INTRODUCTION
Malignant pleural mesothelioma has a known etiological association with asbestos exposure and carries a 75% one-year mortality. It usually runs a rapidly progressive course, with worsening chest pain and dyspnoea, and may even spread extra-thoracically to involve abdominal lymph nodes and viscera. Oesophageal infiltration with dysphagia has been very rarely encountered and is thought to portend a very grim prognosis. We present a case of dysphagia secondary to pleural mesothelioma, which was diagnosed immunohistologically, and managed with palliative oesophageal stenting.

CASE REPORT
A 60 years old ECG technician was admitted with three weeks’ history of right-sided chest pain, cough, dyspnoea and loss of appetite. He had lost eleven pounds in weight over 3 years. He was a non-smoker but had been exposed to asbestos in his youth while working in a tile-manufacturing firm.

Clinical examination and radiographs indicated a right-sided pleural effusion. An aspiration revealed malignant cells. CT scan further showed a grossly thickened pleural ‘rind’ affecting the whole of the right hemithorax, along with posterior mediastinal lymphadenopathy. Histology was consistent with an epithelioid pleural mesothelioma. The patient was referred for a thoracentesis, but his lungs did not re-expand fully, and thus could not have talc pleurodesis.

Three months after initial presentation, a repeat CT scan revealed transdiaphragmatic spread of the mesothelioma, such that it was now displacing the liver downwards, making it palpable in the right hypochondrium. He was started on chemotherapy, which he received over the next 4 months without any major adverse effects.

Six months later, this patient was readmitted with complaint of dysphagia. Endoscopy revealed an ulcerating stricture over the lower 5 cm of the oesophagus. Biopsies were sent for immunohistochemistry and came back positive for infiltrating malignant mesothelioma (CK5/6, Calretinin). A third CT scan done this time confirmed oesophageal involvement (Figure 1), with more extensive coelomic lymphadenopathy. He was commenced on second-line chemotherapy and had a stent inserted for palliation of his dysphagia. One week later, he was transferred to a hospice for terminal care. He is alive 6 months after palliation.

DISCUSSION
Oesophageal involvement is a documented late feature of pleural mesothelioma, taking either of the two forms: dysphagia or achalasia.
Dysphagia is usually due to direct infiltration by the mesothelioma. Johnson *et al.*\(^1\) reported a case in which dysphagia developed two years after initial presentation. It was managed with endo-oesophageal tube but direct invasion could be established only at postmortem 5 months later. Lockwood *et al.*\(^2\) described dysphagia developing 3 years after initial presentation. Immunohistochemistry of oesophageal biopsies established mesothelioma in this case, contradicting the presumed diagnosis of oesophageal adenocarcinoma. This is probably the second reported case of invasive mesothelioma diagnosed antemortem.

Achalasia is another condition that has been reported,\(^3\)\(^-\)\(^5\) as an initial presentation of mesothelioma. Different mechanisms have been suggested to account for it, including direct destruction of the myenteric plexus ganglia by the tumour, infiltration of the vagal nerves, metastasis to the dorsal motor nucleus, paraneoplastic syndrome, and a non-specific response to oesophageal obstruction. Percutaneous endoscopic gastrostomy\(^3\) was placed in one patient, while pneumatic dilatation\(^4\) sufficed for another. Death occurred within days in the former case, but after 6 months in the latter.

REFERENCES