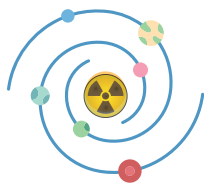


## Management of HER2-Positive AEG Type III Adenocarcinoma Complicated by Recurrent Perforated Diverticulitis: A Case Report



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### Case Presentation

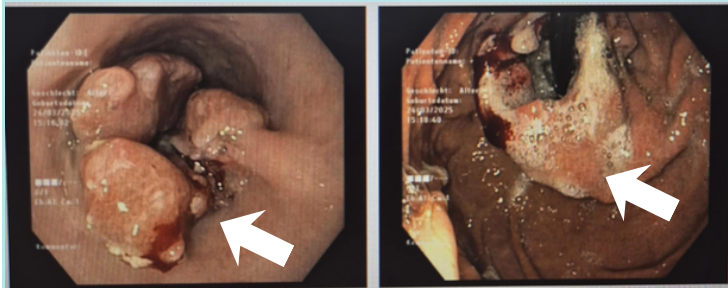
A 58-year-old male presented in March 2025 with progressive dysphagia, epigastric pain, and a 17 kg unintentional weight loss over ten months. Due to severe stenosis at the esophagogastric junction, he was able to tolerate only soft or puréed food. Initial evaluation with gastroscopy, endoscopic ultrasound (EUS), and computed tomography (CT) of the thorax and abdomen identified a stenosing lesion consistent with esophagogastric junction (AEG) type III

adenocarcinoma staged as uT3 with suspected regional lymph node involvement (*Figures: 1 and 2*).

Staging with positron emission tomography–CT (PET-CT) demonstrated hypermetabolic activity in the primary lesion and in regional lymph nodes dorsal to the gastric fundus, without evidence of distant metastases (*Figure 3*).

Diagnostic laparoscopy excluded peritoneal carcinomatosis. Tumour markers revealed a mildly elevated carcinoembryonic antigen (CEA) of 13.5 µg/L, with normal CA 19-9 and CA 72-4 levels. Following multidisciplinary tumour board review and confirmation of human epidermal growth factor receptor 2 (HER2) overexpression, the patient received four cycles of neoadjuvant 5-fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) combined with trastuzumab between April and May 2025. Follow-up CT in June showed significant tumour regression but also identified a contained

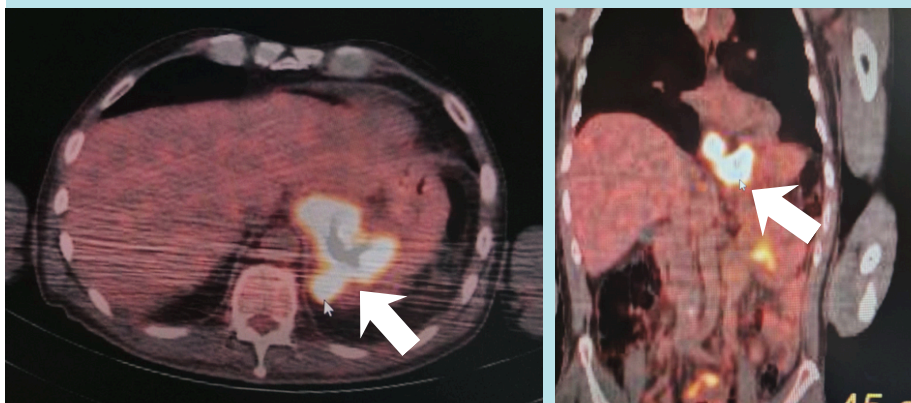
**Fig. 1** Esophagogastroduodenoscopy demonstrating the tumorous lesion



