BUNDABERG BASE HOSPITAL
Department of Medical Imaging - Patient Report

Patient Name: KEMPS GERARD W
UR Number: 007900
Series Number: 14 Sex: M
Attend.Date: 10 DEC 04 Attend Number: 148862
Current Date: 10 DEC 04

Examinations: CT - ABDOMEN,CT - CHEST
Referred: DR P MIACH,BUNDABERG HEALTH SERVICE,PO BOX 34,BUNDABERG,
Location: WD10
Reported By: SG:3880 DR JOHN BRANSON

CLINICAL HISTORY;

Oesophageal malignancy.

CT OF THE CHEST, ABDOMEN AND PELVIS.

TECHNIQUE: Contrast enhanced spiral acquisition. Patient in chronic renal failure.

FINDINGS;

There appears to be considerable thickening of the wall of the thoracic oesophagus from the level of the gastroesophageal junction at least as far as the carina. The findings of oesophageal malignancy on OGD are noted. On the left lateral aspect of the oesophageal wall there is partial infiltration of the surrounding fat and partial loss of definition of the fat plane between the oesophageal wall and the proximal descending thoracic aorta. There appears to be at least one moderately enlarged right para-tracheal lymph node, as well as one mildly enlarged subcarinal lymph node but no generalised inferior mediastinal lymphadenopathy is seen. No enlarged superior mediastinal lymph nodes are seen. The hila appear unremarkable. Focal pulmonary scarring is seen in the left upper lobe. No acute airspace consolidation or atelectasis is seen. There are a few relatively minor para-septal bullae. There are at least four focal intra-pulmonary lesions lying posteriorly in the right lower lobe, the largest of these measuring approximately 12mm in diameter and showing some spiculation of the margins. The others are somewhat smaller. At the peripheri of both lungs, lying in what appears to be a pleural based location there are several small densities seen bilaterally. There is no pleural calcification, but some of these peripheral opacities appear to be pleural based, while others are more difficult to assess. A fairly prominent area of pleural plaque or thickening is seen in the right lung base. No pleural abnormality seen. NO axillary abnormality seen. Below the diaphragm the liver, biliary tree, spleen, pancreas and adrenal glands have a satisfactory appearance. No retro-crural , para-aortic, mesenteric or pelvic lymphadenopathy is seen. The abdominal aorta is somewhat tortuous and shows calcified plaque and is mildly ectatic but no frank aneurysm formation is seen. The common iliac arteries are also somewhat ectatic and show atheromatous unfolding. IVC

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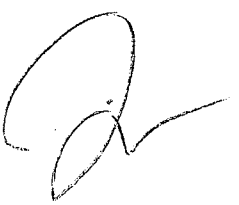
satisfactory. The right kidney is significantly reduced in size, the left kidney also somewhat smaller than average. Neither kidney appears hydronephrotic. The urinary bladder and prostate appear unremarkable. No abnormality of the bowel is seen. No abdominal free fluid or fluid collection noted.

CONCLUSION; Thickened oesophageal wall below the level of the carina with some infiltration of the associated fat planes. Mediastinal lymphadenopathy as described, but no further lymphadenopathy. There are several intra-pulmonary nodules at the right lung base, of which the largest has a spiculated margin. The possibility of metastatic lesions would have to be considered. A primary malignancy is not entirely excluded. There is also some localised pleural thickening as well as several indeterminate peripheral opacities which appear to be pleural based. No pleural calcification is seen but the possibility of non-calcified pleural plaque associated with asbestos exposure is not excluded. NO sign of abdominal or pelvic lymphadenopathy or masses is seen. No sign of hepatic metastatic disease. Small kidneys, particularly the right kidney, in keeping with the history of chronic renal failure.

