Gastric Extremely Well-Differentiated Intestinal-Type Adenocarcinoma: A Challenging Lesion to Achieve Complete Endoscopic Resection

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Among 872 patients with early gastric cancer, 17 EWDAs were identified (1.9%). Endoscopically, the flat or depressed type was significantly more common among EWDAs (88.2%) than among early gastric cancers of other histologies (37.8%; P<0.01). The discrepancy between endoscopically estimated tumor size and tumor size as con-

confirmed in pathology reports was significantly greater among EWDAs (18.4±22.0 mm) than among others (5.8±7.5 mm). Involvement of the lateral resection margin was more common (29.4% vs. 2.5%; P<0.05), and complete resection was achieved less often in EWDAs (47.1% vs. 80.4%; P=0.01) compared to the others.

EWDAs are associated with higher rates of incomplete resection after ESD, especially along the lateral margins. Pathologists should alert endoscopists when this diagnosis is made, with its associated risks; and endoscopists should pay particular attention to the extent of these tumors during resection.

Introduction

Extremely well-differentiated tubular adenocarcinomas (EWDAs) of the stomach are characterized by surface maturation and their mimicking of intestinal metaplasia. Endoscopically, intramusco-

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Table 1

<table>
<thead>
<tr>
<th></th>
<th>EWDA cancer, n=17</th>
<th>Non-EWDA cancer, n=855</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age, years, mean ± SD</td>
<td>55.3 ± 13.5</td>
<td>62.8 ± 9.7</td>
<td>0.04</td>
</tr>
<tr>
<td>Male sex, n (%)</td>
<td>13 (76.5)</td>
<td>678 (79.3)</td>
<td>0.77</td>
</tr>
<tr>
<td>Location, n (%)</td>
<td>0.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper</td>
<td>1 (5.9)</td>
<td>66 (7.7)</td>
<td></td>
</tr>
<tr>
<td>Mid</td>
<td>6 (35.3)</td>
<td>161 (18.8)</td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>10 (58.8)</td>
<td>628 (73.4)</td>
<td></td>
</tr>
<tr>
<td>Macroscopic appearance, n (%)</td>
<td>&lt;0.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elevated</td>
<td>2 (11.8)</td>
<td>532 (62.2)</td>
<td></td>
</tr>
<tr>
<td>Flat or depressed</td>
<td>15 (88.2)</td>
<td>323 (37.8)</td>
<td>&lt;0.02</td>
</tr>
<tr>
<td>Pathologic size, mm, mean ± SD</td>
<td>11.0 ± 5.9</td>
<td>14.8 ± 4.7</td>
<td>&lt;0.04</td>
</tr>
<tr>
<td>Histological type, n (%)</td>
<td>&lt;0.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Differentiated</td>
<td>17 (100)</td>
<td>834 (97.5)</td>
<td></td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>0</td>
<td>21 (2.5)</td>
<td></td>
</tr>
<tr>
<td>Invasion depth, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucosa</td>
<td>14 (82.4)</td>
<td>708 (82.8)</td>
<td></td>
</tr>
<tr>
<td>Submucosa</td>
<td>3 (17.6)</td>
<td>147 (17.2)</td>
<td></td>
</tr>
<tr>
<td>Lymphatic invasion present, n (%)</td>
<td>2 (11.8)</td>
<td>62 (7.3)</td>
<td>0.87</td>
</tr>
<tr>
<td>Venous invasion present, n (%)</td>
<td>0</td>
<td>5 (0.6)</td>
<td>n.s.</td>
</tr>
<tr>
<td>En bloc resection, n (%)</td>
<td>15 (88.2)</td>
<td>831 (97.2)</td>
<td>0.09</td>
</tr>
<tr>
<td>Lateral margin positive, n (%)</td>
<td>5 (29.4)</td>
<td>21 (2.5)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Vertical margin positive, n (%)</td>
<td>1 (5.9)</td>
<td>20 (2.3)</td>
<td>0.03</td>
</tr>
<tr>
<td>Margins indeterminable, n (%)³</td>
<td>1 (5.9)</td>
<td>9 (1.1)</td>
<td>0.18</td>
</tr>
<tr>
<td>Complete resection, n (%)</td>
<td>8 (47.1)</td>
<td>687 (80.4)</td>
<td>0.01</td>
</tr>
</tbody>
</table>

SD, standard deviation; n.s., not significant.
³ Due to electrocautery effect.

