no history of tobacco use, although he had briefly experimented with marijuana in high school and was an occasional alcohol user. Initial evaluation revealed normal vital signs, laboratory values, and chest X-ray. A computed tomography (CT) of the thorax (Figure *1*) demonstrated a large lobulated mediastinal mass (measuring 11.2 x 9.0 x 7.0 cm) invading the lower esophagus and exerting mass effect on the left main bronchus, left atrium, pulmonary veins, and descending thoracic aorta.

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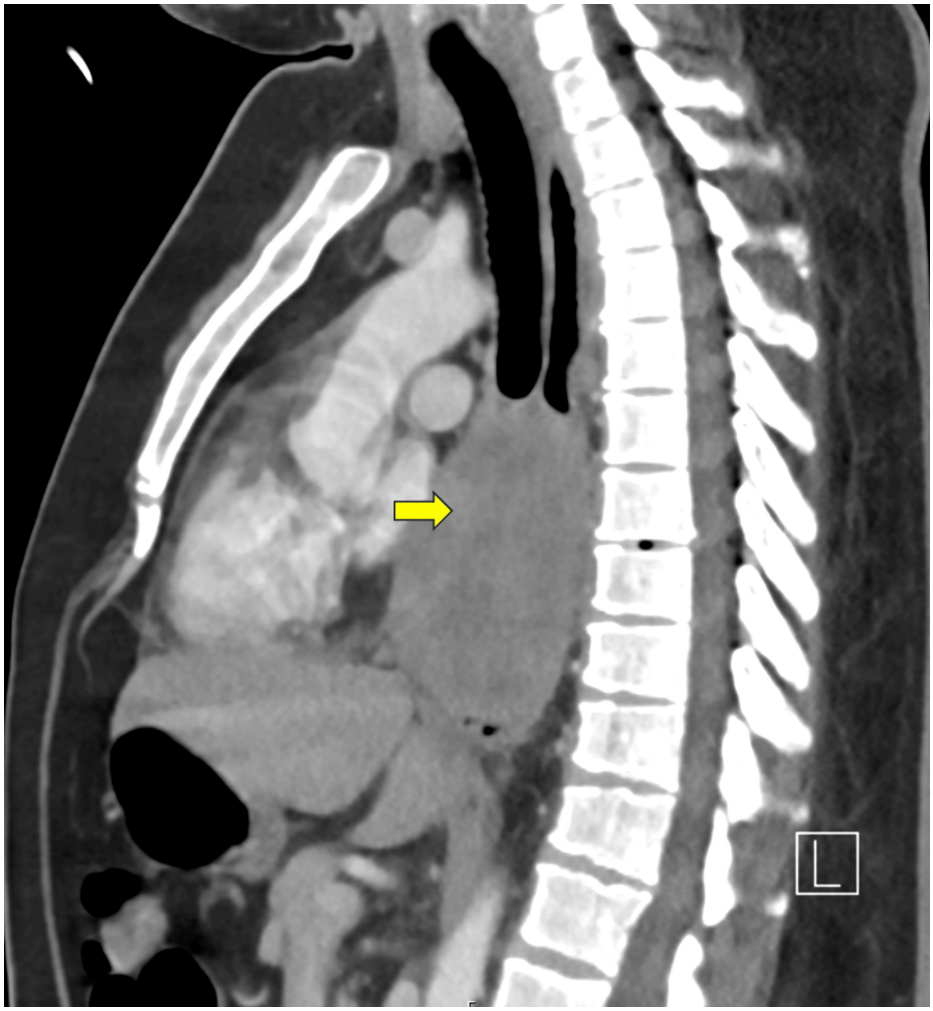


**FIGURE 1: CT thorax.**

Large lobulated mediastinal mass (measuring 11.2 x 9.0 x 7.0 cm) invading the lower esophagus.

CT: computed tomography.

An esophagogastroduodenoscopy (EGD) (Figure *2*) with EUS was performed, revealing a partially obstructing, submucosal mass in the lower third of the esophagus (32-36 cm from the incisors) with mucosal erosion.

