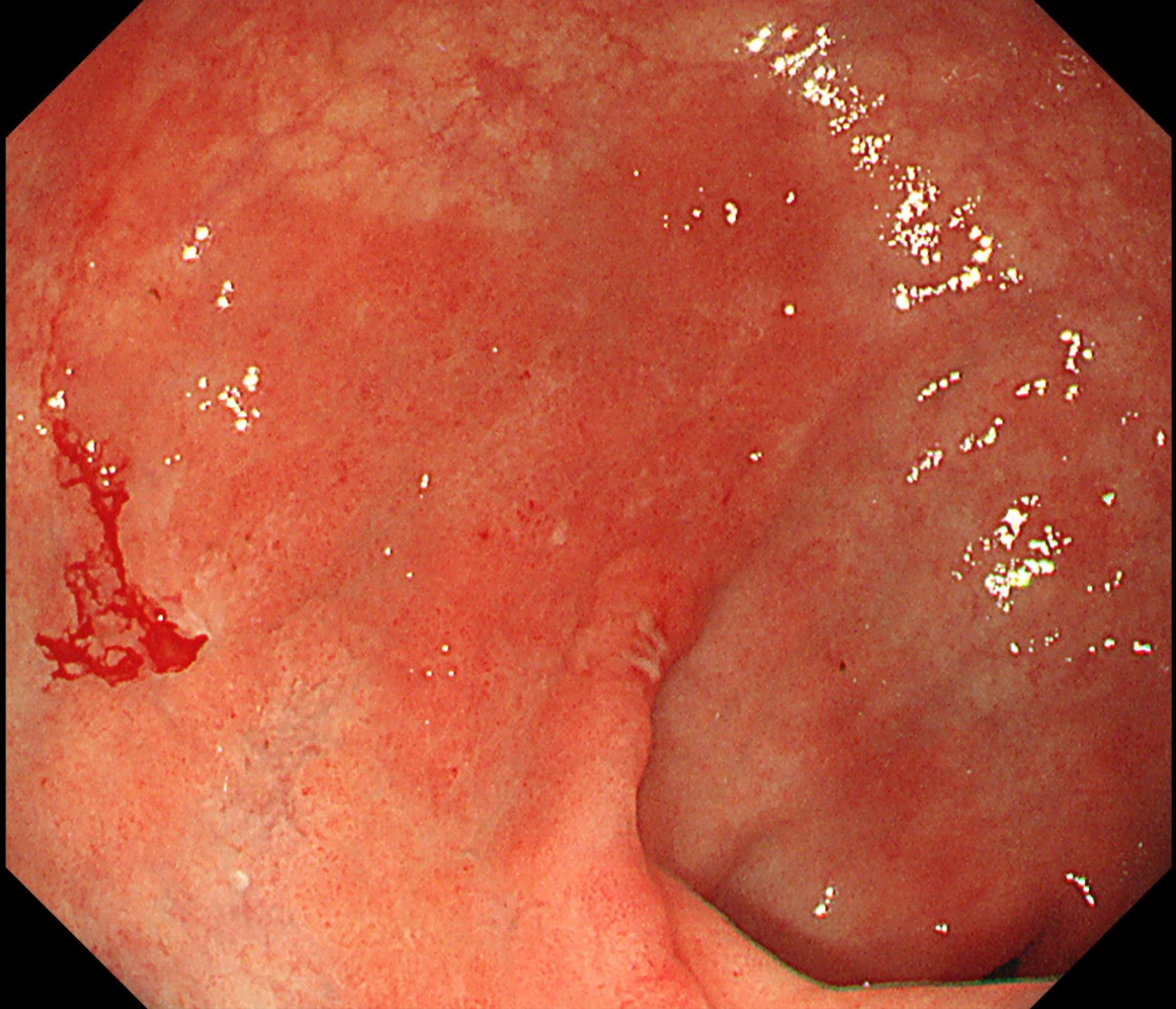
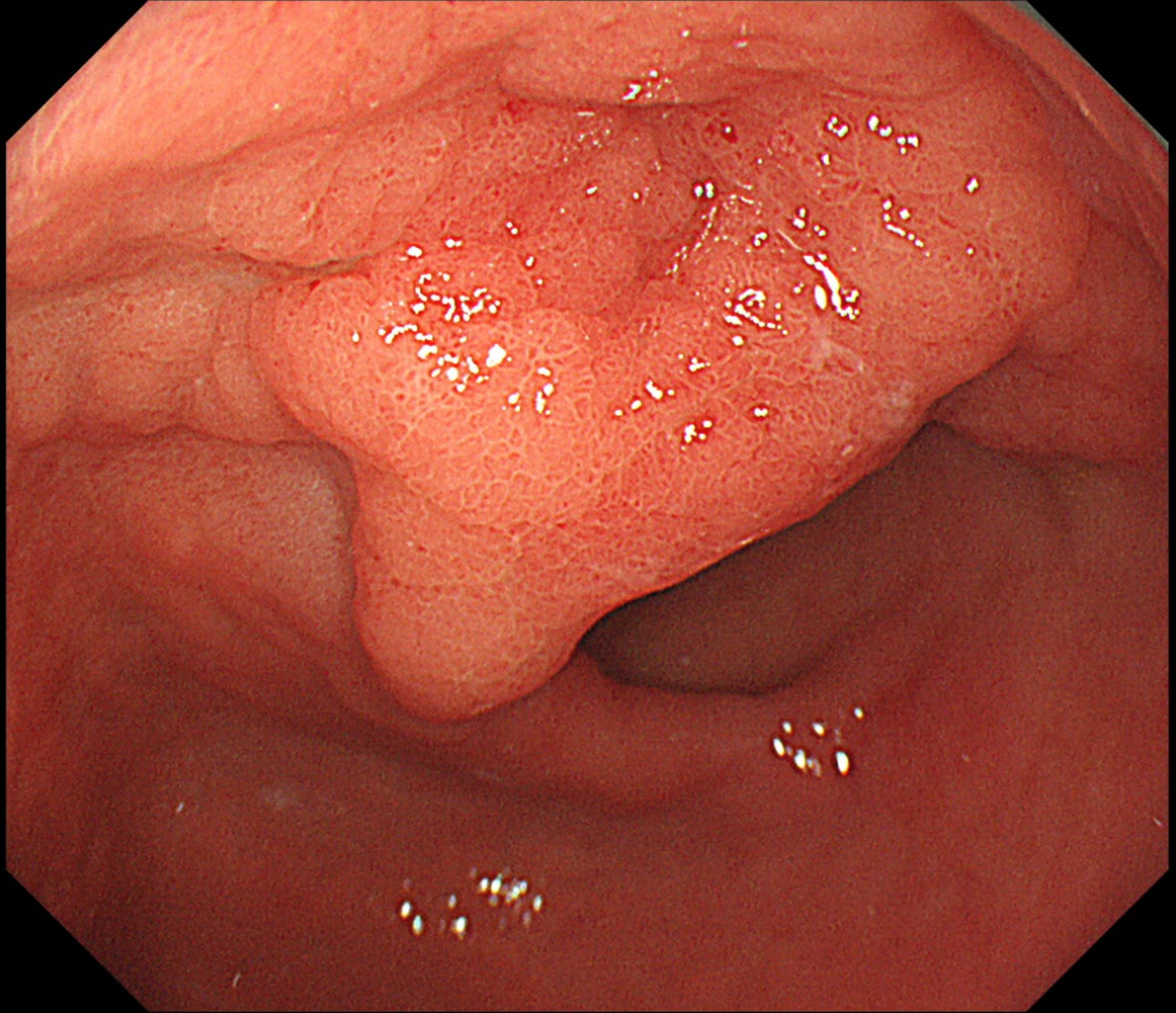
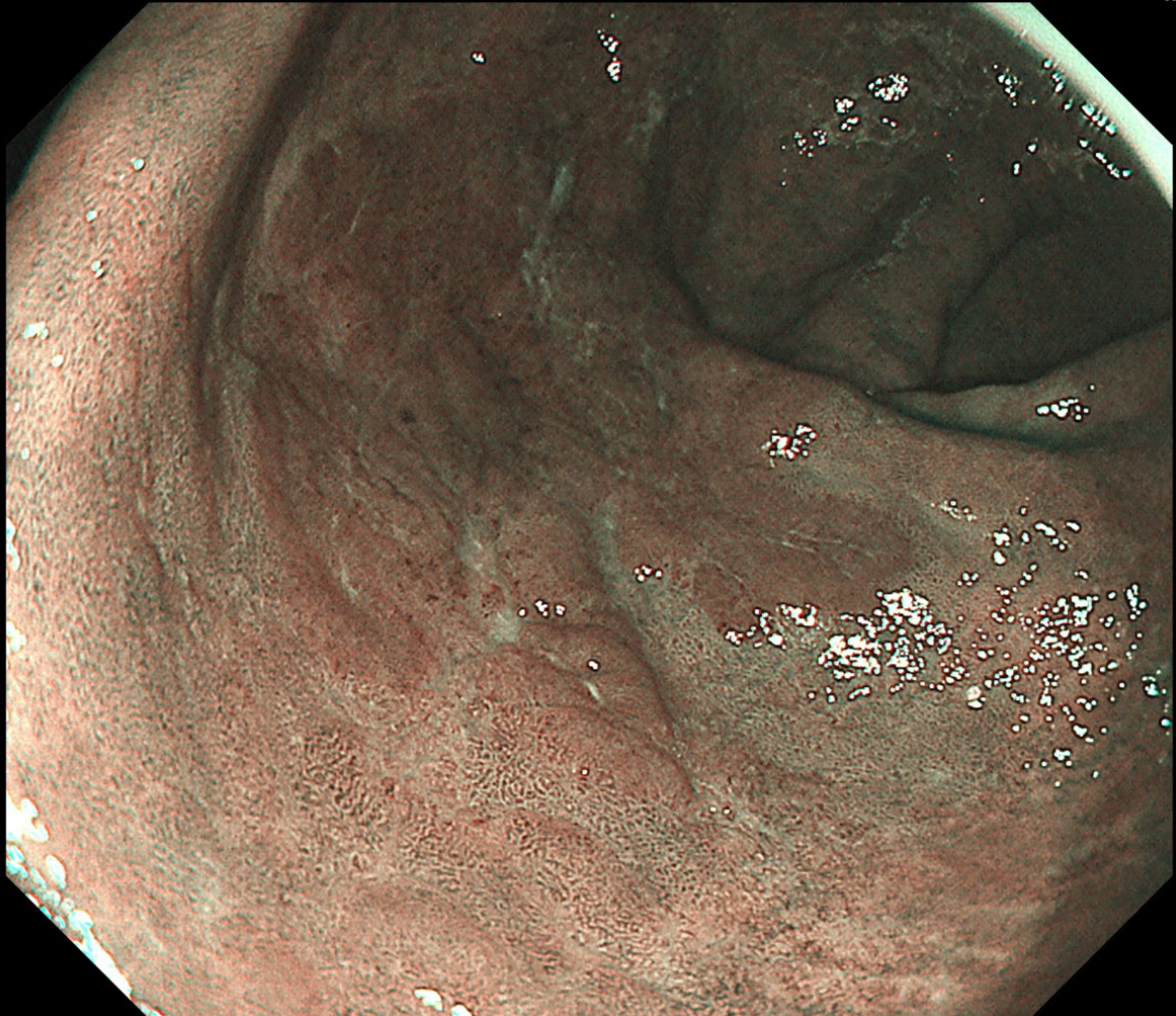
Mapping
胃

