DYSPHAGIA AND MALIGNANT BILIARY STRICTURE

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We present an 80 year old white male with dysphagia to mainly solid foods. He described food getting stuck in his throat, solids were more difficult to swallow than liquids. He was a non-smoker and non-alcoholic. He denied any weight loss and anorexia. The past medical history was significant for angina, cholecystectomy for cholelithiasis and TURP two year ago. The physical examination was grossly normal except for heme occult positive stools. A CBC and SMA was completely normal except for LDH = 394. A barium swallow showed only small hiatial hernia. EGD revealed mild GERD and small duodenal ulcer with positive H. pylori infection. Empirical bougienage was performed. He was treated with proton pump inhibitors and antibiotics. Colonoscopy showed small hyperplastic polyps. One month later, he was admitted with severe left flank pain. An X-Ray of the abdomen, renal sonogram, IVP, and CT scan of the abdomen were normal. Because the patients still complains of dypsphagia, a repeat EGD was done which showed healing of the duodenal ulcer and negative for H.Pylori. Two weeks later, the patient presented with acute urinary retention. Cystoscopy revealed urethritis and cystitis. The PSA was 1.6 (normal). Two week later patient presented with jaundice, weight loss, and dysphagia- T Bil 4.4 mg/dl, Alk Phos 3445 i.u./L, AST 344 i.u./L, LDH 350 i.u./L. ERCP showed a 3 cm stricture in the distal CBD with proximal dilatation- consistent with malignant biliary stricture. Pancreatogram could not be obtained. Ampulary biopsy and cytology were negative for malignant cells. The CEA was 13.1. Although the jaundice improved, he continues to have marked weight loss, anorexia, and expired at another hospital two month later. Dysphagia could be a paraneoplastic symptom of malignant biliary stricture/pancreatic carcinoma.