Results

Among the 872 patients who underwent an ESD, 17 had EWDAs (1.9%) and 855 non-EWDAs (Table 1). Endoscopically, the flat or depressed type was significantly more common among EWDAs (88.2%) than among other histologic subtypes (37.8%; P<0.01). The discrepancy (mean±SD) between pathologic tumor size and endoscopic tumor size was significantly greater for EWDAs (18.4±22.0 mm) than for others (5.8±7.5 mm) (P<0.05).

The rate of complete resection was significantly lower in EWDAs (47.1%) than in others (80.4%) (P=0.01). There were seven EWDAs with incomplete resection (positive lateral margins [n=5], positive vertical margin [n=1], and undetermined margins [n=1]) after ESD. The average follow-up period was 14.6±8.8 months, and there was no recurrence in the patients who underwent argon plasma coagulation ablation (n=1), additional ESD (n=3), or surgery (n=3).

Discussion

In this series, we investigated the differences in the effectiveness of endoscopic resection between EWDAs and non-EWDAs after ESD. We showed that the rate of complete resection was significantly lower in EWDAs than in other neoplasms. In particular, the rate of positive lateral margins was much higher in EWDAs. Gastric EWDAs are reported as very rare, comprising 0.1% of gastric adenocarcinomas [9]. However, in our series, the incidence of...
EWDA cancer was 1.9%. The design of the study (i.e., restricted to early gastric cancers manageable by ESD) may explain the relatively high incidence of this subtype. Endoh et al. were the first to report these diagnostically challenging well-differentiated adenocarcinomas that mimic the complete type of intestinal metaplasia and display a WHYX architectural pattern [3]. Microscopically, it is difficult to discriminate EWDA from regenerative or inflammatory changes of metaplastic epithelium [3]. Endoscopically, most EWDA in our series demonstrated limited color contrast against the surrounding mucosa and/or a slight depression. These subtle mucosal changes may explain the higher positive rate of lateral resection margins in EWDA in spite of thorough chromoendoscopic evaluations. In this study, the en bloc resection rate was 88.2% in EWDA and 97.2% in non-EWDA cancers.

With regard to non-EWDA cancers, the en bloc resection rate in our series was similar to that in a previous report [10]. In EWDA, the incomplete resection rate in our series (52.9%) was higher than the incomplete resection rate of non-EWDA after ESD in the previous study, because of higher rates of lateral resection margin involvement after the ESD procedure.

Despite our findings, endoscopic resection should remain the first therapeutic option because these neoplasms generally demonstrate slow tumor growth and a low ability to infiltrate submucosa [11, 12]. In practice, the completeness of resection can be difficult to predict for EWDA because the lesion spread can be wider than is estimated endoscopically [13, 14]. However, a pre-ESD biopsy diagnosis of EWDA is critical information that should help to guide the endoscopist to achieving complete resection.

**Fig. 1** a Endoscopic appearance of a gastric carcinoma. b Tumor topography on the primary endoscopic submucosal dissection. The yellow line illustrates the boundary of the neoplasm. The proximal, anterior, and posterior sites of the specimen were located at the 12 o’clock, 9 o’clock, and 3 o’clock positions, respectively (safety margins: 0.1 cm distally, 0.2 cm proximally, 0.6 cm anteriorly, and 0.2 cm posteriorly). c Pathologic findings. Extremely well-differentiated tubular adenocarcinoma confined to the lamina propria of the gastric mucosa (H&E, × 20). The neoplastic tubules show branching, tortuous, anastomosing structures associated with cryptitis.

**Fig. 2** Pathologic findings of the second endoscopic submucosal specimen (same patient as in Fig. 1). a The residual neoplasm was limited to the lamina propria and did not involve the resection margins (H&E, × 4). b, c Higher magnification views of extremely well-differentiated tubular adenocarcinoma (b) and adjacent complete intestinal metaplasia (c) (H&E, × 20).
In conclusion, this study represents the first attempt to investigate the effectiveness of ESD for gastric EWDAs. Compared to ESD for non-EWDAs, the complete resection rate was significantly lower, and we conclude that the higher rate of positive lateral resection margins results from the difficulties in determining the tumor boundaries of EWDAs endoscopically. Consequently, pathologists have an important role to play in guiding therapy by informing the endoscopists when a diagnosis of EWDA is made on preoperative biopsies. Endoscopists should then pay particular attention to the extent of these tumors and make every attempt to perform a wide excision when performing an ESD in order to achieve satisfactory lateral clearances.

Competing interests: None

References

Kang KJ et al. Gastric extremely well-differentiated intestinal-type adenocarcinoma... Endoscopy 2012; 44: 949–952