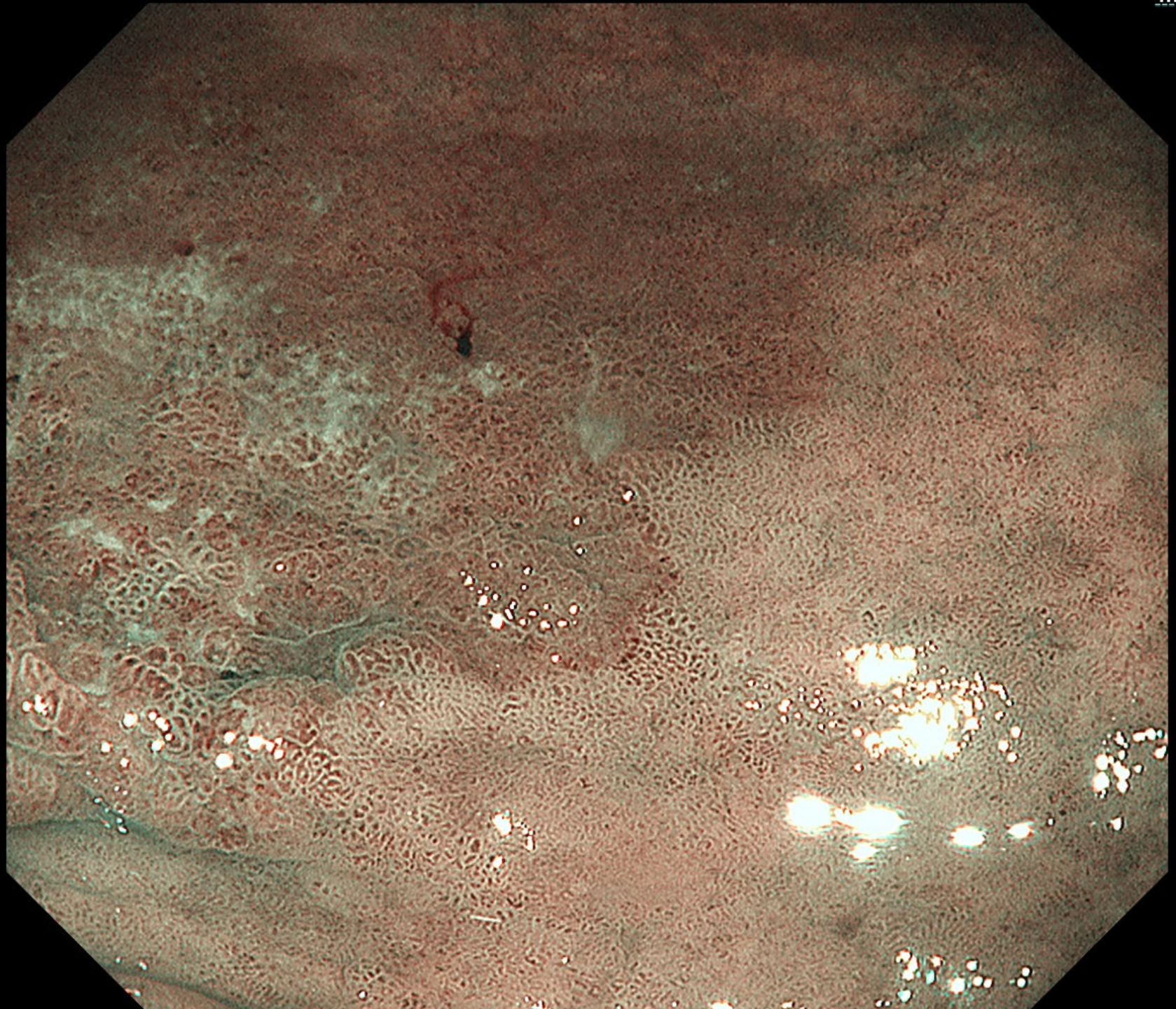
担当：大薄　直也

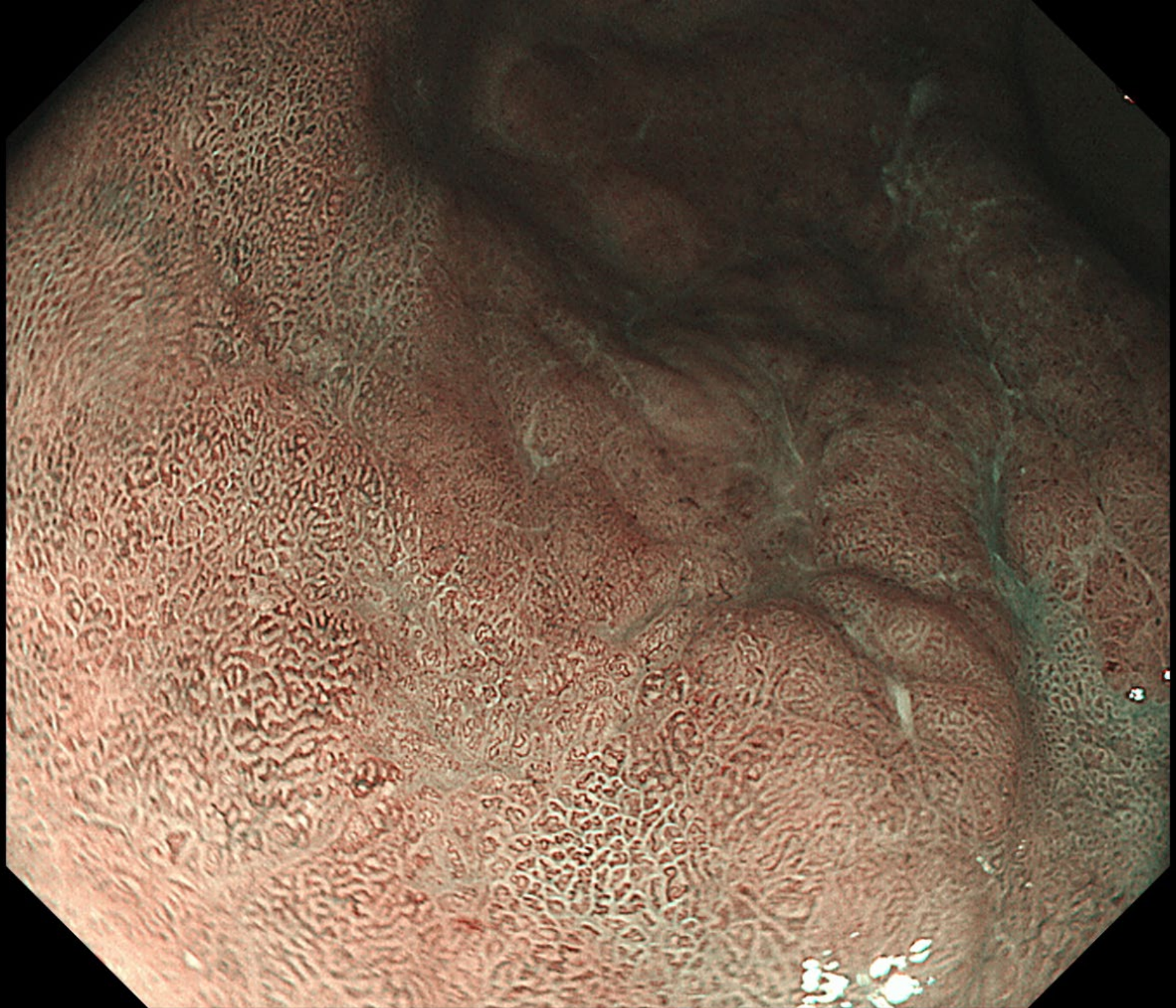
白色光・NBI
（6年前/初回ESD前）

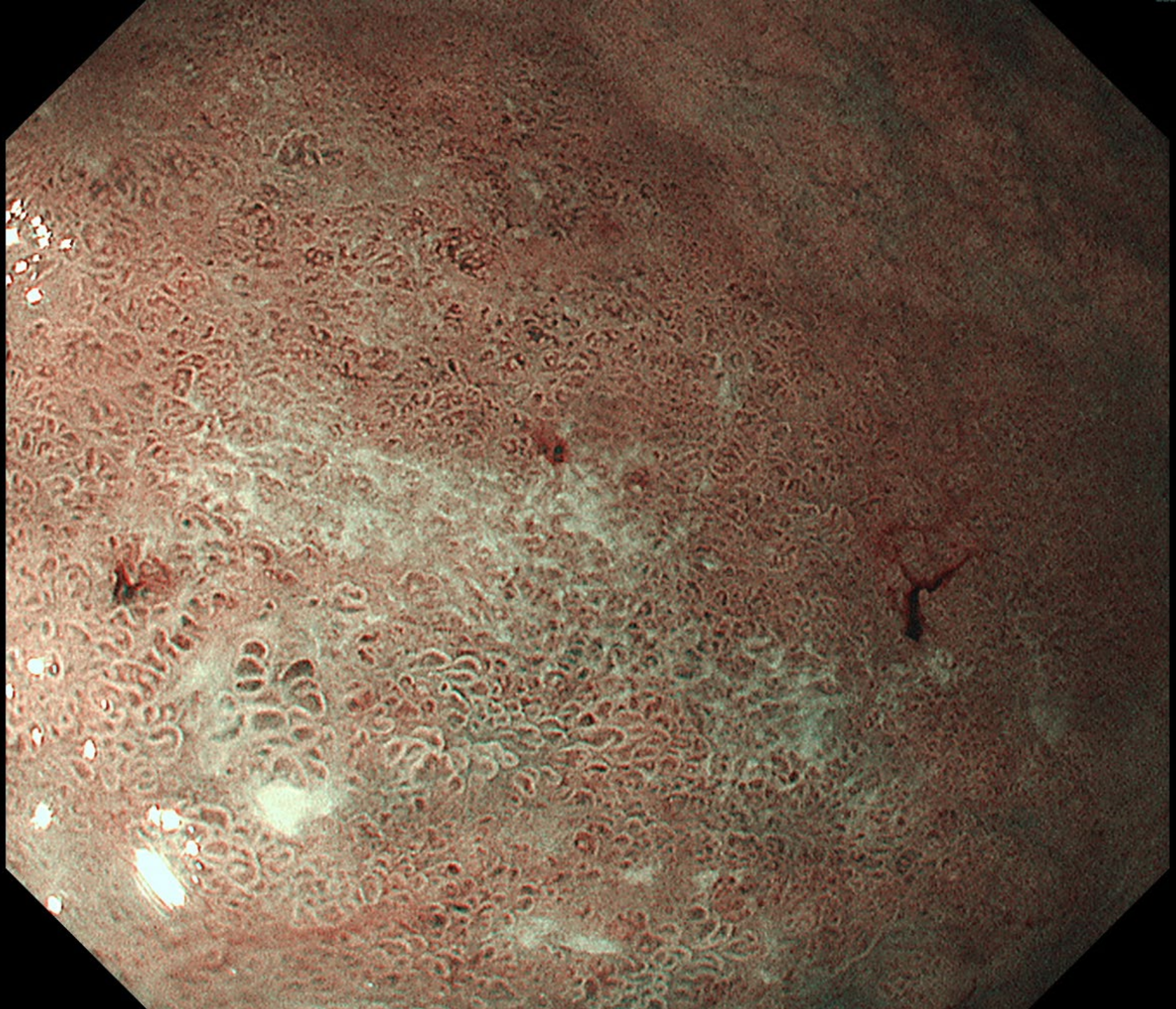


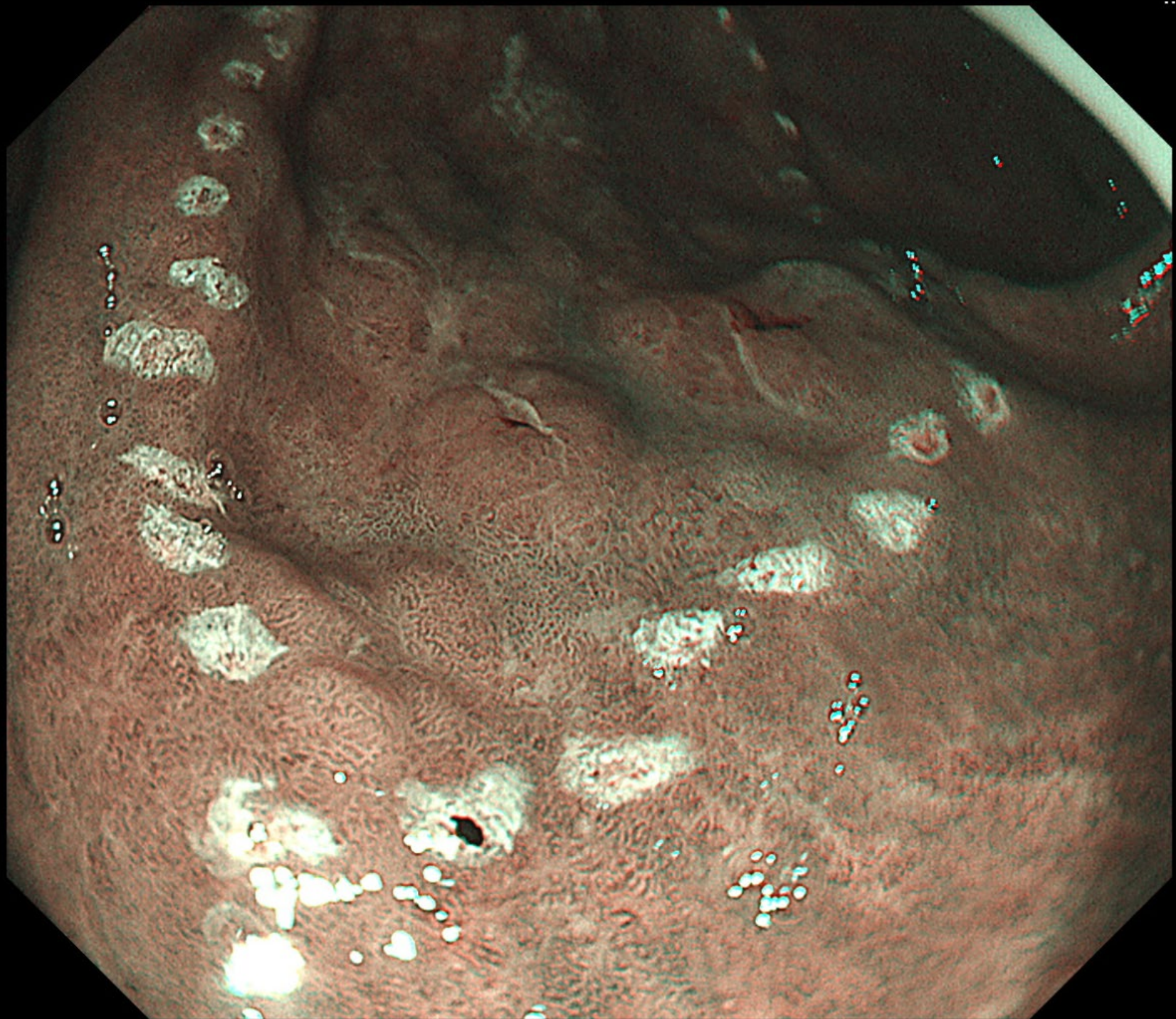


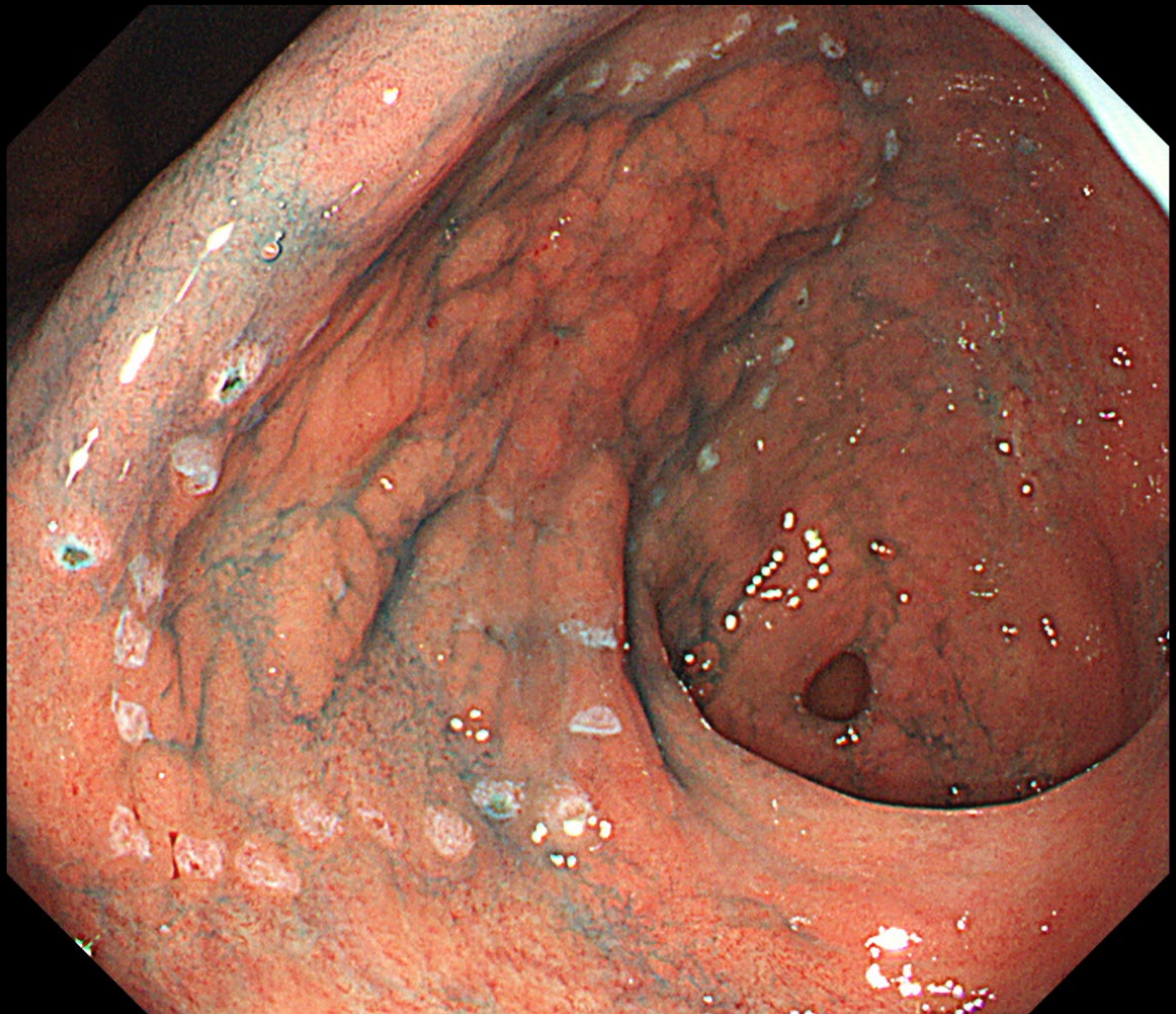


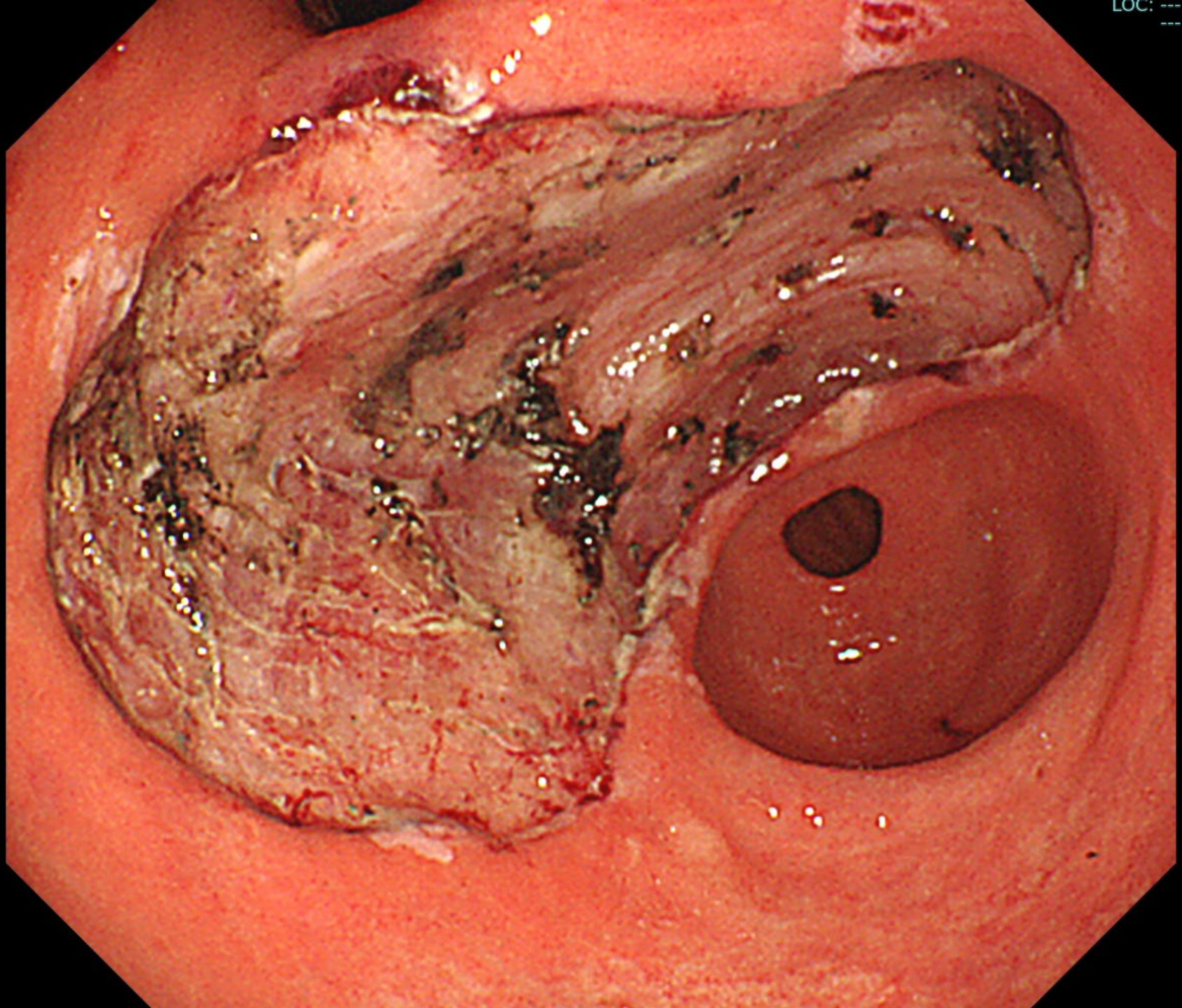











LOC: ---

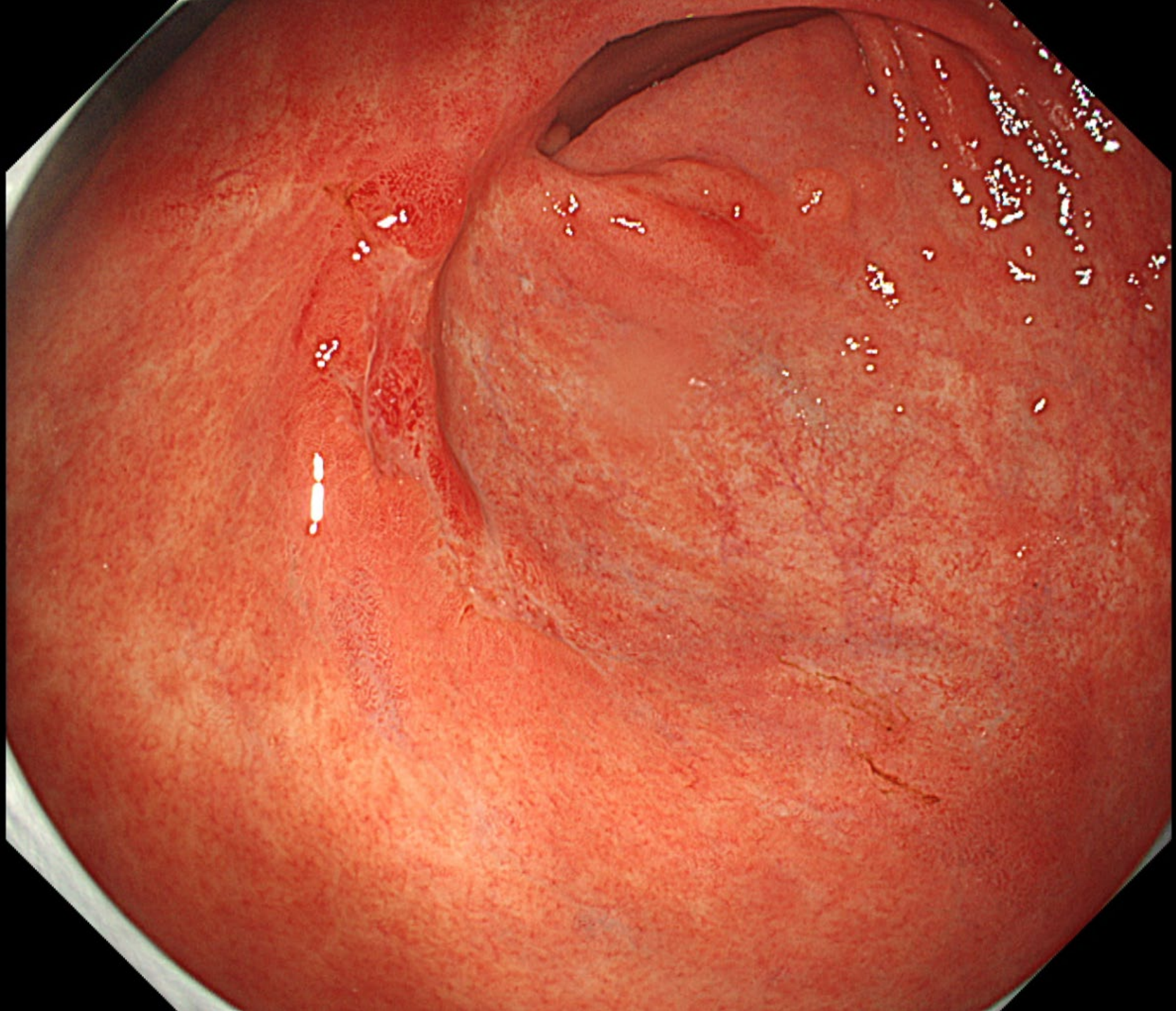
ESD病理結果

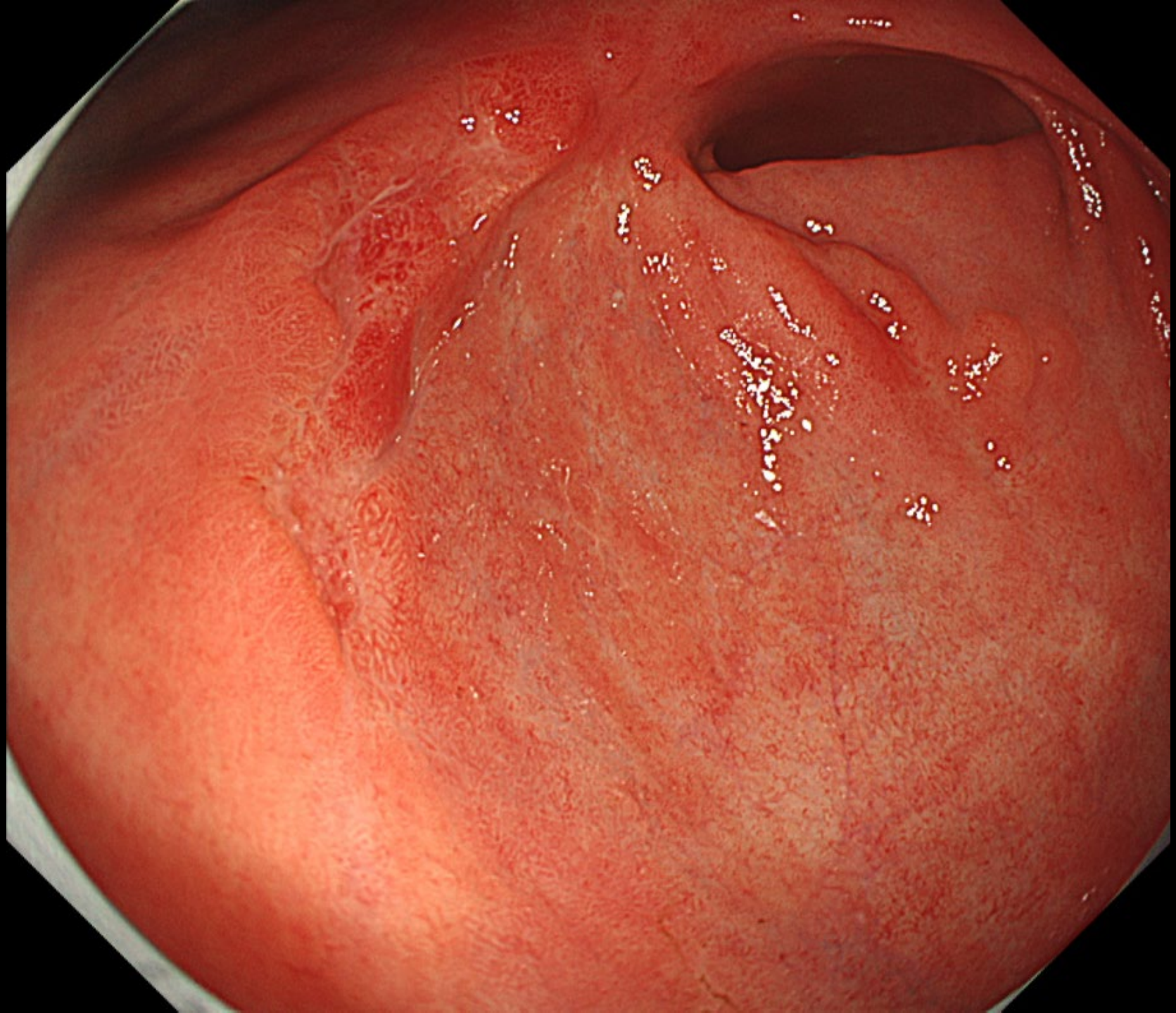
Stomach, ESD: tubular adenocarcinoma,
well differentiated (tub1>tub2>por), M, early, UL0,
Ly0, V0, HM0(see comments), VM0).

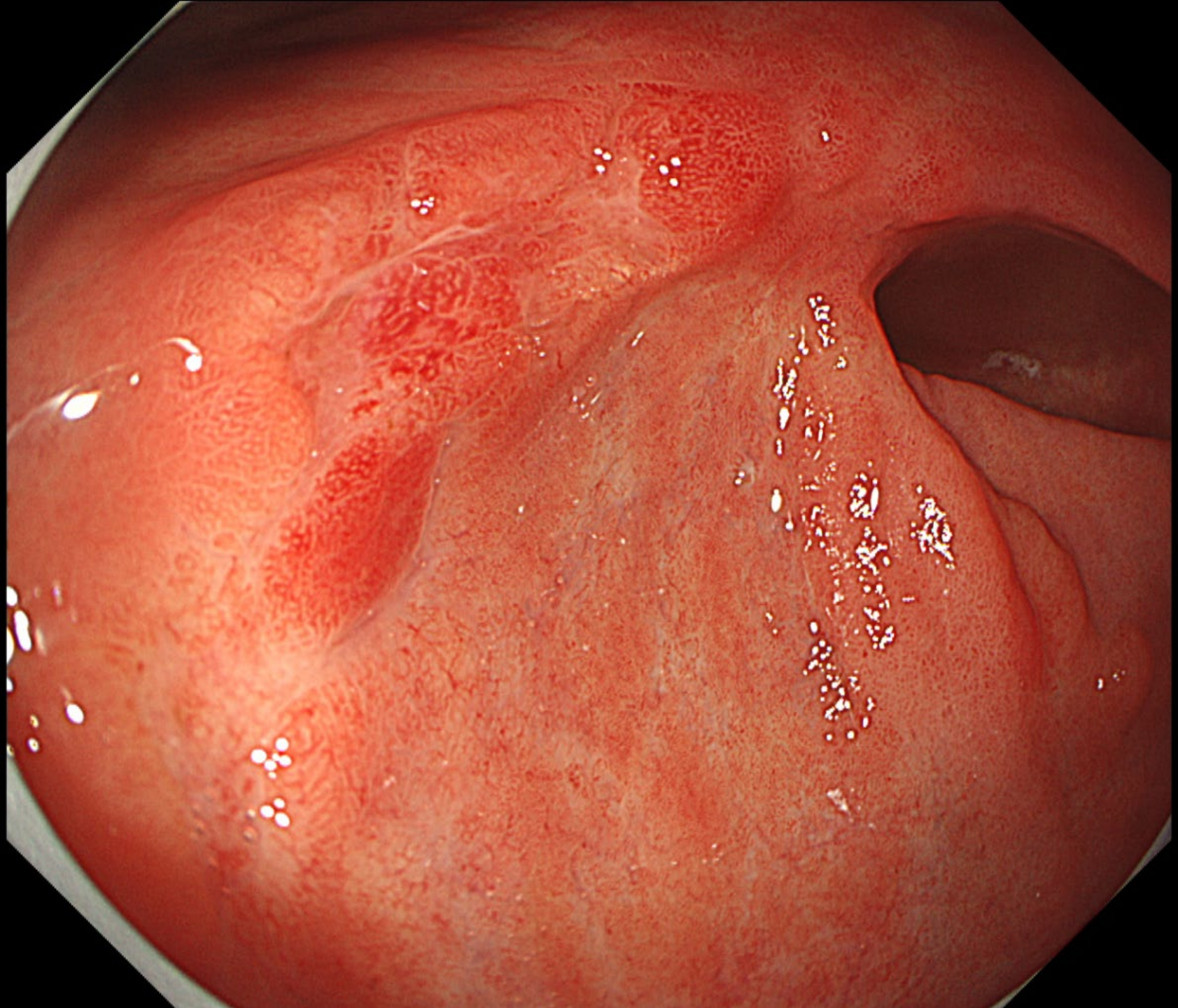
(追加訂正報告2018.9.19)