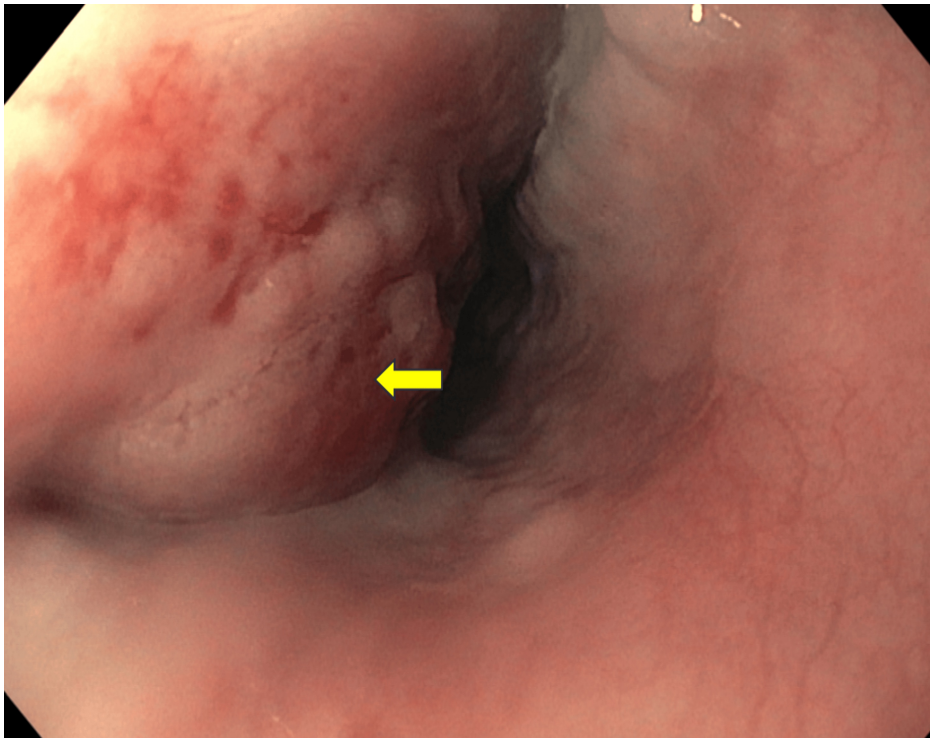


**FIGURE 2: Esophagogastroduodenoscopy.**

Partially obstructing submucosal mass in the lower third of the esophagus with mucosal erosion.

EUS (Figure *3*) demonstrated a 64 x 43 mm hypoechoic, irregular mass in the mediastinum with poorly defined margins.

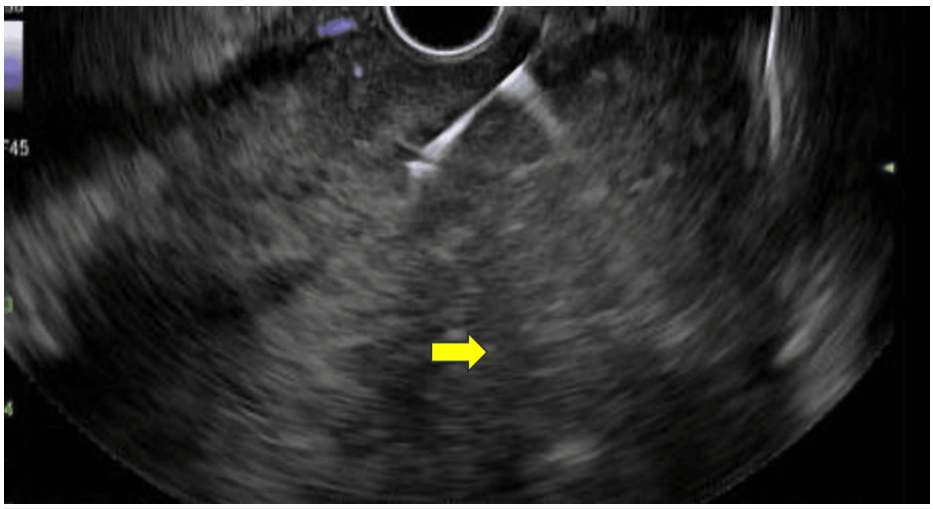


**FIGURE 3: Endoscopic ultrasound.**

64 x 43 mm hypoechoic, irregular mass in the mediastinum with poorly defined margins.

