History of ban case study

Business

A recent study of patients with respectable disease demonstrated 5 year overall survivals of 81%, 51 14%, and 0% for stage I through IV respectively . Previously implicated risk factors for esophageal demarcation include gastrointestinal reflux disease, tobacco use, Obesity, and Barrette's esophagi. Prior reports have also suggested that chronic bulimia nervous (BAN) is a risk factor for the development of esophageal demarcation. Repeated microcircuit, due to vomiting, may contribute to the malignant transformation of the esophageal tissue.

We report the case of a 27 year old female patient with a remote history of BAN recently diagnosed with demarcation of the esophagi.

Case presentation A 27 year old female presented with a one year history of progressively worsening epigenetic pain, reflux, and fatigue. She was initially treated with acid suppression therapy by her primary care physician, which temporarily relieved her symptoms. However, her symptoms became refractory to medication and she noted the onset of dysphasia. She reported a remote history of bulimia nervous (BAN) of approximately one year duration at the age of 17.

She reported episodes of binge eating and self- induced vomiting, at least once a day.

She denied any further history of bulimia since that time, which was corroborated by her mother. The patient reported smoking approximately 10 cigarettes per day since the age of 20, and had recently quit. She denied alcohol and drug abuse, and had no family history of malignancy. On physical examination the patient's weight was 102 lbs (IBM18. 7).

There were no physical findings suggestive of chronic bulimia such as dorsal finger calluses, dental erosion, or parroted enlargement. She denied recent weight loss.

The patient had mild epigenetic tenderness on palpation of the abdomen. The remainder of her examination was within normal limits. Routine laboratory tests were normal Upper gastrointestinal endoscope revealed a 10 mm ulcerated lesion with diffuse rather near the gastrointestinal (GE) Junction (Figure 1).

Biopsies from this area demonstrated poorly differentiated demarcation (Figure 2). Endoscopies ultrasound revealed a 20 mm x 20 mm, hypotonic, non-circumferential mass at the SE Junction with evidence of serial invasion, but no nodal disease. CT scan revealed no evidence of nodal or metastasis disease.

The patient was clinically staged as having TO NO MO disease (Stage “ a). Figure 1. Endoscope.

Shown is a small 10 mm ulcerated lesion at the GE Junction (blue arrow) seen on endoscope. Figure 2 Biopsy from endoscope. High power and low power images from endoscopies biopsy are shown above. Invasive demarcation and glandular metastasis can be seen beneath the intact exogamous epithelium on the lower power image. Signet rings (red arrows) are seen in the higher power image.

The patient elected to undergo nonadjacent contradiction with exaltation, 5-IF, and Executrix with concurrent radiation to a dose of 5040 cagy.

She had I-tube placement prior to treatment. She required one admission for fluids and nutritional support during treatment. Six Knees after completing nonadjacent contradiction she underwent an Ivory Lewis esophageal, during which a right ovarian mass was noted and biopsies. Frozen section revealed metastasis and a right peremptory was performed. Pathology revealed signet ring cell demarcation of the GE Junction and ovary, three positive gastric lymph nodes and three negative esophageal nodes.

She then received adjutant chemotherapy with prurience, captains and capacitance for six cycles. The patient was then followed regularly every three months with CT imaging. Interval evaluation at twelve months after diagnosis, five months after completing adjutant Chemotherapy, demonstrated no evidence of disease. Unfortunately, CT performed thirteen months after diagnosis demonstrated interval development of pleural effusions, ascetics and a large pelvic mass, likely arising from the left ovary, consistent Ninth recurrent metastasis disease.

Discussion rhea present case report demonstrates the importance of diagnosing esophageal cancer early, particularly in young patients, as advanced disease carries a devastating prognosis. Previous studies have demonstrated an associated between demarcation of the esophagi and reflux , the length and severity of reflux], and rugs which relax the lower esophageal sphincter.

These studies have suggested up to a 44 fold increase in the risk of developing demarcation of the esophagi with severe reflux and a 30-125 fold increase in risk in patients with Barrette’s esophagi 7].

It appears family history is not strongly associated with the risk of developing esophageal cancer [8]. In the case of our patient there was no history of chronic reflux disease, with reflux symptoms only arising near the time of diagnosis. Furthermore, she had limited exposure to cigarettes and alcohol, which are more molly associated with exogamous cell carcinomas of the esophagi. Given the lack of other risk factors, it seems reasonable to consider her history of bulimia as a possible risk factor for her cancer.

Similar to chronic reflux, bulimia may cause Chronic irritation and trauma to the esophagi leading to dysphasia and ultimately timorousness. It is difficult to determine Ban’s exact prevalence due to changes in definition and difficulty in obtaining accurate responses in surveys, but it appears to be about 2% . Esophagi and Barrette’s esophagi are known complications of BAN , forever only a few cases of esophageal cancer arising in patients with BAN have been reported. Two cases of women in their ass’s with a history of BAN who developed esophageal cancer have been reported but no further details were provided.

Another case report described a young male patient with demarcation of the cervical esophagi who and a history to BAN and alcohol abuse.

Endoscope demonstrated extensive Barrette’s esophagi and high grade dysphasia of the entire esophagi with superimposed candidly infection. A patient with longstanding BAN who developed demarcation of the stomach has also been reported Another case report ascribes a 42 year old woman with a history of BAN, without a history of smoking or drinking, who developed exogamous cell carcinoma (SAC) of the distal esophagi.

The present case report describes a 27 year old female with a remote history of BAN, which Nas of short duration, who was subsequently diagnosed with demarcation of the esophagi. This patient is unique for a number of reasons including her young age and the relatively short history of bulimia, which was significantly less severe than prior case reports. Conclusion Studies suggest that there are long delays in the diagnosis of esophageal cancer.

Determining which factors put a patient at increased risk is critical as advanced disease has a poor prognosis.

Esophageal cancer is most prevalent among older patients; however BAN may represent an important risk factor in younger patients. Several prior case reports describe patients who were diagnosed at a young age . Irish suggests that endoscope may be warranted in younger patients with BAN who present with new onset of persistent pain, weight loss, ethnography or dysphasia. rhea course of the present patient suggests that even a remote, short history of BAN may increase the risk for demarcation of the esophagi.