側方断端に関して、#8,10,11等では1-2mmと近接していますが、明らかな癌の焼灼・変性を認めず、陰性と推測されます(HMXをHM0に訂正しました)。
ただし、#1で腫瘍性か反応性か判断が難しい異型腺管を認め、
フォローアップをお願いします。

(前回報告2018.9.19)
#1-18：#1-16に高-低分化の腺癌が見られます。粘膜下組織への浸潤や脈管浸潤は明らかでありません。標本上の最大径は約37mm、16スライスに及ぶので48mm以下と思われます。#1で検体を裏返して、再度標本を作製した所、異型腺管が見られます。Ki-67陽性細胞が表層まで増加している部分も僅かに認め、腫瘍性変化か反応性変化か判断が難しく、フォローアップをお願いします。
また、#7は削ぎ切りになっており、側方断端の評価ができていません。

白色光(2024/6)
（3枚）







インジゴカルミン
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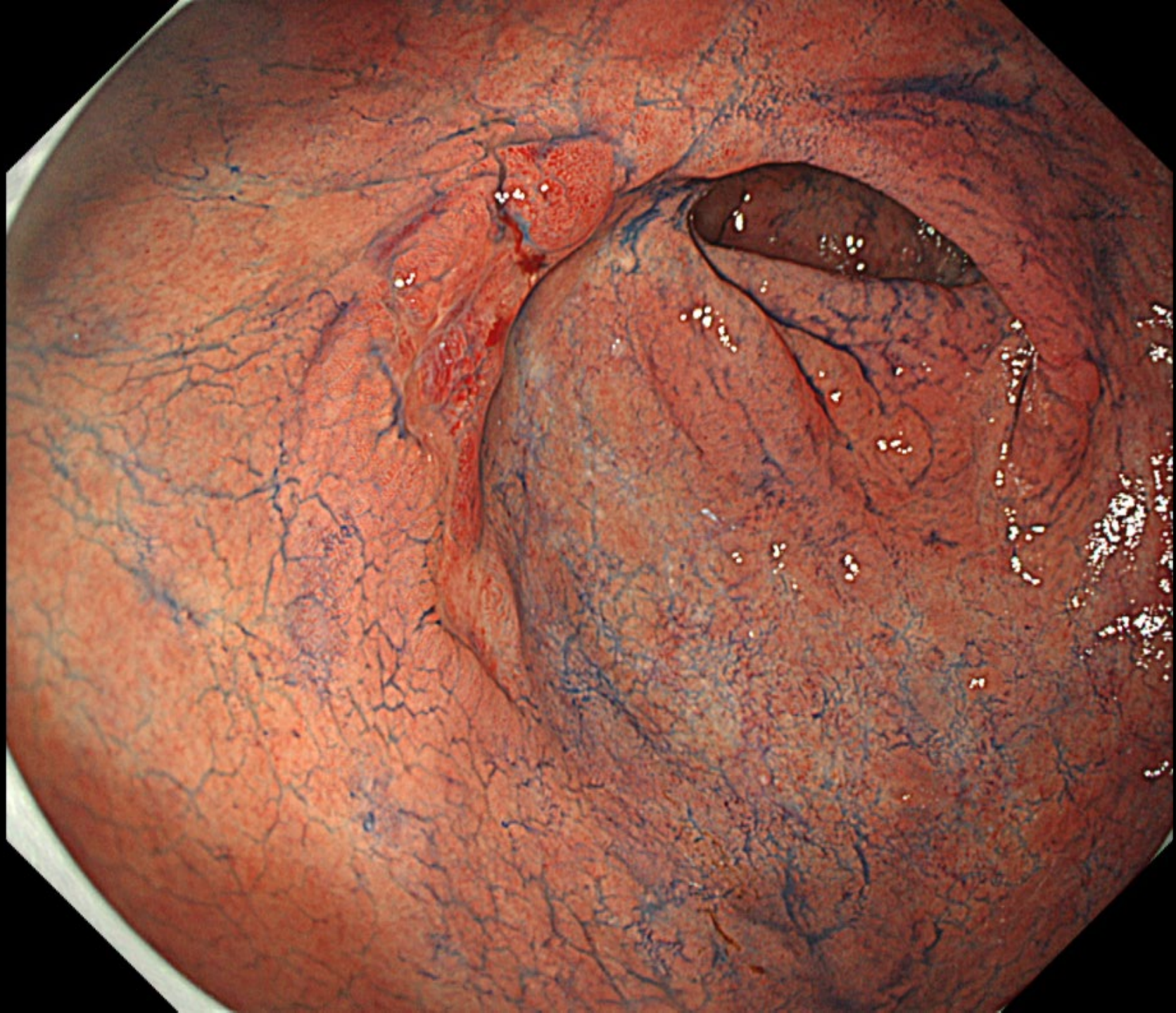
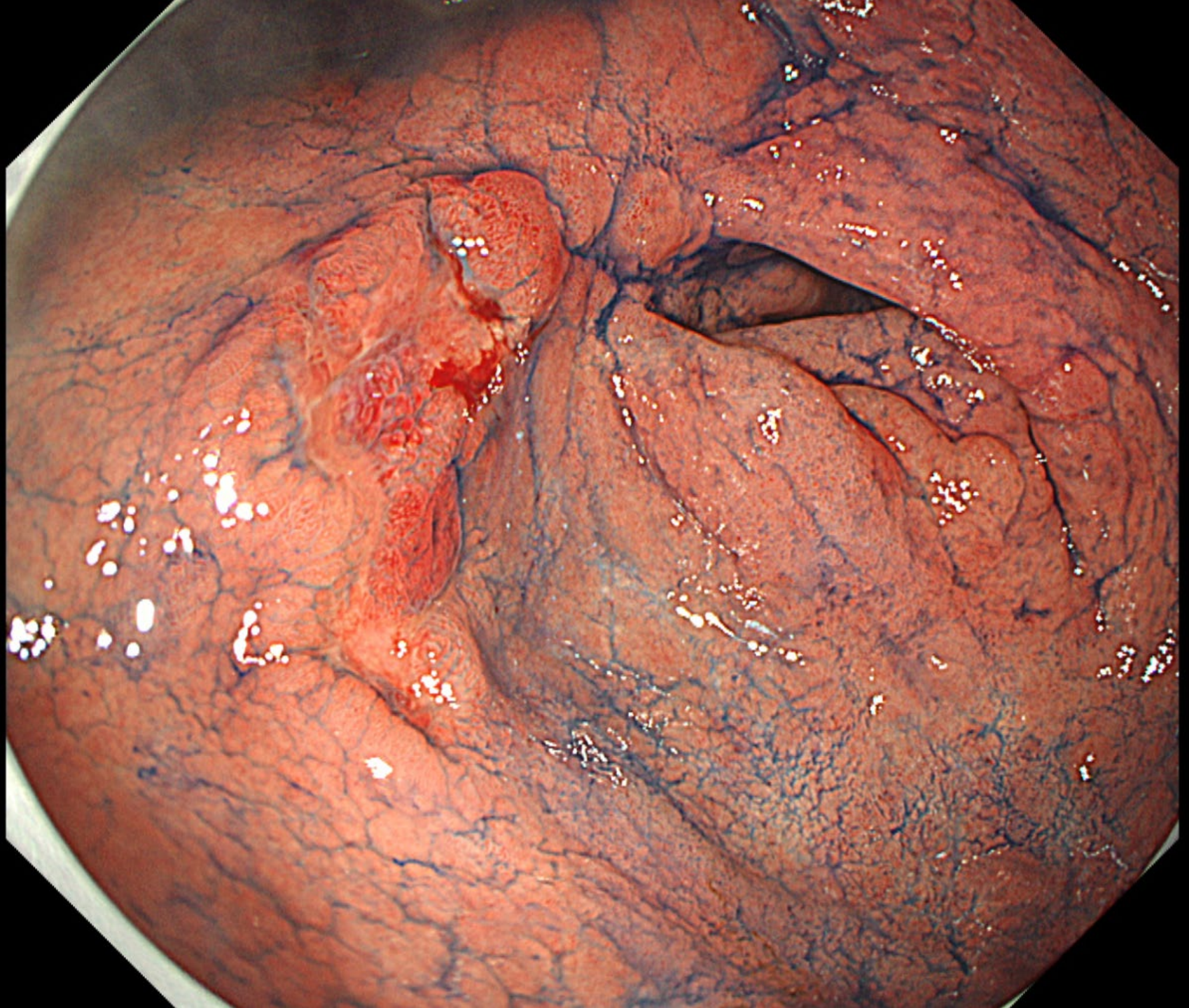
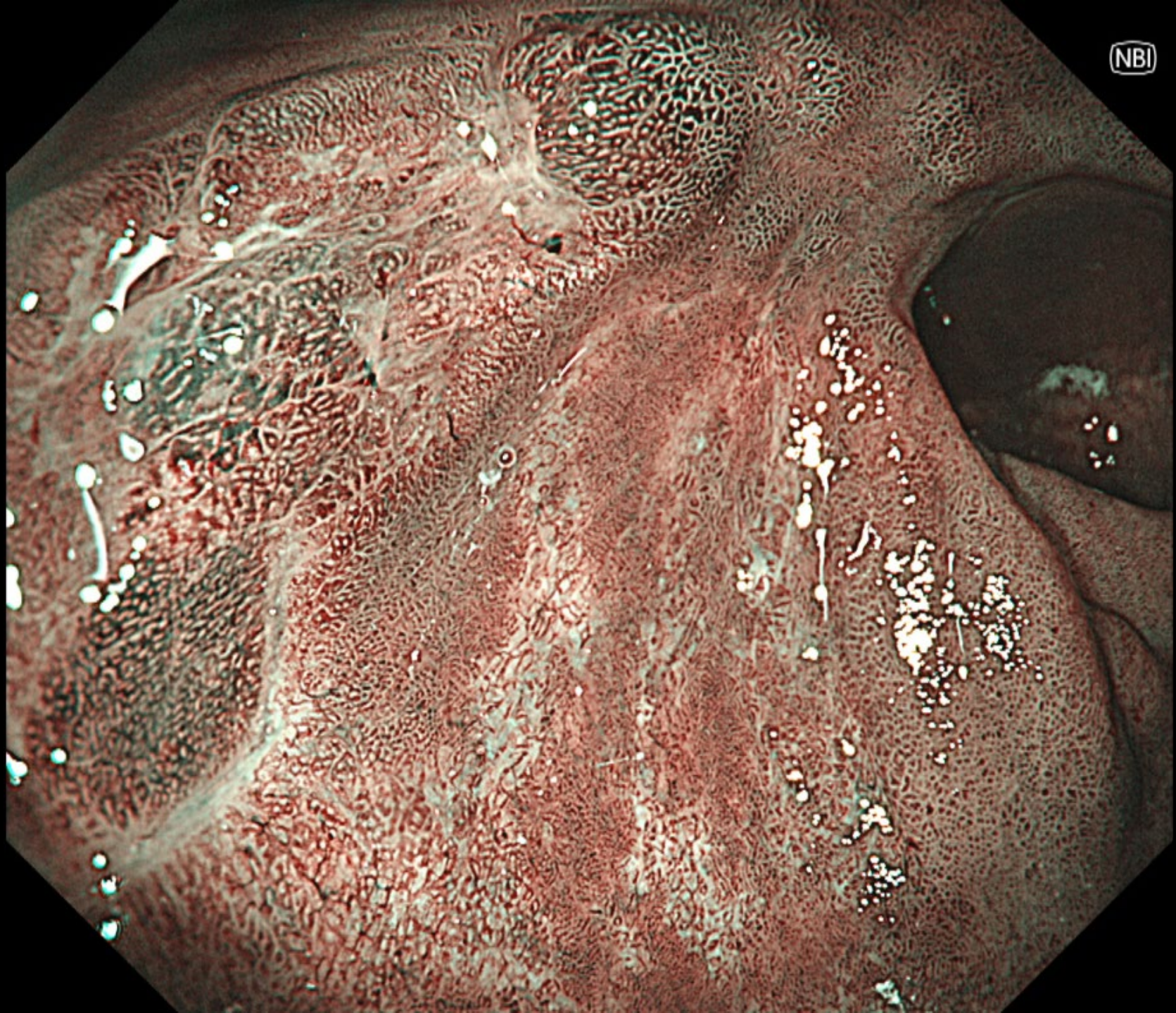