EUS fine-needle biopsy (FNB) was performed. Additional findings included a small left pleural and pericardial effusion and an indeterminate hypodense lesion in the right hepatic dome. CT abdomen revealed retroperitoneal lymphadenopathy, enlarged gastrohepatic and celiac lymph nodes, and a 2 cm mass in the dome of the liver, suspicious for metastatic disease. Magnetic resonance imaging (MRI) of the brain demonstrated no evidence of intracranial metastatic disease. Pathology revealed malignant cells consistent with small cell carcinoma. Immunohistochemistry (Figure *4*) was positive for synaptophysin, chromogranin, and CD56, with a high Ki-67 index (60%), consistent with SCLC.

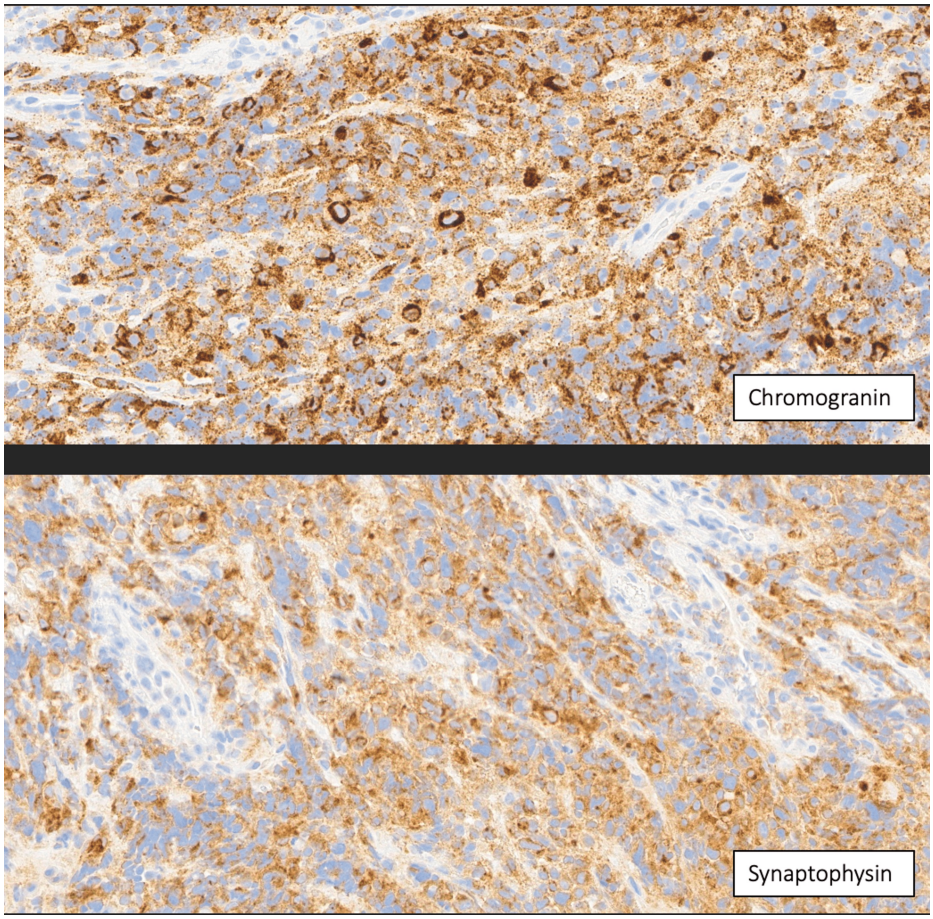



**FIGURE 4: Immunohistochemical staining for chromogranin and synaptophysin.**

Given ongoing dysphagia and inability to tolerate oral intake, the patient underwent percutaneous endoscopic gastrostomy (PEG) tube placement. The patient was subsequently referred for outpatient oncology follow-up and initiated on lurbinectedin therapy.

