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Concomitant Esophageal Subepithelial Tumor Causing Dysphagia in a Patient with PD: A Case Report

Na Young Kim, Joon Sung Kim, Mi-Jeong Yoon, Soo Hoe Lee, Bo Young Hong

Department of Rehabilitation Medicine, Saint Vincent's hospital, College of Medicine, The Catholic University of Korea

Background

Dysphagia in Parkinson's disease (PD) is typically attributed to oropharyngeal discoordination or neurogenic esophageal dysmotility.

We report a case where obstructive dysphagia caused by an esophageal subepithelial tumor (SET) was found concomitantly in a patient with suspected PD.

Case Presentation

A 54-year-old male presented with a 6-month history of dysarthria and gait disturbance. Brain PET-CT showed decreased dopamine transporter (DAT) uptake in the left striatum and cerebellar atrophy. **(Fig 1)** Under presumptive diagnosis of Parkinson's disease (PD) or Multiple System Atrophy.

Levodopa/Benserazide 12.5/50mg was prescribed. One week after, the patient presented to the emergency room with a newly developed sensation of food getting stuck in the throat and chest area.

Physical examination revealed bradykinesia and postural instability without other focal neurologic deficits. This led to the initial clinical impression that the dysphagia was attributed to the progression of his neurodegenerative condition.

For evaluation, Video Fluoroscopic Swallowing Study (VFSS) showed no oral phase impairment with intact bolus formation and efficient propulsion. The swallowing reflex was triggered without delay, and PAS score was 1-2 across all consistencies. Notably, the AP view revealed significant residue and reflux in the upper esophagus just below the upper esophageal sphincter, suggesting a mechanical obstruction rather than purely neurogenic dysmotility. **(Fig 2)**

Subsequent chest and neck CT scans identified a mass encasing the trachea and the right main bronchus, also obliterating the esophageal lumen. **(Fig 3)**

Esophagogastroduodenoscopy revealed luminal narrowing in the upper esophagus. While initial biopsy was inconclusive, Endoscopic ultrasonography suggested a Gastrointestinal Stromal Tumor (GIST).

The patient is scheduled for surgical intervention by the Department of Thoracic Surgery.

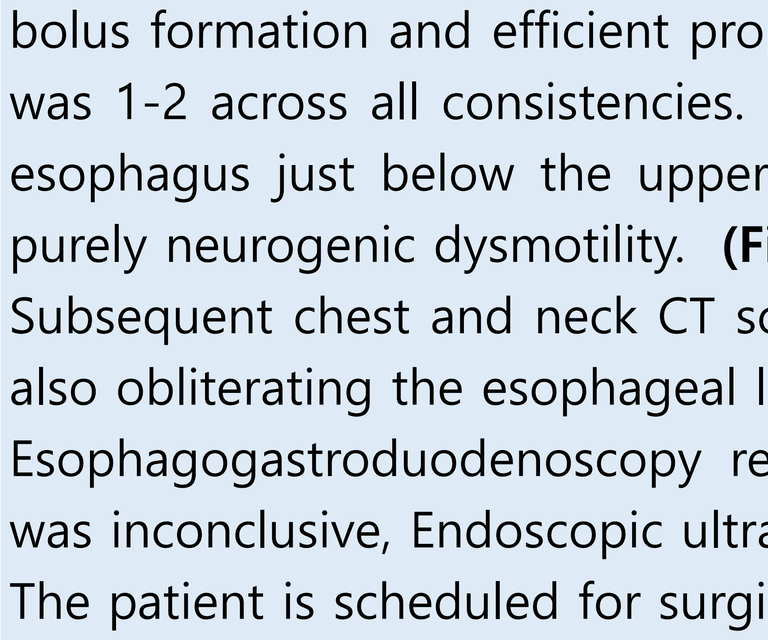

Figure 1. Brain PET CT
Decreased dopamine transporter (DAT) uptake in left striatum, consistent with the patient's parkinsonian features