NBI
（14枚）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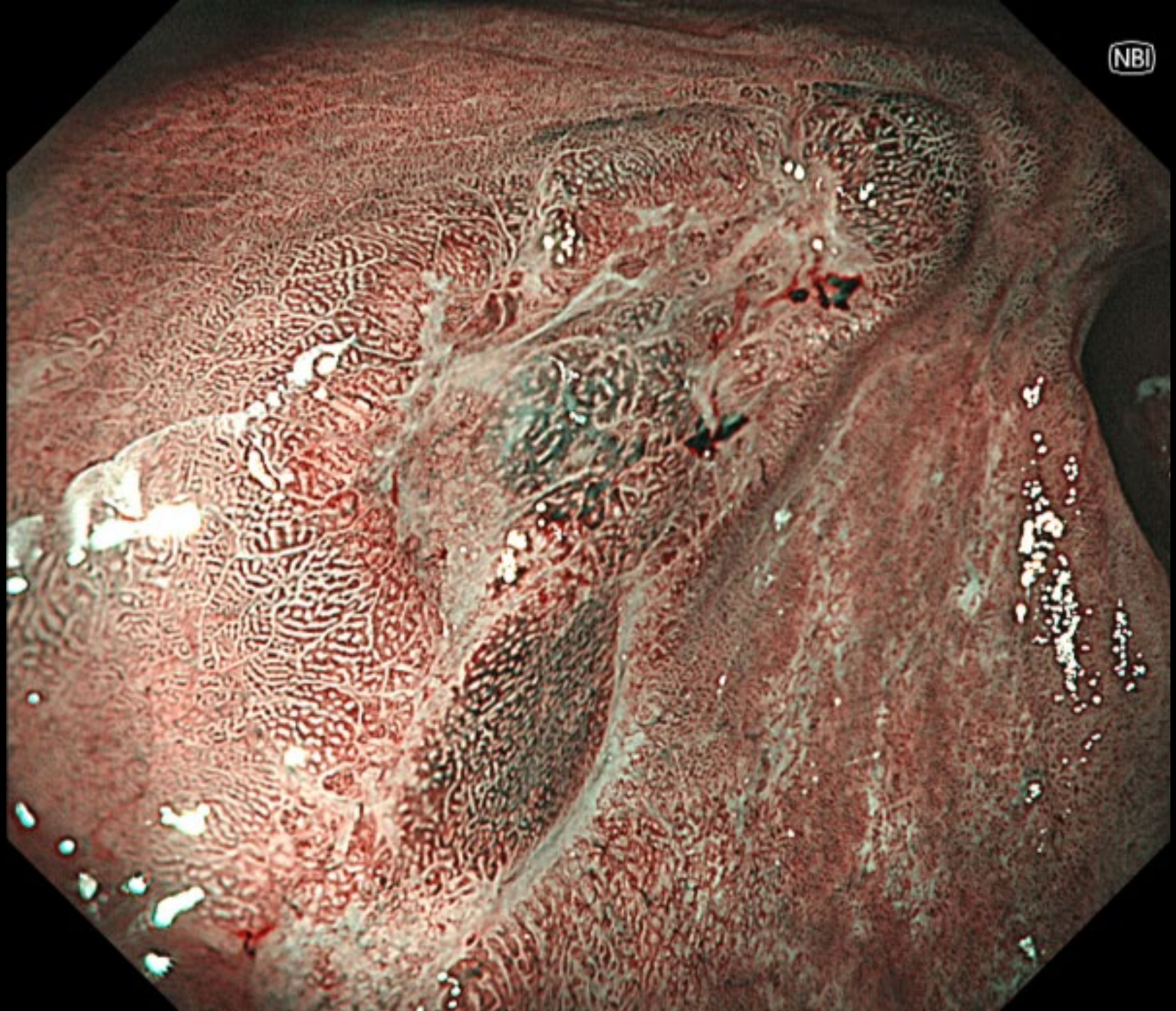
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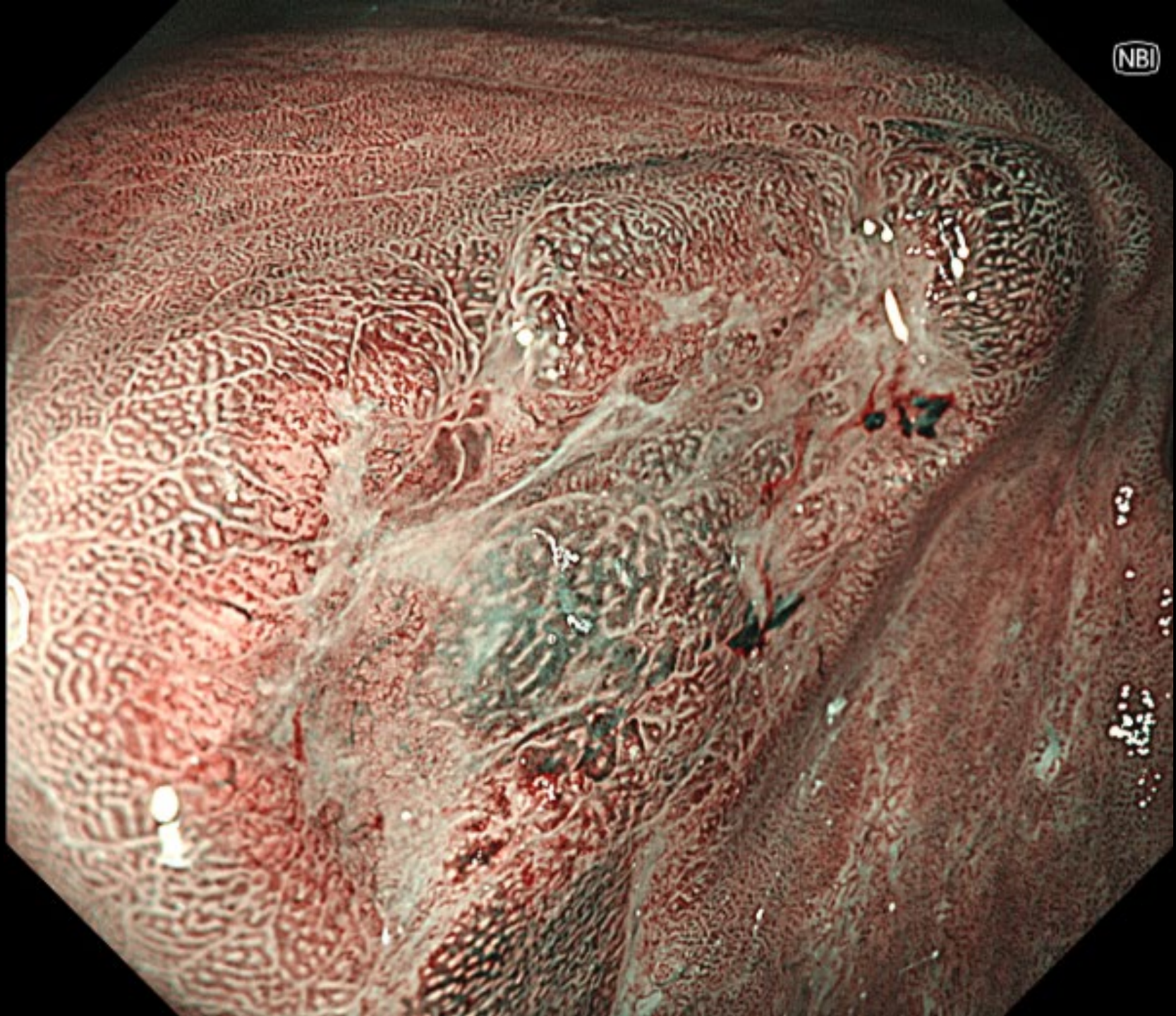
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