Successful Treatment of Esophageal Granular Cell Tumor by Endoscopic Submucosal Dissection

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Granular cell tumors (GCTs) are rare lesions with a reported incidence of 0.02-0.03% of all tumors in the general population. Treatment strategy for esophageal GCT still remains controversial. We present here a case of an esophageal GCT successfully treated by endoscopy. A 32-year-old woman was referred to our hospital for a further evaluation of an esophageal tumor. The patient had a 6-month history of persistent odynophagia. An upper gastrointestinal endoscopy revealed a sessile yellow-white submucosal tumor measuring approximately 10 mm in diameter in the cervical esophagus, 18 cm from the incisor teeth. We considered that the tumor was confined to the submucosal layer without infiltrating the muscle layer, because the tumor was well movable when grasped with a forceps during endoscopy. An endoscopic punch biopsy revealed a GCT, showing growth of large cells with fine eosinophilic granules. We tentatively diagnosed that the symptom was caused by the esophageal GCT; therefore, the patient underwent endoscopic excision.

Endoscopic submucosal dissection (ESD), which was one of the endoscopic resection techniques, was successfully carried out under general anesthesia without any complications. The specimen measured 11 X 7 X 3.5 mm, and showed a sessile, yellow-white polypoid lesion of 8 X 3 mm. Pathology including immunohistochemical study indicated a benign GCT. The margins were free of tumor cells. The patient had an uneventful post-ESD course and was discharged from the hospital 4 days after the ESD. To date, she has remained free of symptoms. ESD is a powerful technique for treating esophageal cancer, which enables the complete removal of the primary tumor as a single fragment with a cancer-cell-negative lateral margin. We believe that ESD could also be a promising procedure to remove esophageal GCT.
Microscopic Cancer Cell Deposits in Gastric Cancer: Whole-section Analysis of the Mesogastrium.

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**Purpose:** On routine pathologic examination of resected gastric cancer specimens, cancer cells are often found in the adipose connective tissue apart from the primary lesion or around the lymph nodes. Furthermore, several reports suggested that such a pathological finding could be an independent negative prognostic factor for postoperative survival. However, the methodologies to detect these cancer cells were inconsistent among studies. To investigate the incidence and distribution of the microscopic cancer cell deposits around the lymph nodes, whole-section analysis of the mesogastrium was conducted.

**Method:** One thousand five hundred fifty-two sections of the mesogastrium obtained from 37 patients with gastric cancer were examined. To accurately identify cancer cell deposits, an antihuman cytokeratin antibody (AE1/3, DAKO, Copenhagen, Denmark) was used. A monoclonal antibody D2-40 (Signet Laboratories, Dedham, MA, USA), a specific marker of lymphatic vessels, was also used to identify lymphatic vessels.

**Results:** As a whole, microscopic deposits were detected in three (8%) of the 37 patients examined. Microscopic deposits were found in three of the 12 patients with advanced cancer, while not in 25 patients with early stage cancer, which was defined as a lesion confined to the mucosa or submucosa regardless of the presence or absence of lymph node metastasis. The distributions of microscopic deposits were classified into three types: cancer cell deposits in adipose connective tissue apart from the primary lesion or around the metastatic lymph nodes in 3 cases, cancer cell deposits in the lymphatic vessels in 2 cases, and cancer cell deposits as the result of the rupture of the metastatic lymph node capsule followed by infiltration around lymph nodes in 2 cases. These patients had an undifferentiated type of tumor (two with poorly differentiated adenocarcinoma, and one with mucinous adenocarcinoma), lymph node metastasis, and peritumoral lymphatic invasion.

**Conclusions:** Microscopic cancer cell deposits may be present in the mesogastrium apart from metastatic lymph nodes. Therefore, we should pay particular attention to the potential existence of microscopic deposits when curative resection of gastric cancer is attempted.
Successful Treatment of Duodenal Carcinoid Tumor by Laparoscopy-assisted Endoscopic Full-thickness Resection with Lymphadenectomy

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Endoscopic full-thickness resection of the duodenum using endoscopic submucosal dissection (ESD) technique has never been reported. We present here a case of a duodenal bulb carcinoid tumor successfully treated by laparoscopy-assisted endoscopic full-thickness resection (LAEFR). An asymptomatic 65-year-old woman had a 10-mm, submucosal tumor on the anterior wall of the duodenal bulb. Abdominal computed tomography revealed an enlarged lymph node adjacent to the duodenum and pancreas. Although we informed the patient of the need for pancreateoduodenectomy with a lymphadenectomy, the patient expressly requested the LAEFR. After a confirmation of negative nodal metastasis by an intraoperative frozen section of the enlarged nodes, LAEFR was carried out using ESD technique under the laparoscopic assistance. The duodenal wall defect was closed by laparoscopy with an Albert anastomosis. The entire circumferential margin of the specimen was histopathologically negative for carcinoid tumor cells. In summary, LAEFR enables en-bloc and whole-layer excision of nonperiampullary duodenal lesions with an adequate sufficient surgical margin, both vertically and laterally. LAEFR is a minimally invasive and effective treatment for selected patients with duodenal carcinoid tumor.

A Case of the Sigmoid Colon Cancer with Abdominal Wall Abscess

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A 63-year-old man was admitted to hospital because of an abdominal mass and fever, 38.0°C. Computed tomography revealed an abscess (21 × 20 cm) in the abdominal wall and the sigmoid colon tumor. Cancer of the sigmoid colon complicated by an abscess of the abdominal wall was diagnosed. Abscess drainage and transverse colostomy was done for life saving. After 1st operation, Chemotherapy (CapeOx ×3) was done for curative operation. 3 months after the 1st operation, Sigmoidectomy and stoma closure was done. Macroscopic and Microscopic examination of the resected specimen showed no remnant of cancer. In patients of advanced colon cancer with involvement of abdominal wall, two staged operation and preoperative chemotherapy would be necessary for curative resection.