DICTATED û BUT NOT READ



QHPS- Bundaberg Hospital
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Patient Location	Staff Specialists (BNH)	UR No	BN007900	IS 4
Consultant	Patel, Jayant (BNH	Name	KEMPS	
Req. Officer	Dr S Kariyawasam Bundaberg Hospital Bourbong St Bundaberg QLD 4670	Given Name	Gerard W	Sex M

Collected ??:?? 20-Dec-04 Lab No 18916-1117

Histopathology Report Biopsy No:

HISTORY
COJ tumour.

MACROSCOPIC
Received in formalin labelled stomach and oesophagus includes distal oesophagus and a major portion of stomach. Total length is 16 cm. The oesophageal segment is 6.3 cm in length and is 3.6 cm in diameter is firm and rigid and has a palpable mass which extends involves the stomach, extending to within 2 cm of the distal margin which is closed with a row of wire sutures. On the lesser curvature at the gastroesophageal junction area there is a firm fusiform mass approximately 3 cm in diameter. The fat is removed from the greater curvature and contains a few small nodules. The fat from the lesser curvature contains several hard and firm nodules up to 2 cm in diameter. The stomach is opened along the greater curvature with the opening extended the length of the oesophagus. The tumour mass has an exophytic lobulated surface. Its proximal end is approximately 1.3 cm from the oesophageal margin. It extends for an apparent length of 10.5 cm to within 1.5 cm of the distal surgical margin and is nearly circumferential at the gastroesophageal junction. The mass is up to 3.5 cm in width on the lesser curvature of the stomach. On section the tumour mass is up to 1.5 cm in thickness at the distal margin of the oesophagus. Within the stomach it is up to 1 cm in thickness. Just distal to the gastroesophageal junction it appears to extend through the muscularis propria directly into surrounding fat. The uninvolved portion of the stomach has prominent rugal folds with apparently intact mucosa. There are no additional ulcers or masses.
Sections (1A, 1B and 1C) - Distal margin of resection ,(1D) - Oesophageal tumour, (1E) - Tumour at proximal gastric margin, (1F) - Distal portion of gastric tumour, (1G) - Portion of oesophagus not grossly involved with tumour, (1H) -Uninvolved portion of stomach.
Sections of lesser curvature lymph nodes are submitted: the samples of macroscopically positive nodes in blocks (1I, 1J and 1L). (1K) is multiple small nodes. (1M) also includes small nodes. The fat of the greater curvature contains only a few tiny nodes. They are all submitted in (1N).

MICROSCOPIC
The distal oesophagus and stomach are involved by a glandular epithelial neoplasm which has abundant mucus production. The neoplastic glands are of variable size and have epithelial cells with large nuclei, prominent nucleoli and sparse amounts of cytoplasm with numerous secretory vacuoles and cystic spaces containing secretions as well as extra luminal secretions. The neoplasm involves the oesophagus partially replacing squamous epithelium. It extends into the muscularis propria and in submucosal tissue extends to the proximal margin of resection. There is no involvement of the distal margin of resection sections. The central portion of the tumour extends through the wall of the oesophagus and stomach and onto the serosal surface. Vascular invasion is prominent in the outer layers of the stomach.

ANATOMICAL PATHOLOGY

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The uninvolved portion of gastric wall has normal mucosa.
There is extensive involvement of the fat of the lesser curvature mesentery.
There is also extensive extranodal involvement of the fat and areas of vascular invasion are noted. An estimated 17 lymph nodes are identified. All are partially to completely involved by metastases.
Greater curvature fat contains no lymph nodes and is negative for metastatic disease.

DIAGNOSIS

Distal oesophagus and proximal stomach, resection: Mucinous adenocarcinoma involving stomach and oesophagus with extension to oesophageal margin. Metastases to 17 of 17 lymph nodes from the lesser curvature with extranodal fat involvement.

COMMENT

The findings favour origin in the stomach with extension into the oesophagus. TNM = T2 N2 MX.

Dr J Sawyer/jm
QHPS Rockhampton
Reported: 22 December 2004

T-57000 M-81403

ANATOMICAL PATHOLOGY

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