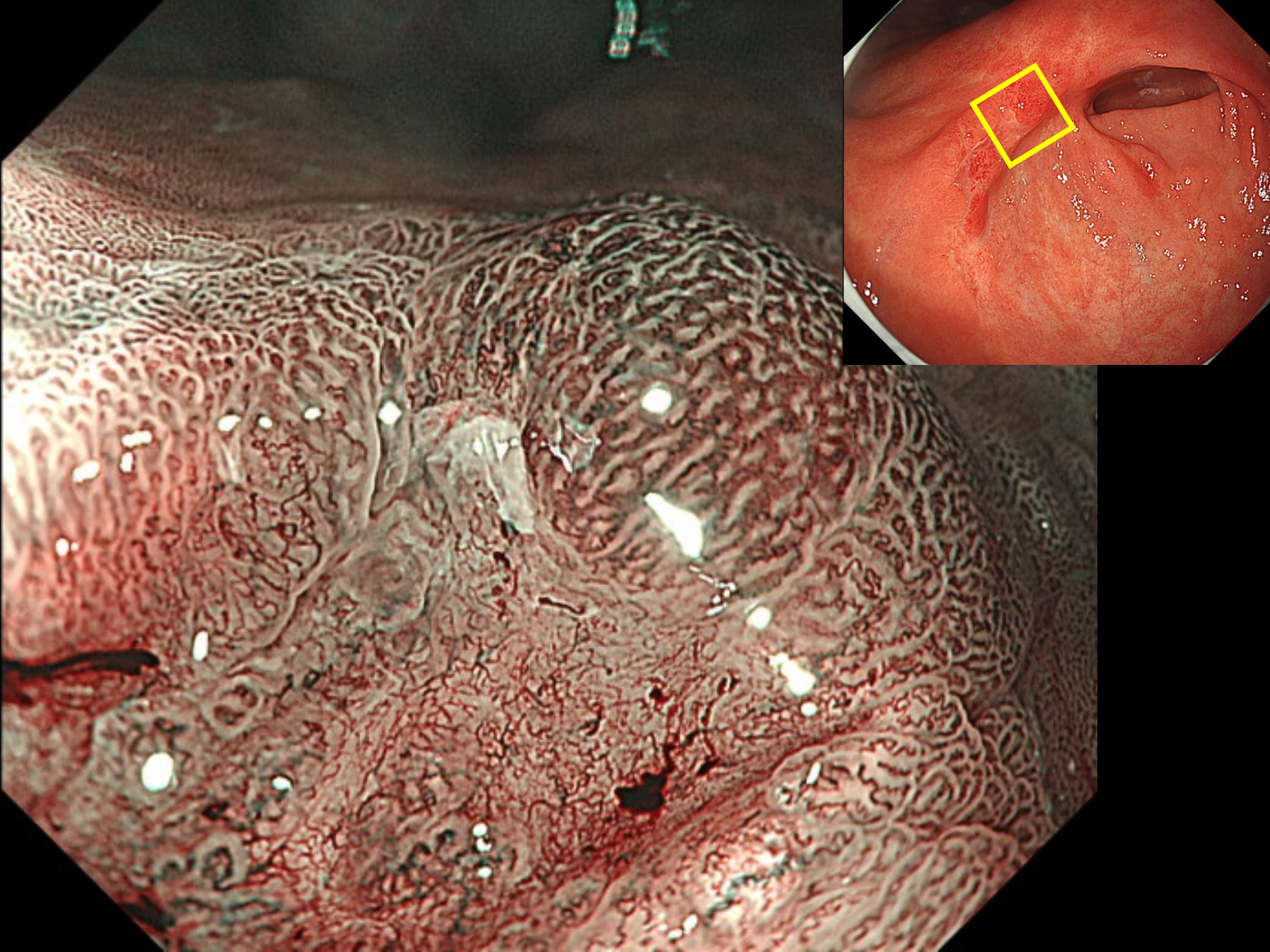
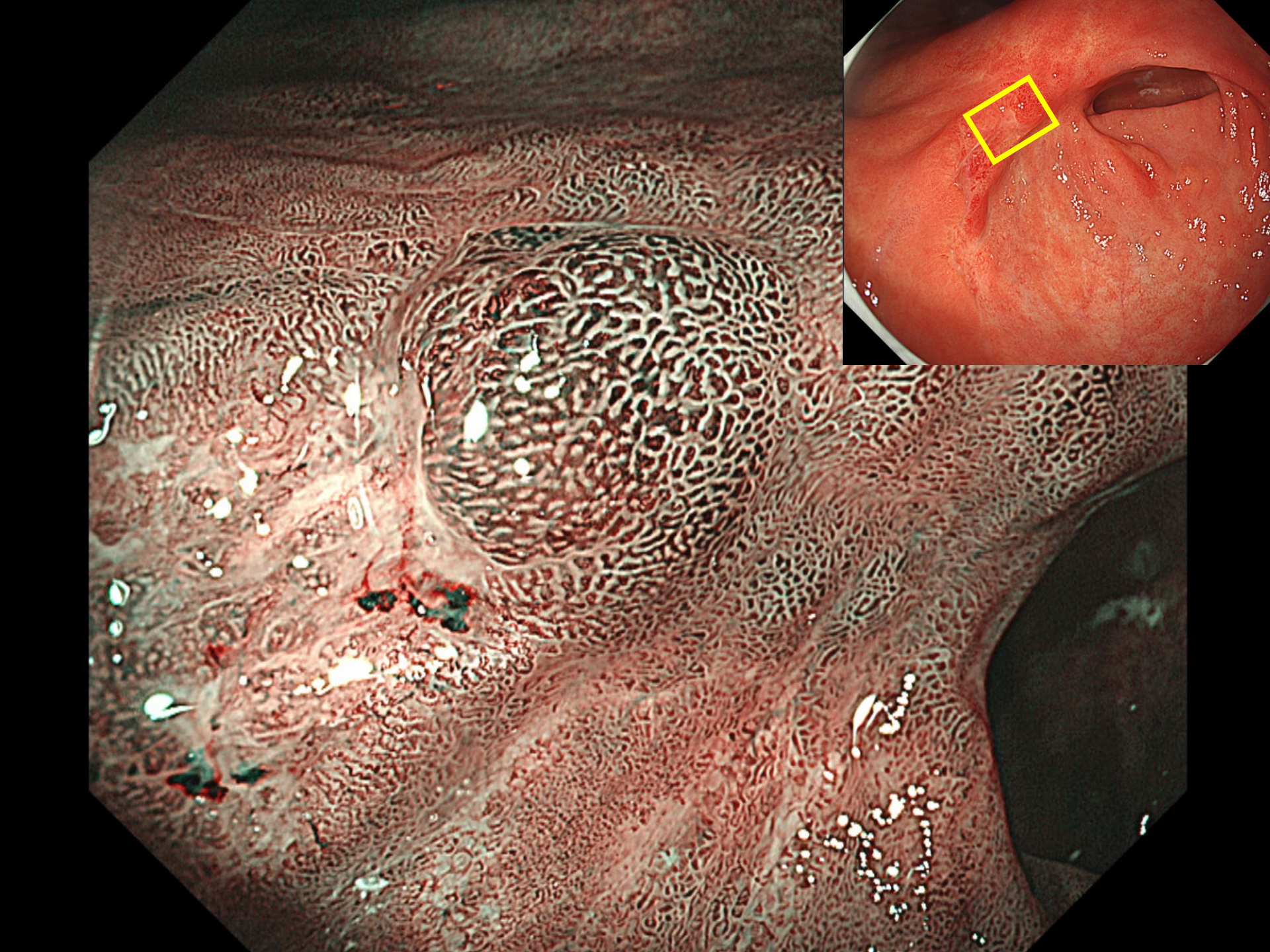
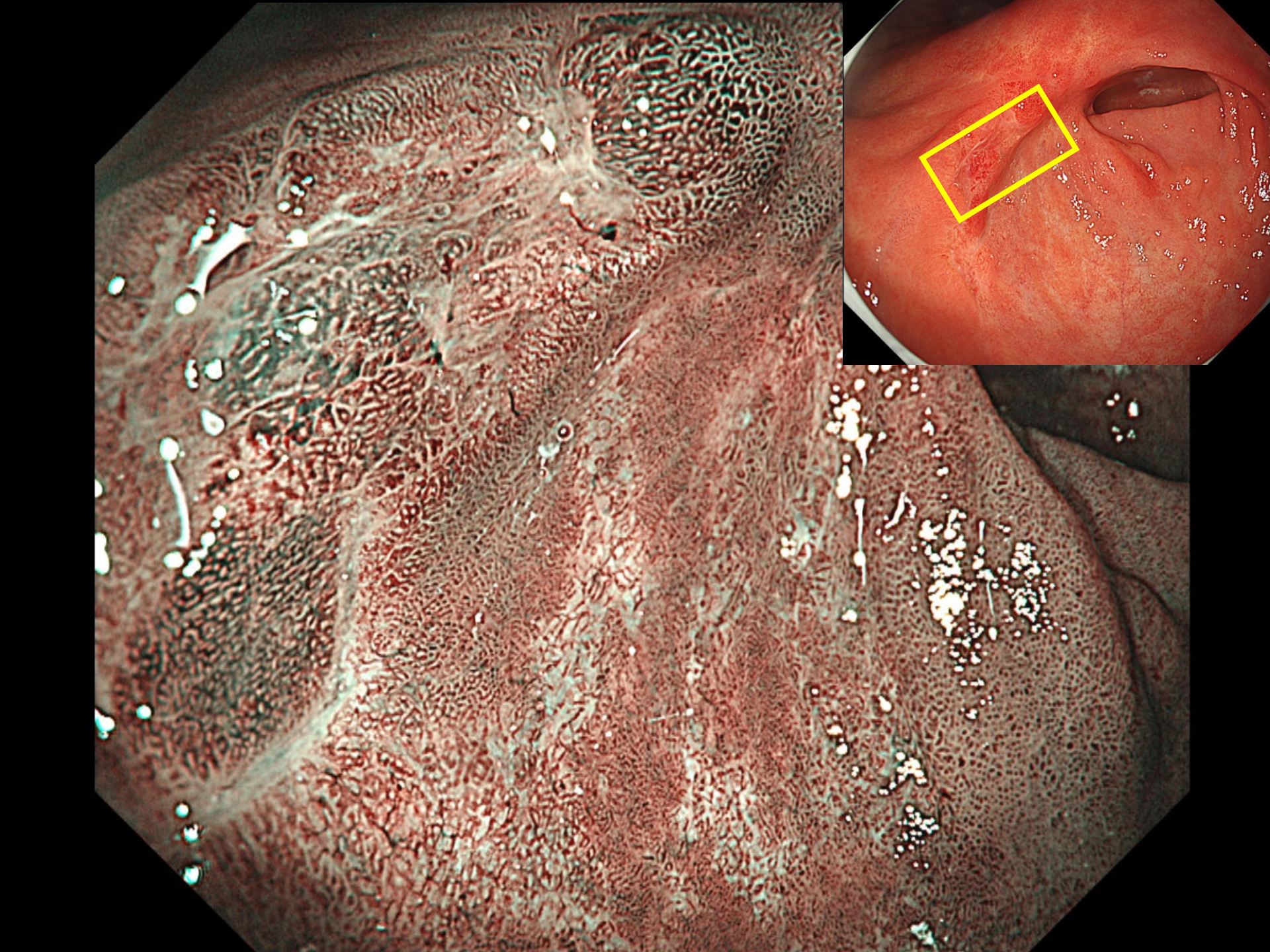
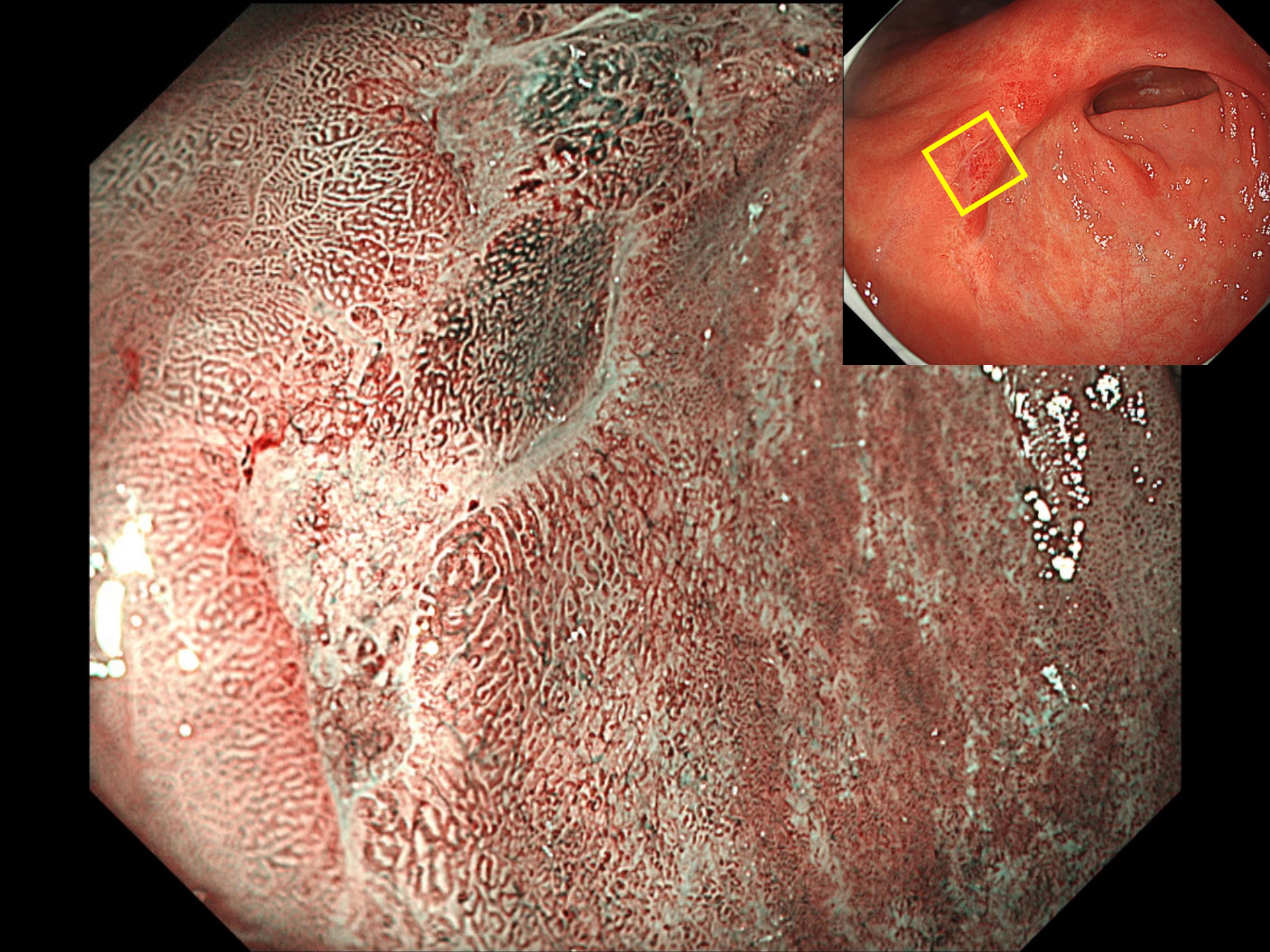
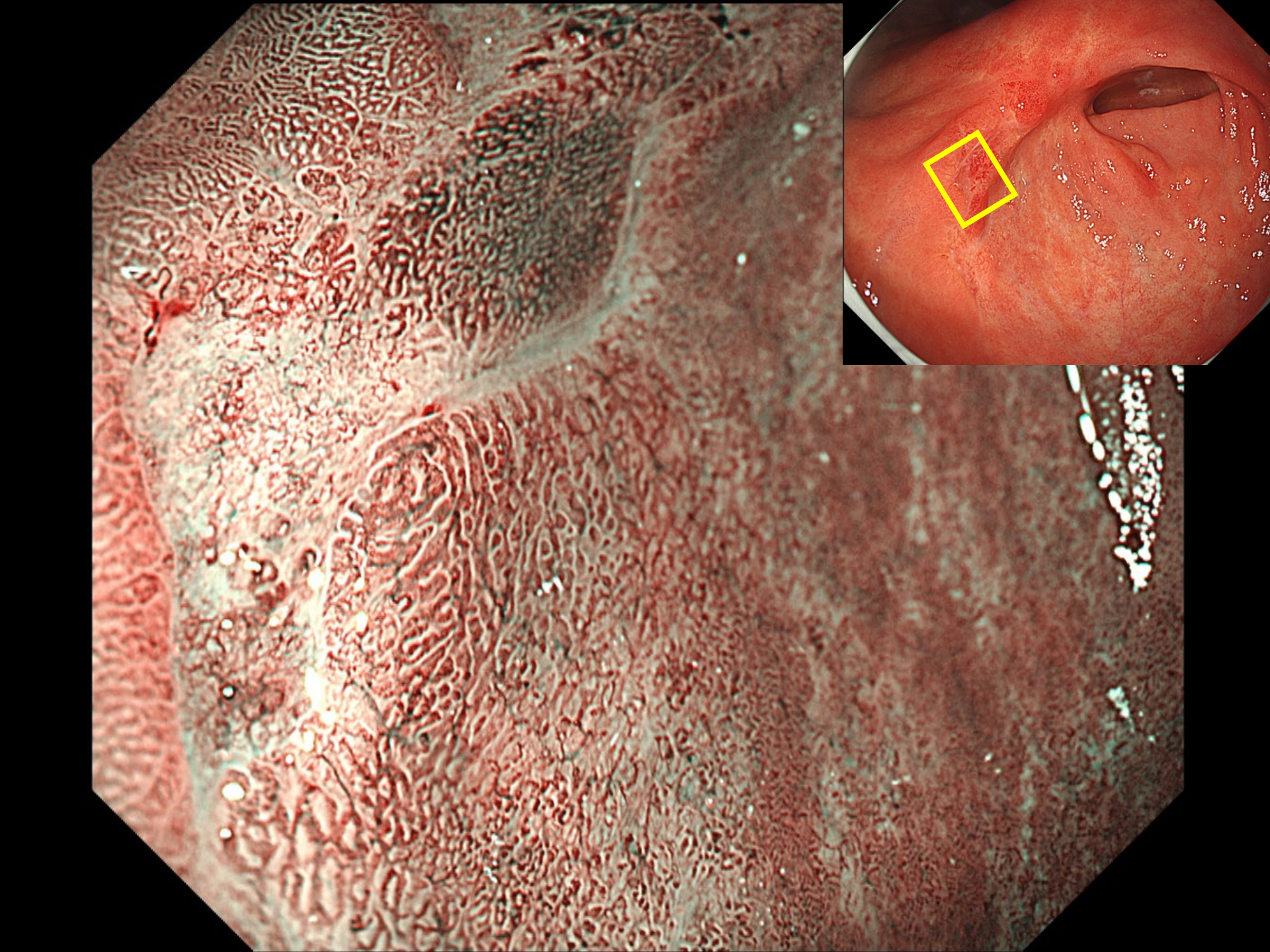
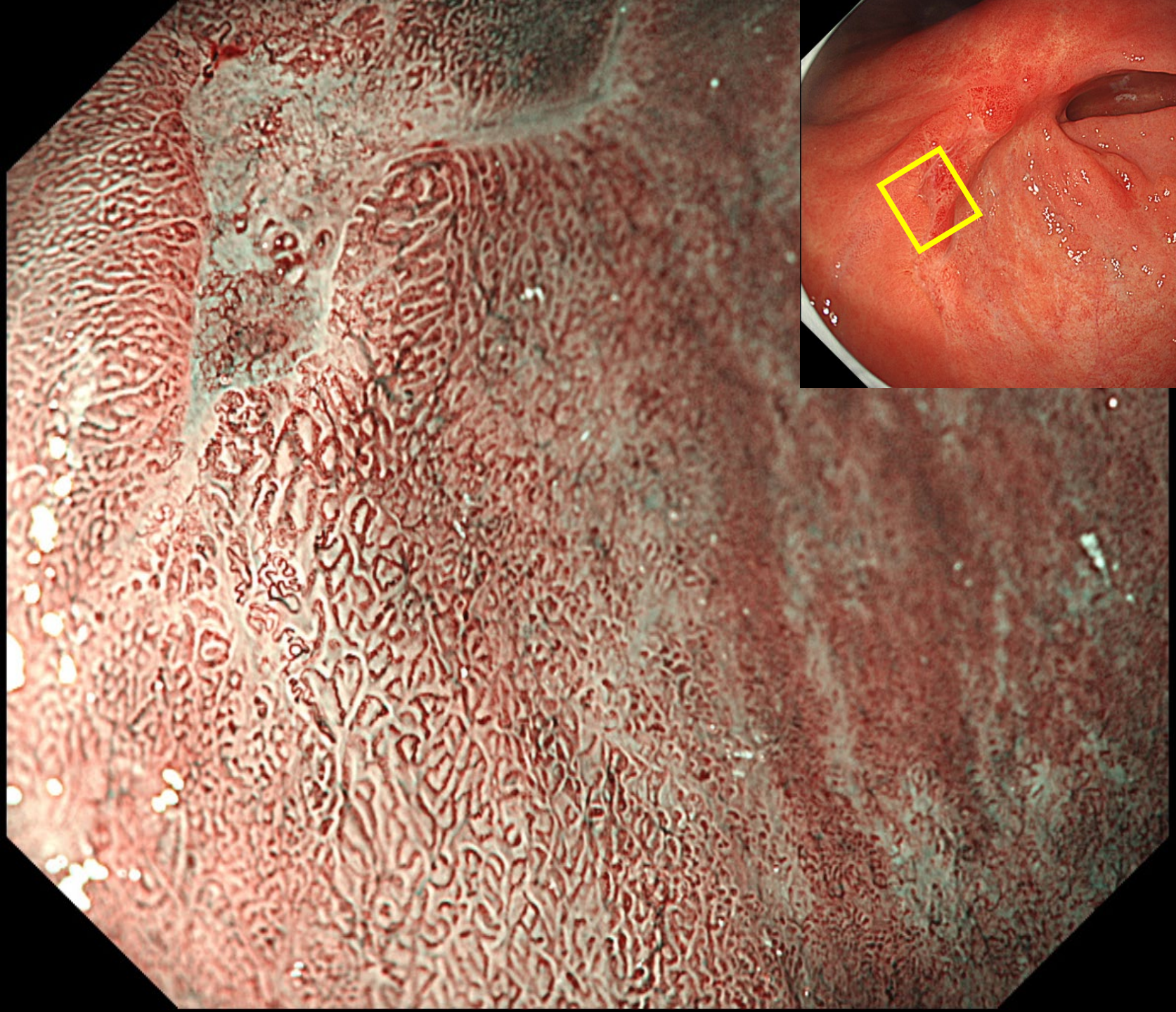