## Discussion

Dysphagia is an uncommon but clinically significant presenting symptom in lung cancer. Traditionally, lung cancer presents with pulmonary complaints such as cough, hemoptysis, dyspnea, or chest pain. Our case highlights such a rare instance where a 29-year-old man was diagnosed with SCLC, with dysphagia being the presenting symptom. Studies estimate that dysphagia is present in approximately 1-2% of lung cancer patients, with even fewer presenting with it as the primary complaint. In a SEER analysis, 4% of older adults had a dysphagia diagnosis before lung cancer diagnosis, and those with pre-existing dysphagia had a significantly decreased survival compared to those without (HR: 1.34; 95% CI: 1.28-1.35) [7]. Three potential mechanisms have been described. The most common cause is extrinsic compression of the esophagus within the mediastinum. A second mechanism involves compression of the pharynx and proximal esophagus by cervical lymph node involvement. The least frequent mechanism is esophageal stenosis resulting from prior mediastinal radiotherapy [5].

The etiology of dysphagia in lung cancer is multifactorial. In a prospective study, dysphagia among lung cancer patients was found to be due to four main causes: secondary achalasia (50%), mediastinal lymphadenopathy (20%), esophageal candidiasis (20%), and chemoradiotherapy-related strictures (10%) [8]. Mediastinal lymphadenopathy, particularly involving the subcarinal or periesophageal nodes, is anatomically poised to compress the esophagus, leading to mechanical dysphagia. The subcarinal nodes, when enlarged, tend to expand posteriorly due to limited lateral space, directly encroaching on the esophagus. This form of extrinsic compression was observed in our patient, in whom bulky hilar and mediastinal lymphadenopathy led to mid-esophageal narrowing [9].

While pulmonary symptoms predominate in SCLC, mediastinal spread is common due to early lymphatic involvement [10]. In the present case, SCLC manifested solely as progressive dysphagia, with imaging revealing subcarinal and hilar lymphadenopathy compressing the esophagus. The diagnostic approach to

esophageal dysphagia with inconclusive endoscopic findings can be challenging. CT helps identify extrinsic masses or lymphadenopathy, while upper endoscopy delineates mucosal integrity. However, in patients with extrinsic compression and intact mucosa, tissue diagnosis often requires endosonographic guidance [11].

In our case, EUS-FNB provided tissue confirmation of metastatic SCLC, which facilitated early initiation of chemoradiation. This highlights the importance of integrating both imaging and endoscopic modalities when evaluating patients with esophageal symptoms and a history or risk factors for malignancy. Therapeutically, patients with malignant dysphagia may benefit from systemic treatment, local radiotherapy, and occasionally esophageal stents. In a 10-year retrospective study of 84 lung cancer patients with dysphagia, esophageal stenting provided significant symptomatic relief, improving swallowing function and quality of life [12].

## Conclusions

This case highlights the importance of considering mediastinal etiologies as the cause of malignant dysphagia, with the utility of upper endoscopic ultrasound for evaluation of masses adjacent to the esophagus. While gastrointestinal malignancy is often suspected first, lung cancer and mediastinal masses should remain on the differential, particularly when imaging or endoscopy reveals extrinsic esophageal compression.

## Additional Information

### Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

**Concept and design:** Mutaz Kalas, Shivangini Duggal

**Drafting of the manuscript:** Mutaz Kalas, Shivangini Duggal

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**Acquisition, analysis, or interpretation of data:** Lakshmi Kattamuri, M Ammar Kalas, Sherif E. Elhanafi

**Critical review of the manuscript for important intellectual content:** Lakshmi Kattamuri, M Ammar Kalas, Sherif E. Elhanafi

### Disclosures

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