**Fig. 2** CT demonstrating the tumorous lesion



**Fig. 3** PET/CT demonstrating the tumorous lesion



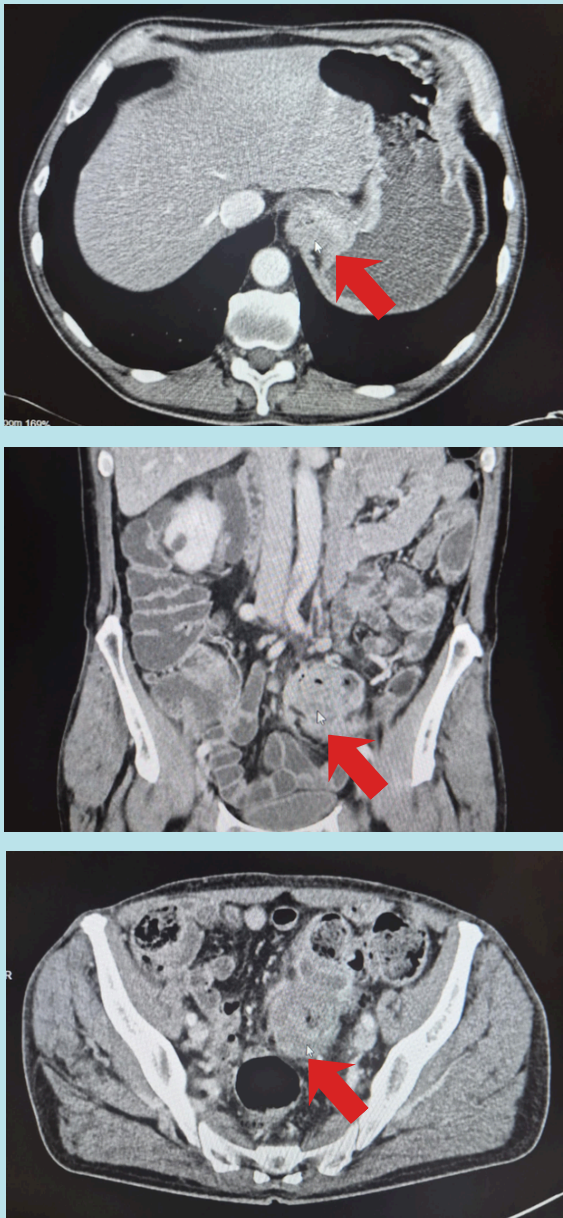
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perforation of the sigmoid colon with perisigmoidal abscess secondary to diverticulitis, consistent with the patient's intermittent left lower abdominal pain (*Figure 4*).

The diverticulitis was managed conservatively with antibiotics, resulting in clinical improvement. After repeat tumour board evaluation, he was deemed suitable for curative-intent surgery.

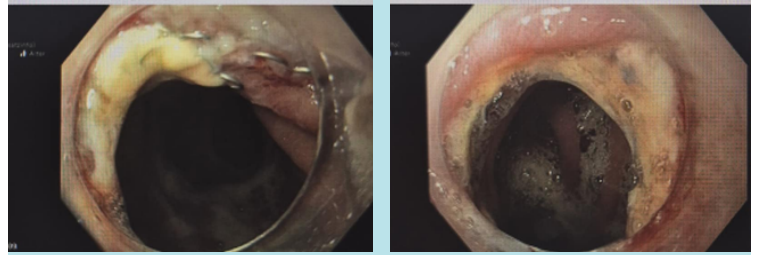
**Fig. 4** CT demonstrating perisigmoidal abscess



In July 2025, the patient underwent minimally invasive robotic Ivor-Lewis esophagogastric resection with extended lymphadenectomy and intrathoracic anastomosis (*Figure 5*).

Preoperative pyloric dilatation was performed to facilitate postoperative gastric emptying. Histopathology revealed ypT3, ypN0 (0/28), L0, V0, Pn0, R0, G3, and HER2-positive adenocarcinoma, confirming complete resection.

**Fig. 5** postoperative Esophagogastroduodenoscopy



Postoperatively, recurrent left lower abdominal pain prompted CT imaging, which confirmed recurrent sigmoid diverticulitis with perisigmoidal abscess.

Conservative management was continued, followed by two additional cycles of FLOT plus trastuzumab between late August and early September 2025. Due to persistent recurrence, elective laparoscopic rectosigmoid resection was performed in October 2025. Intraoperatively, a suspicious lesion in the ileocecal region warranted extension to right hemicolectomy. Histopathology of both specimens demonstrated only purulent inflammation and abscess, with no malignancy.

After the final tumourboard review in November 2025, with all curative-intent treatment completed, the patient was enrolled in structured oncologic follow-up, including periodic CT imaging, endoscopy, and clinical assessment. At the time of this report, there was no evidence of residual or recurrent disease.