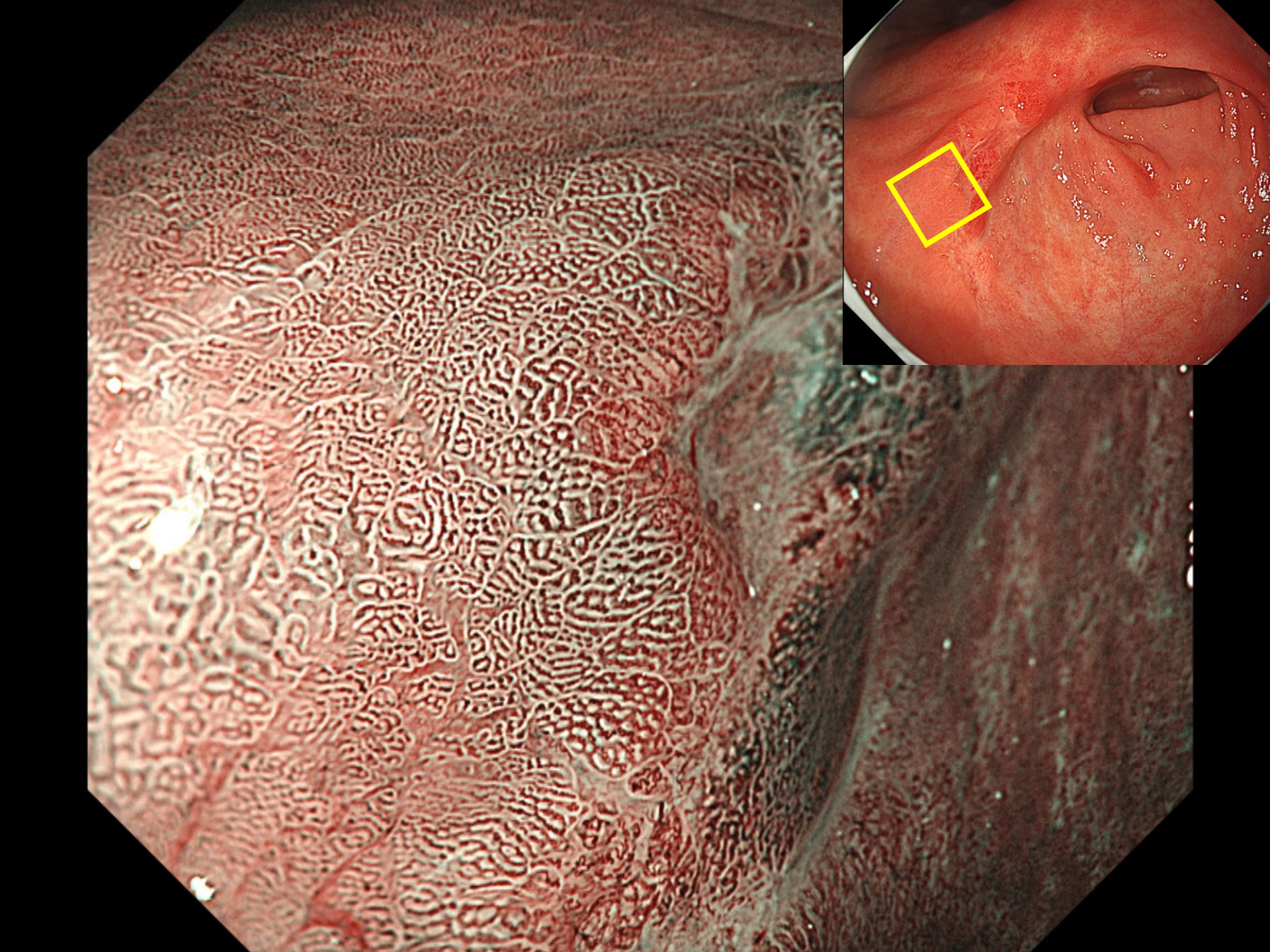


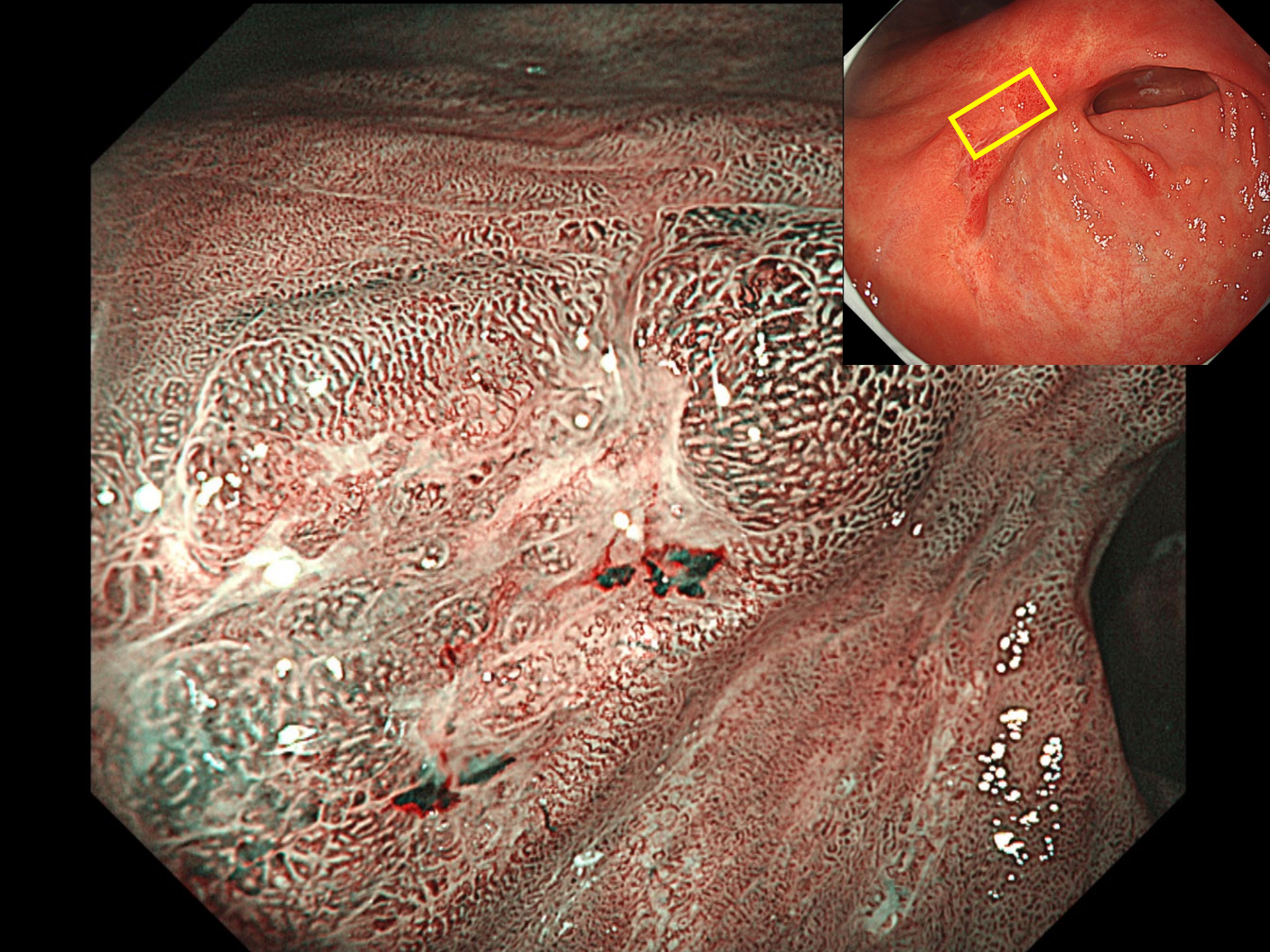


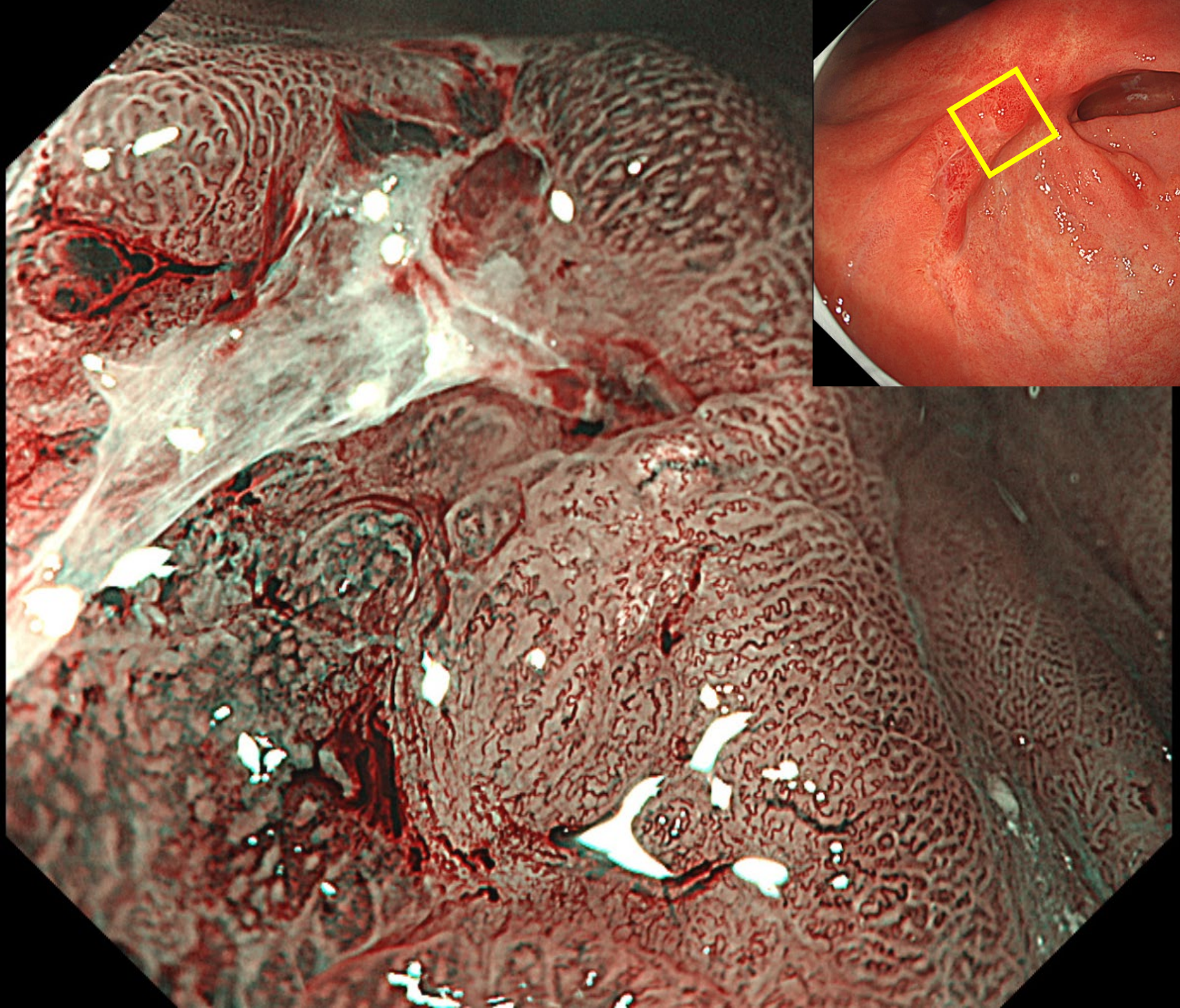


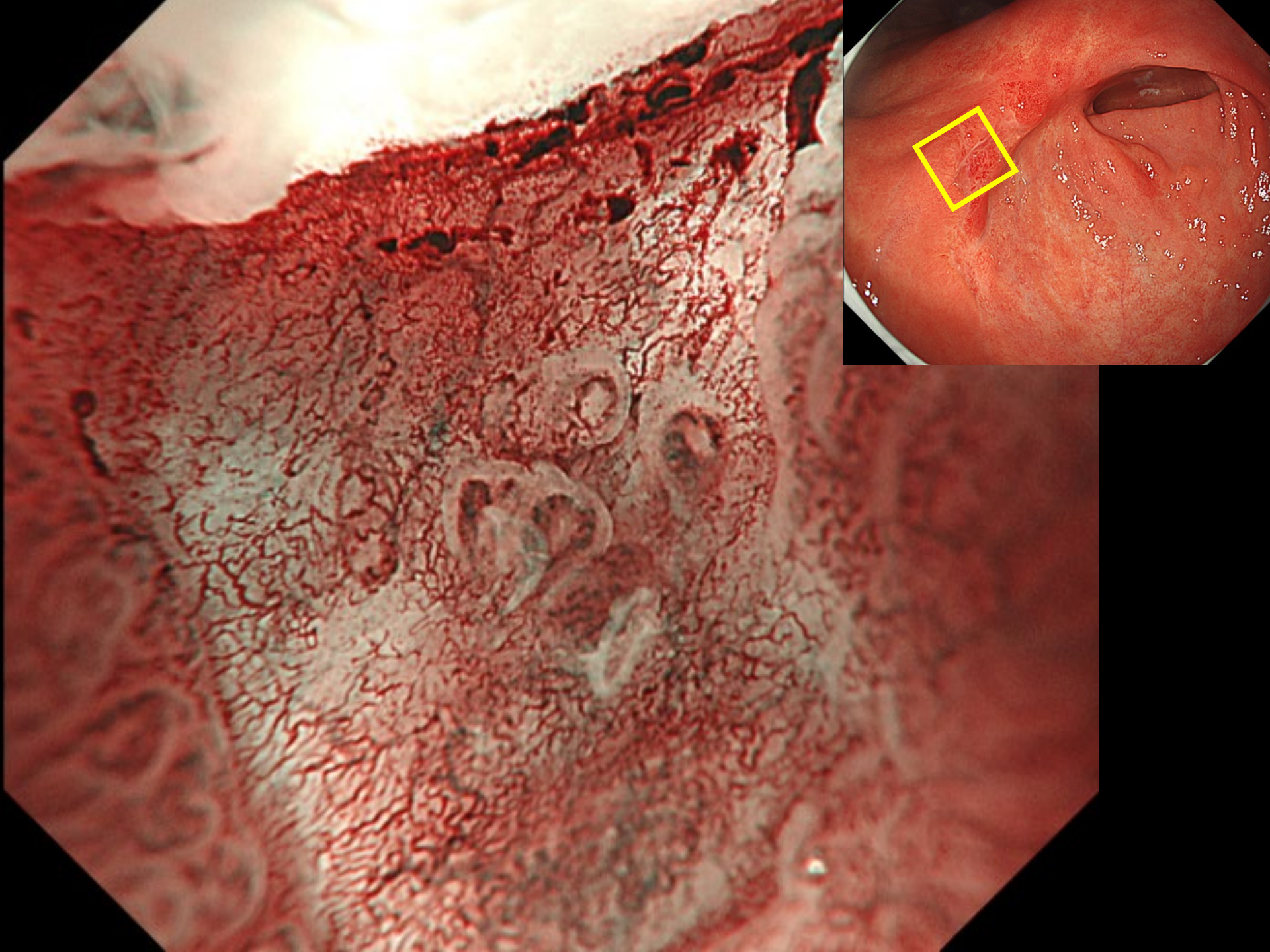


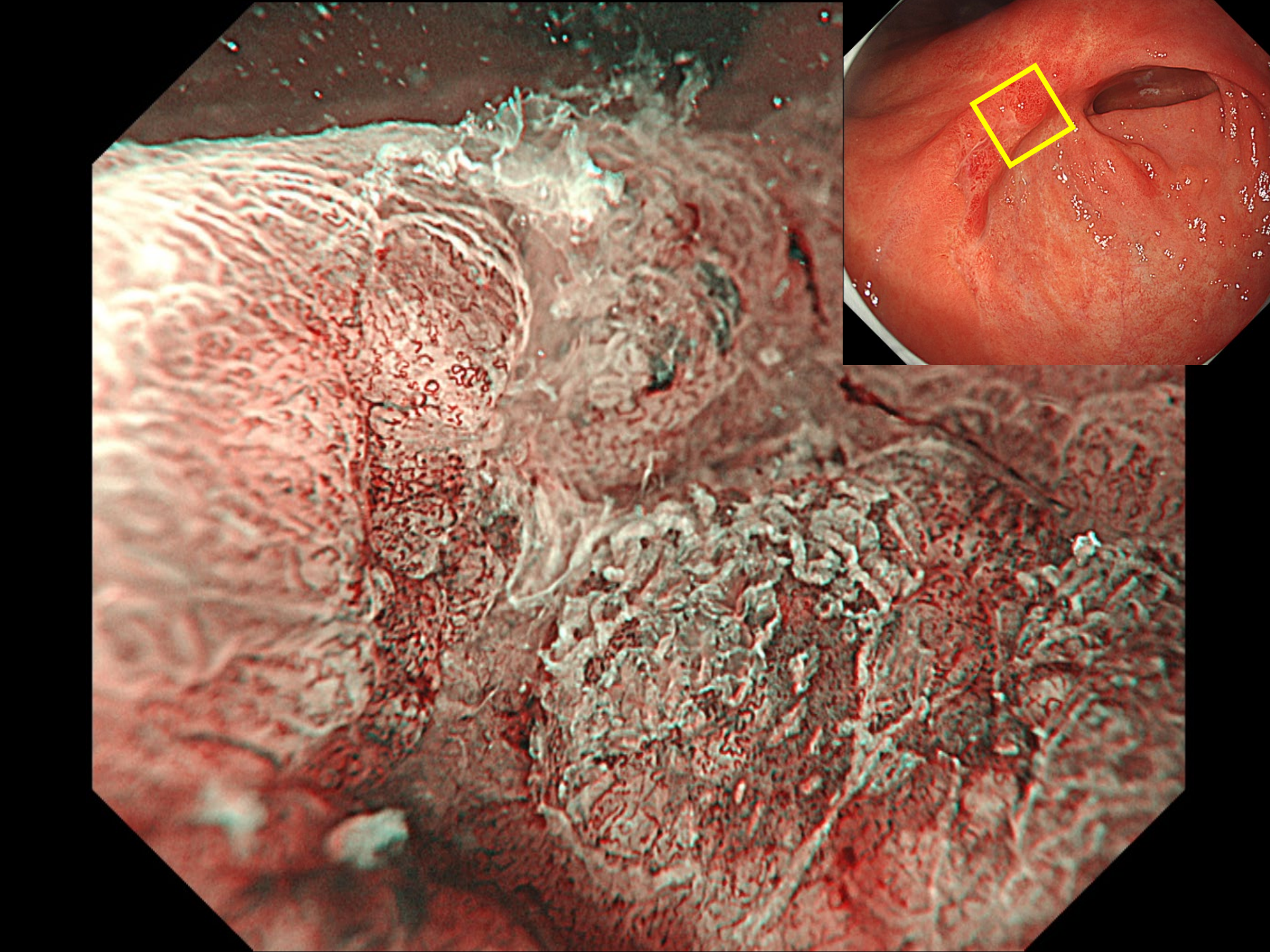








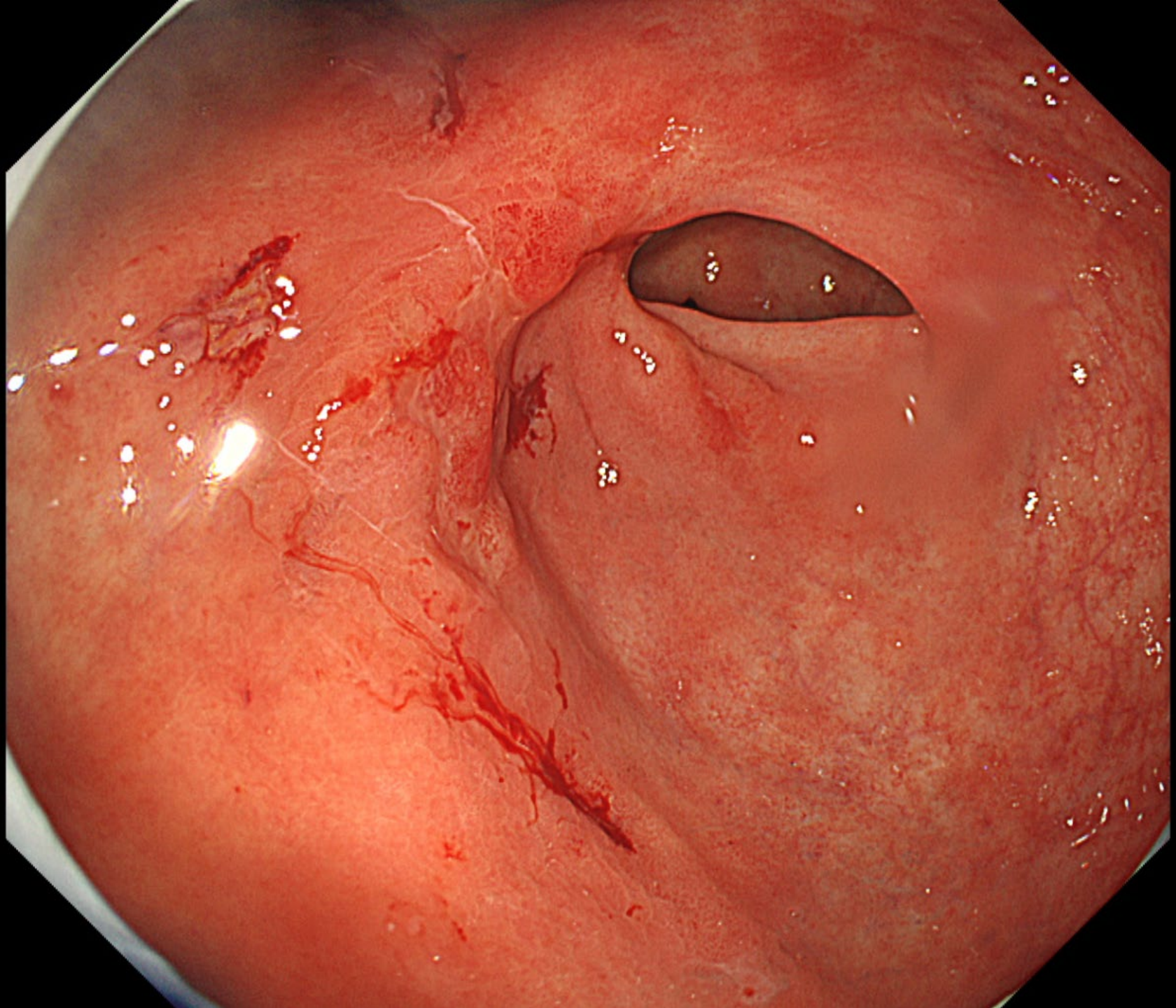