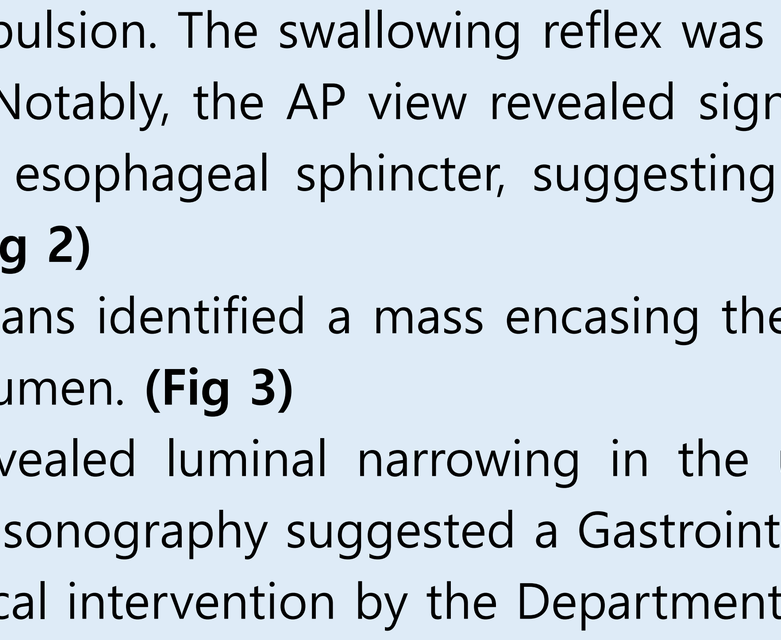

Figure 2. VFSS, AP view
Post-swallow residue (arrow) is observed in the upper esophagus

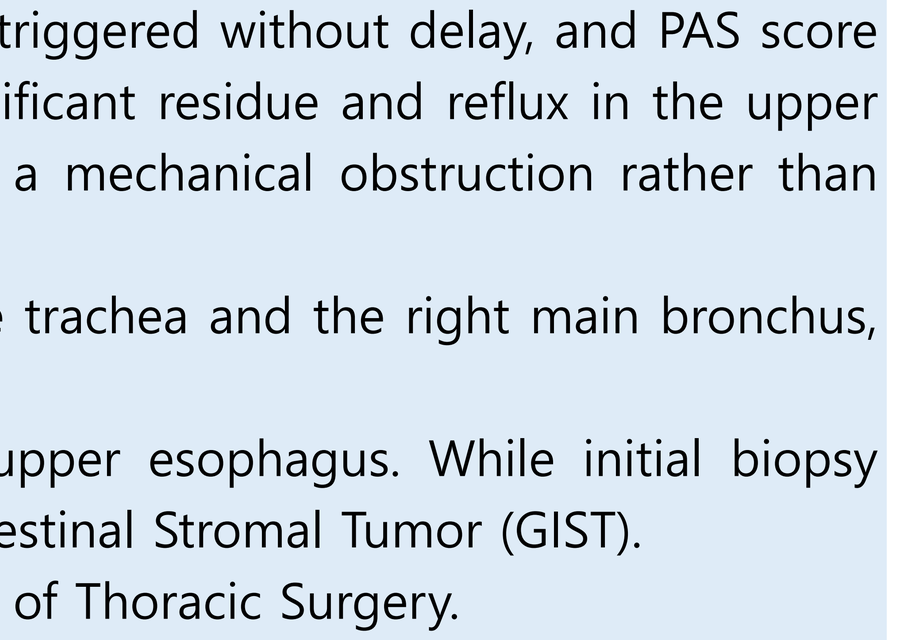

Figure 3. Neck CT:
A circumferential mass (asterisk) encasing the trachea, causing complete luminal obliteration of the esophagus

CONCLUSION

In neurodegenerative diseases, dysphagia is often presumptively attributed to disease progression.

This case demonstrates that structural lesions can present with similar symptoms, masking alternative etiologies.

While the lateral view is standard for aspiration risk, the AP view is crucial for evaluating the esophageal phase. Significant esophageal pooling on the AP view served as a decisive "red flag" for mechanical obstruction.