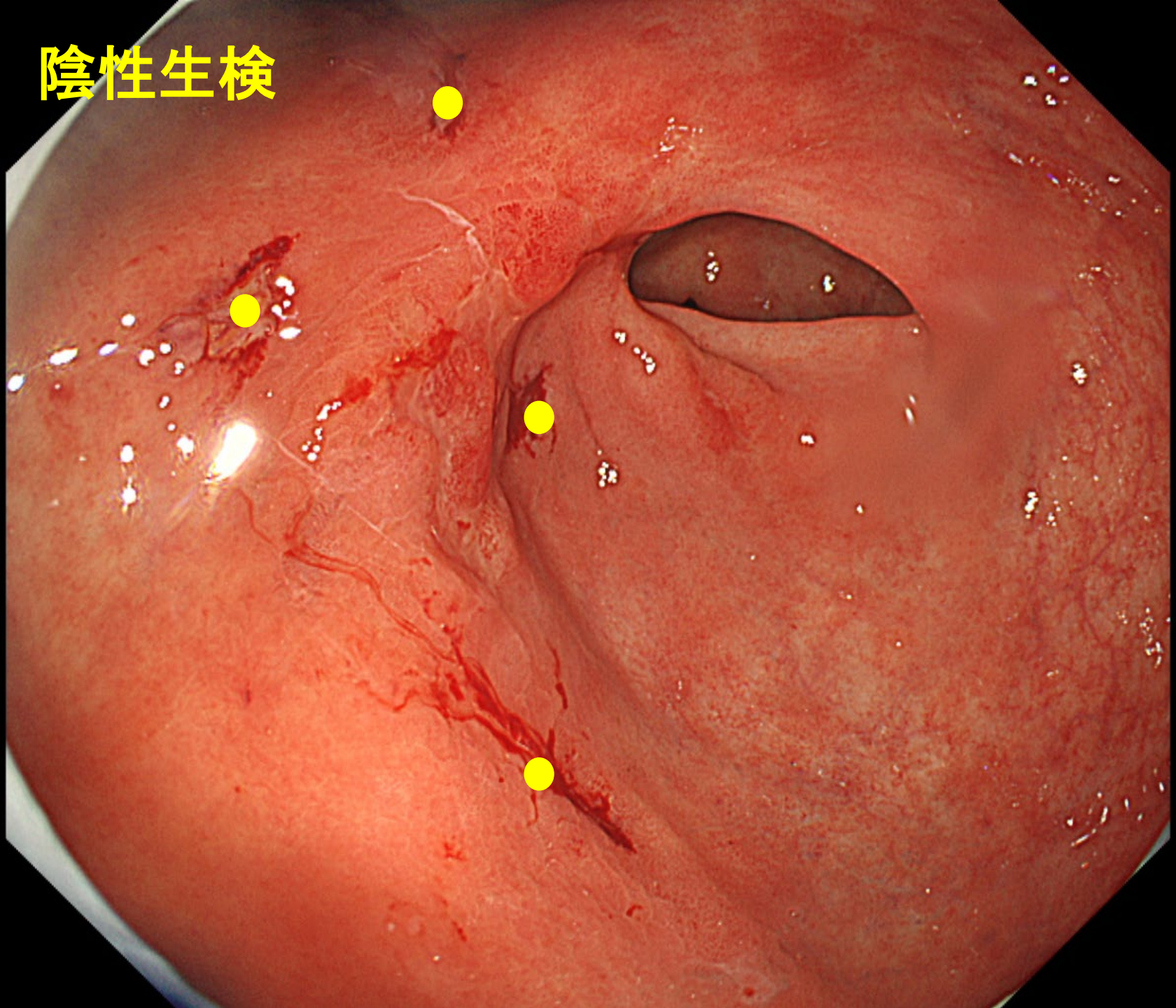


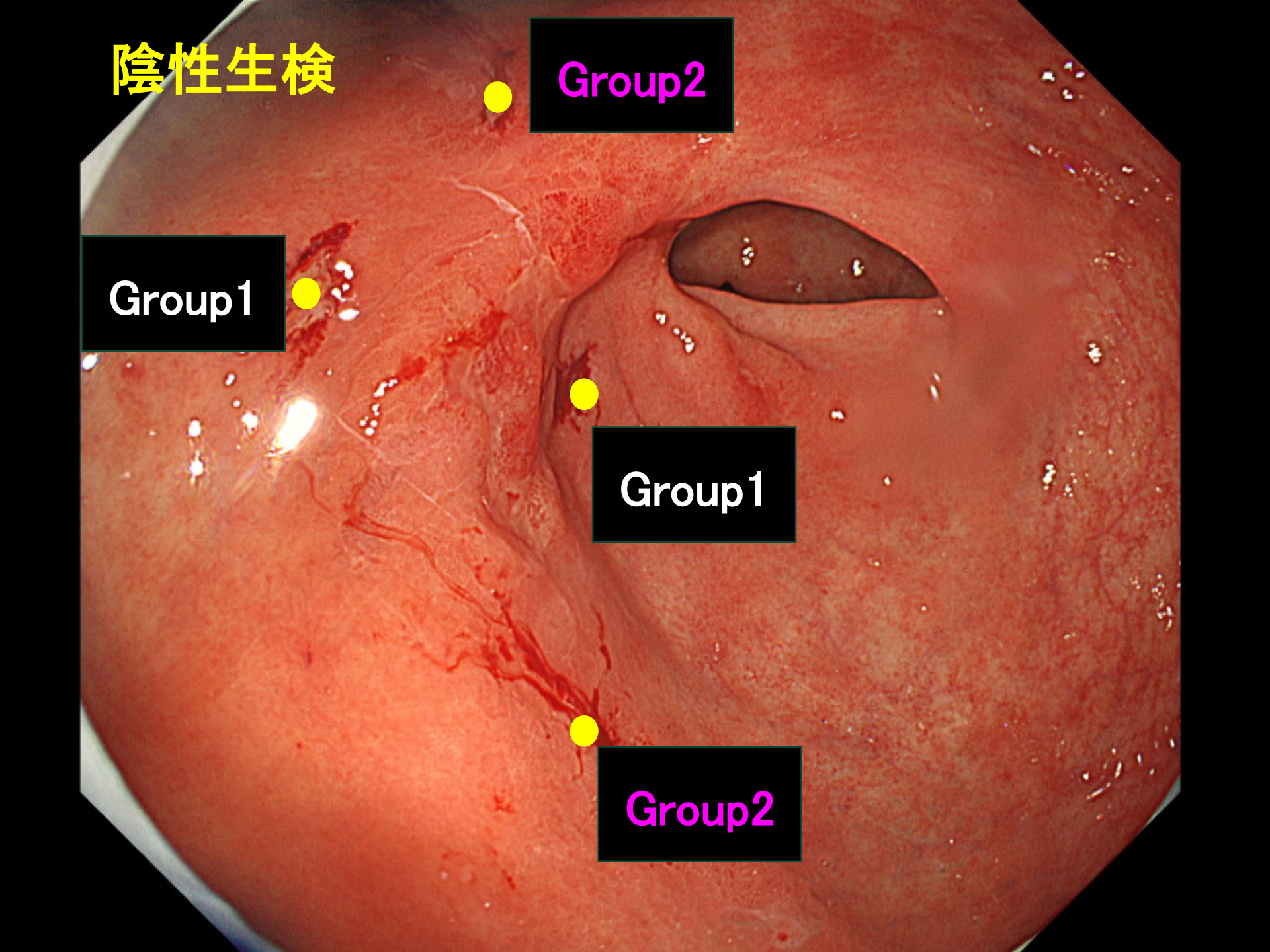
内視鏡診断

早期胃癌(前庭部前壁) ESD後再発疑い

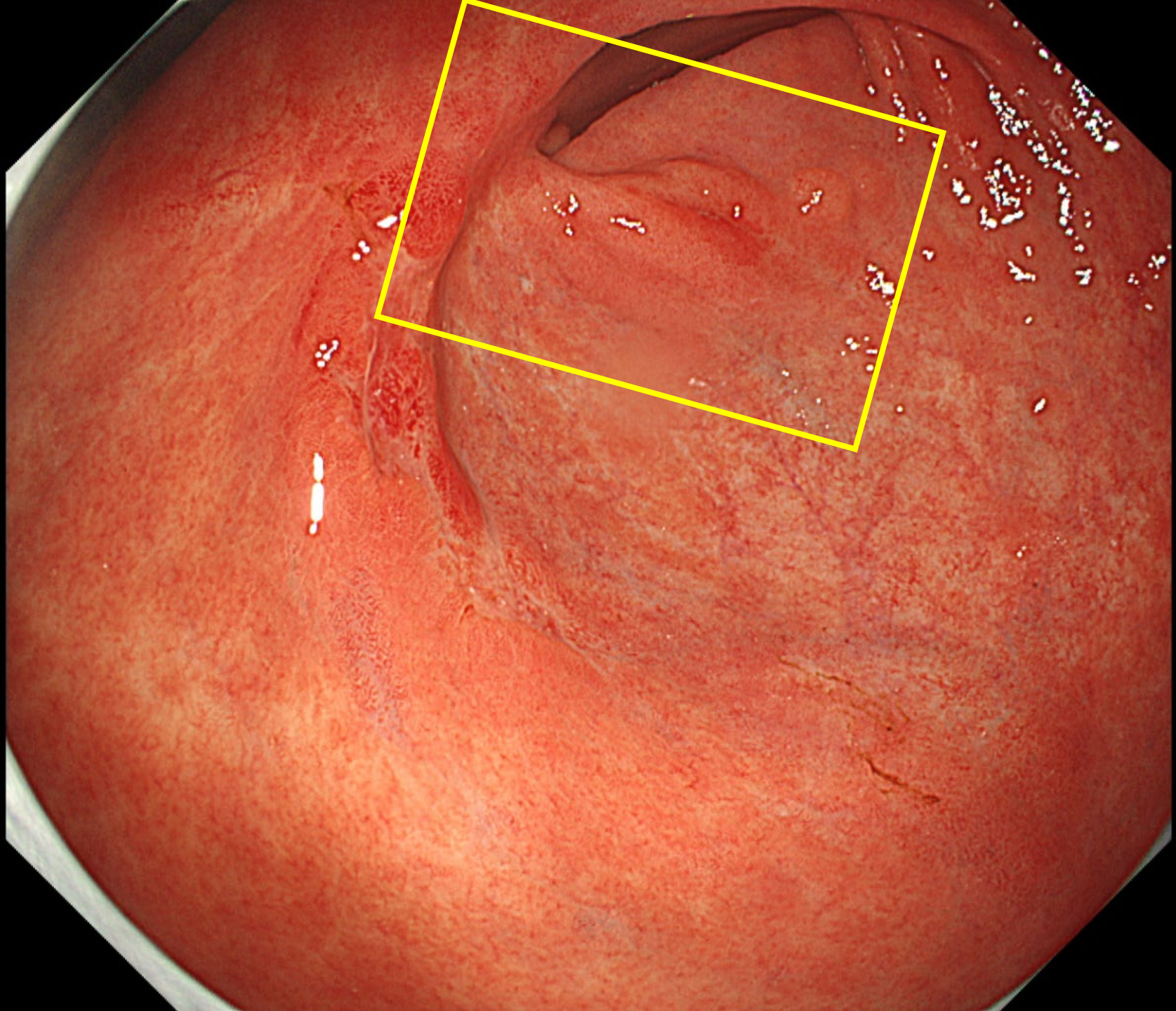
大きさ:18mm程度　肉眼型:0-Ⅱc, 未分化型
深達度:M～SM、UL 0
NBI観察:DL absent,
　　微小血管構造: irregular,
　　表面微細構造: absent

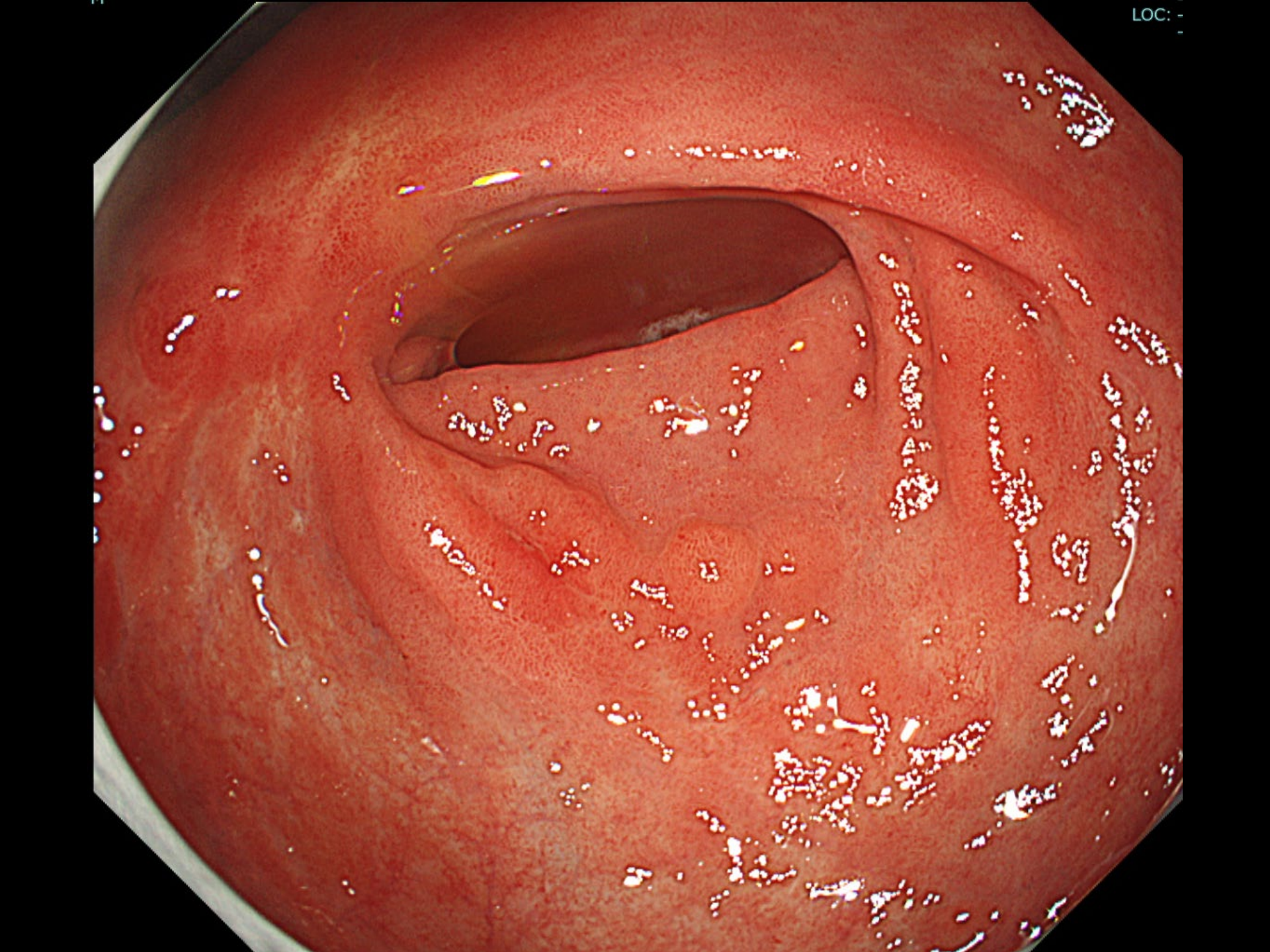



陰性生検


陰性生検
Group2
Group1
Group1
Group2

ESD

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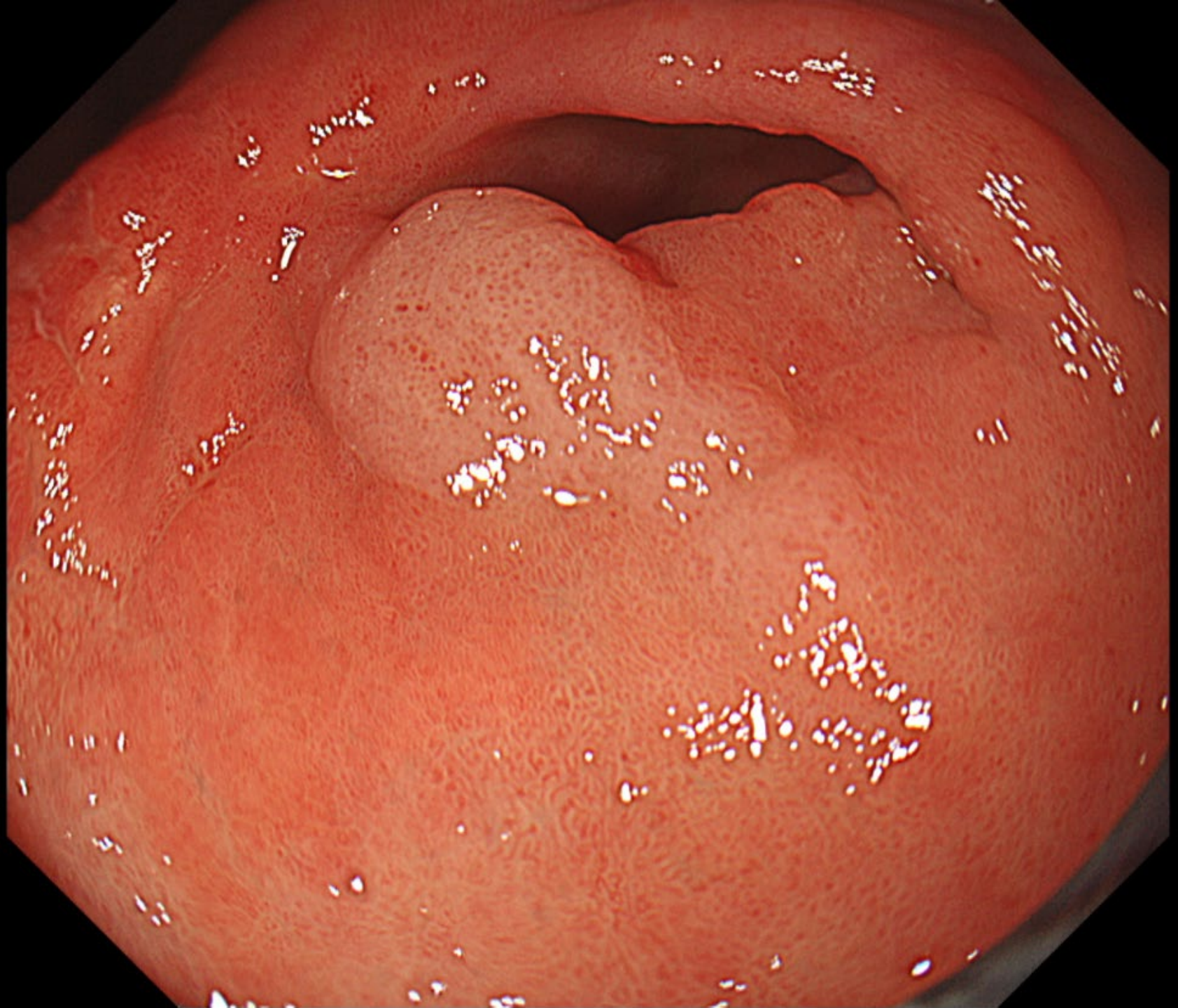
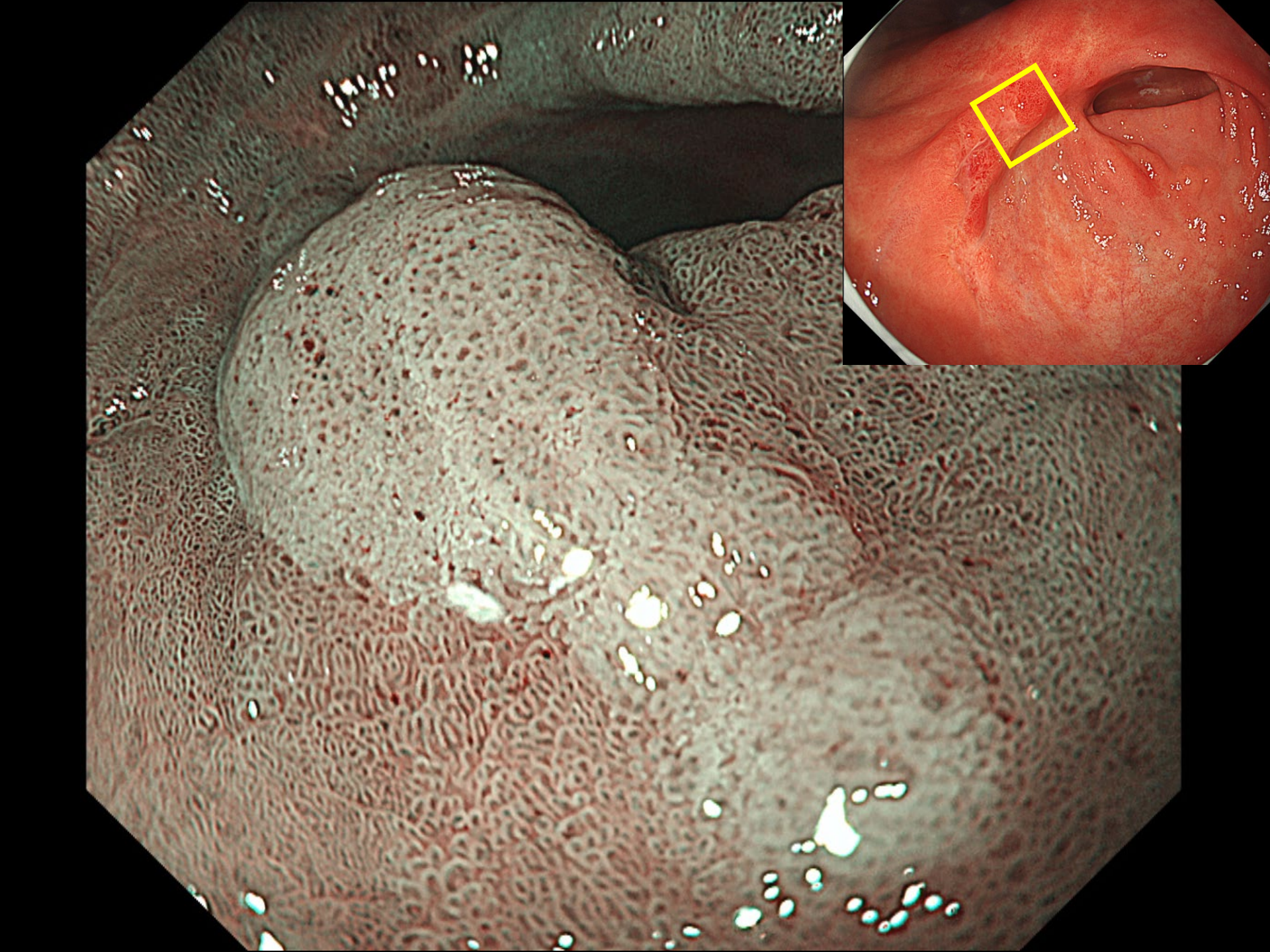
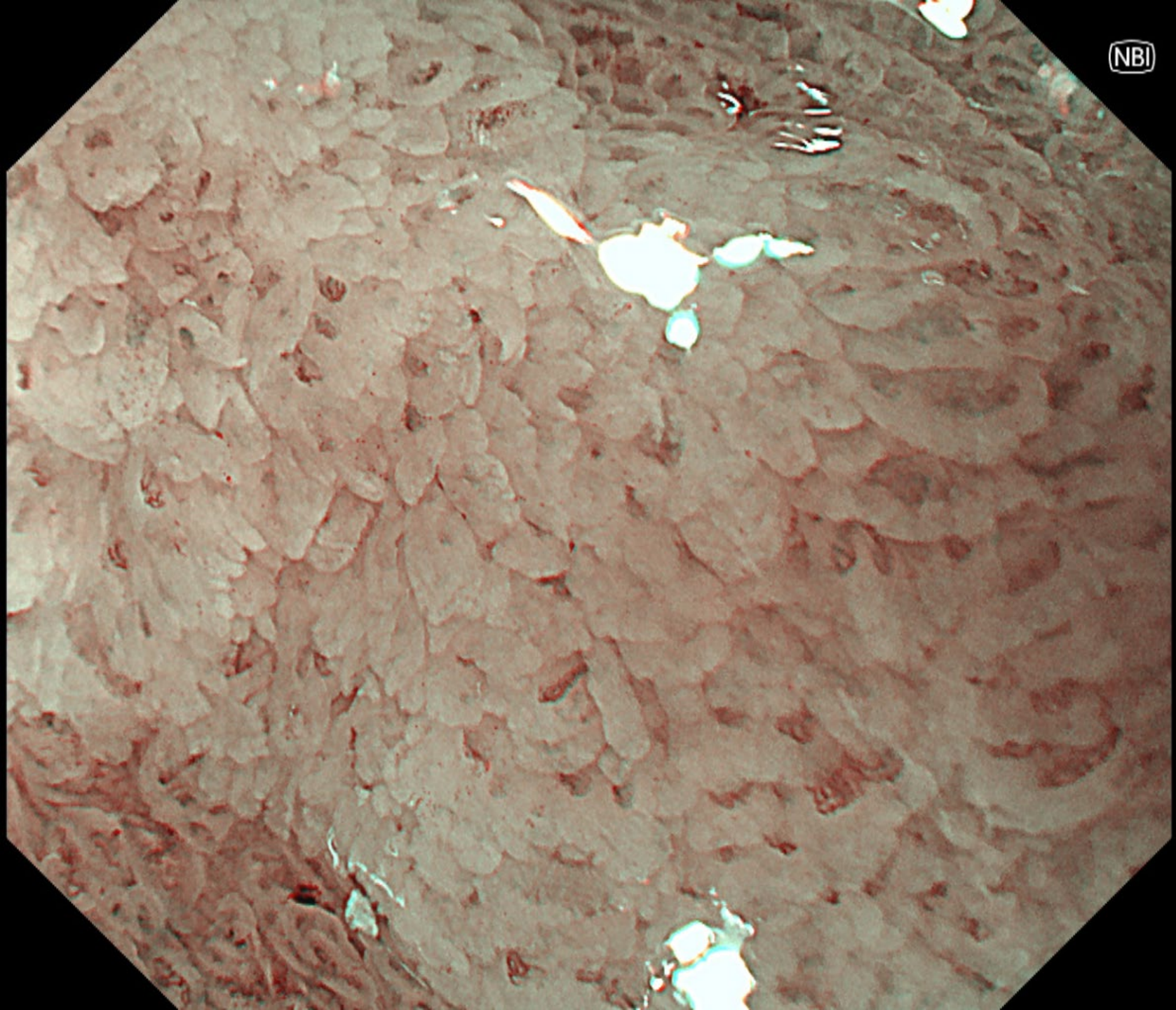
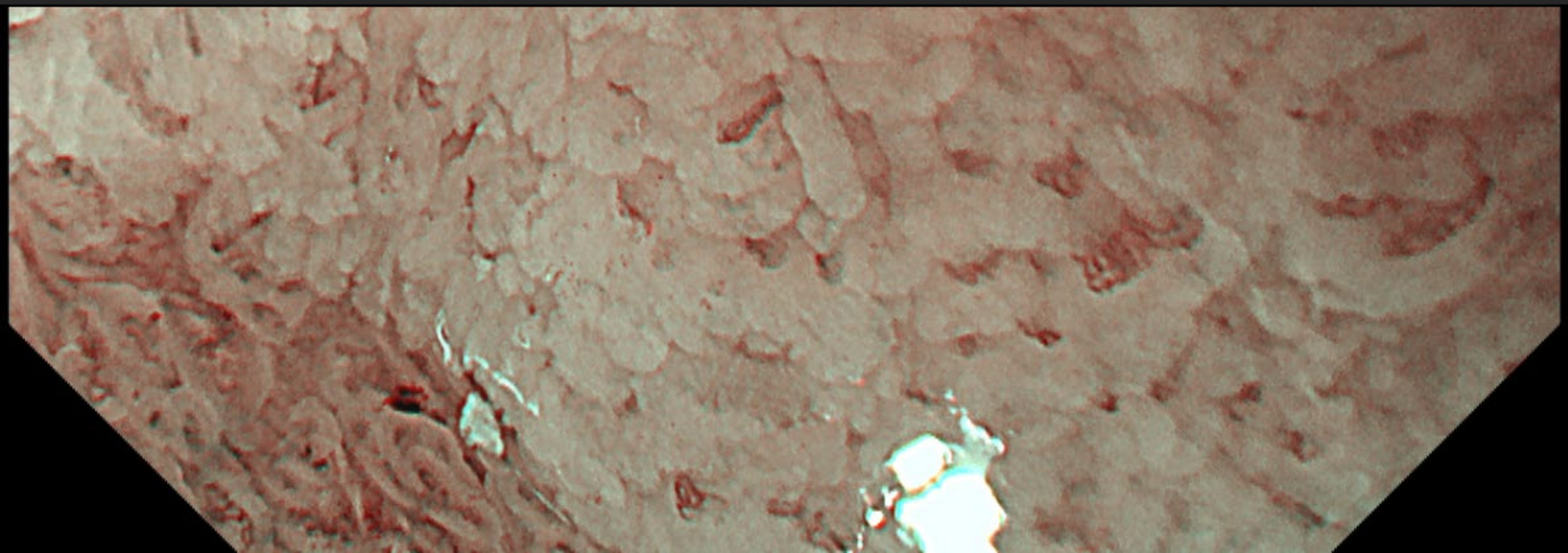
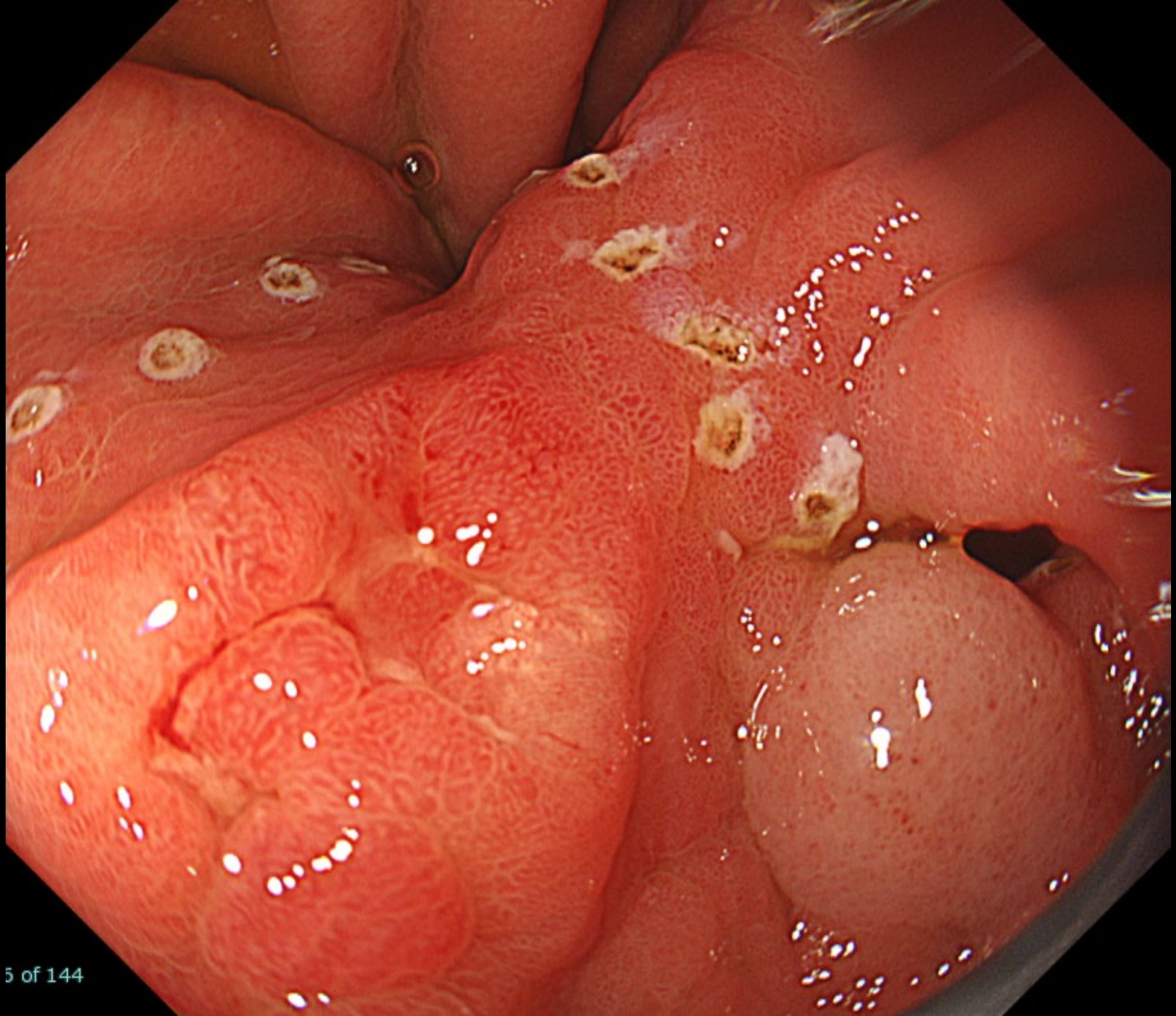





NBI

腸型腺腫～高分化型腺癌の可能性も
否定できず、一括切除の方針とした

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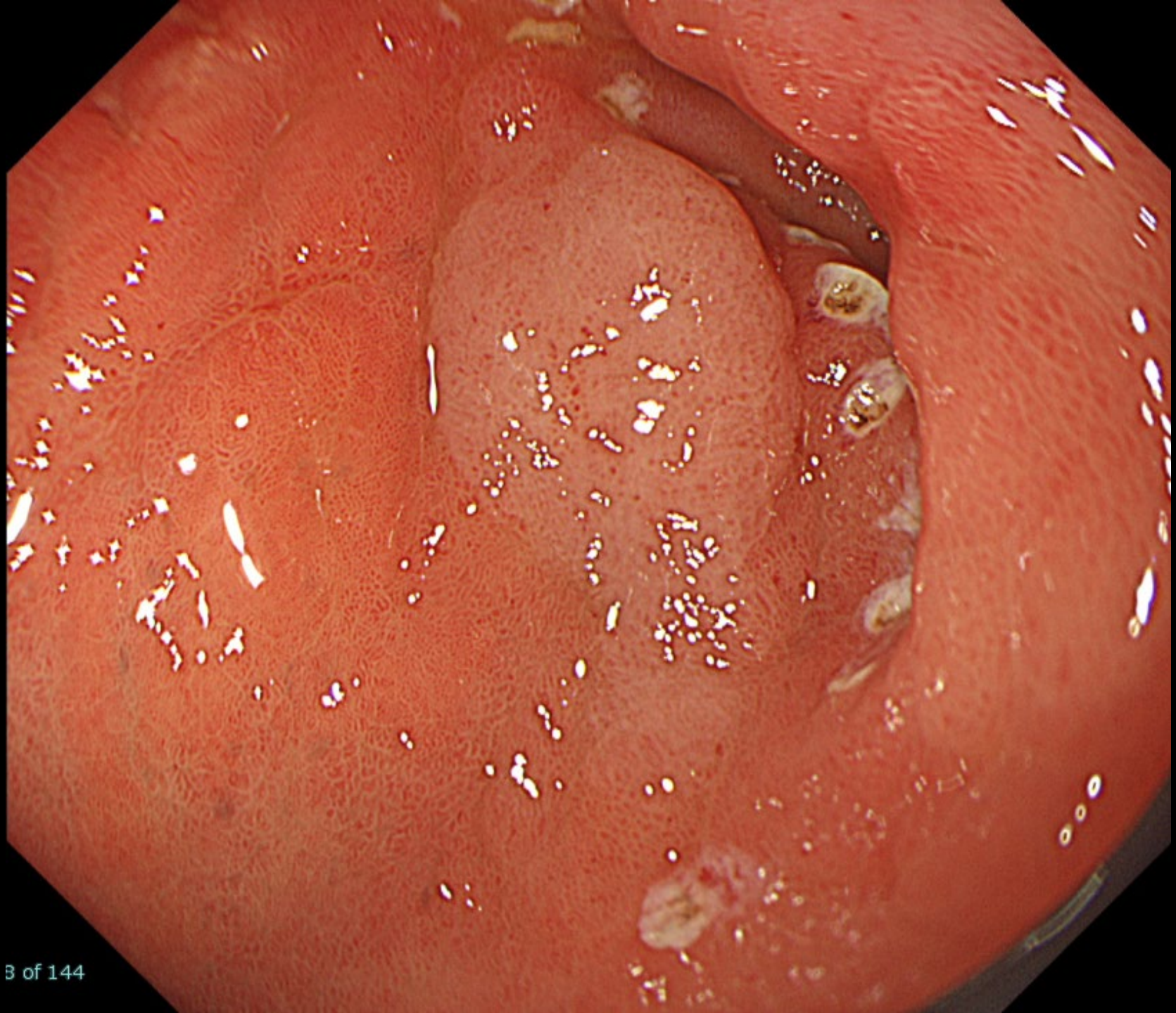
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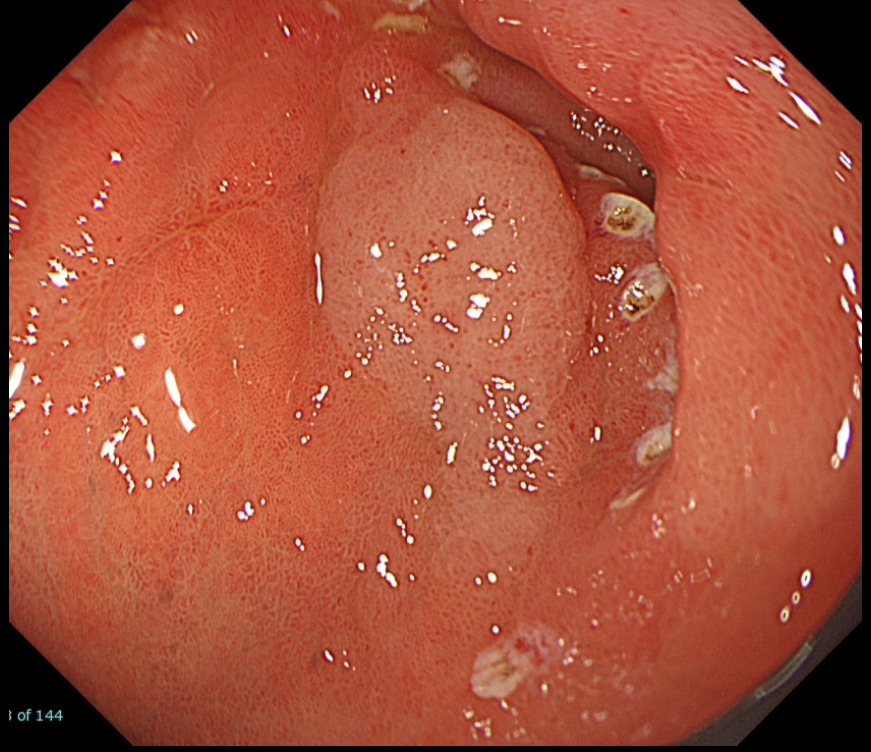
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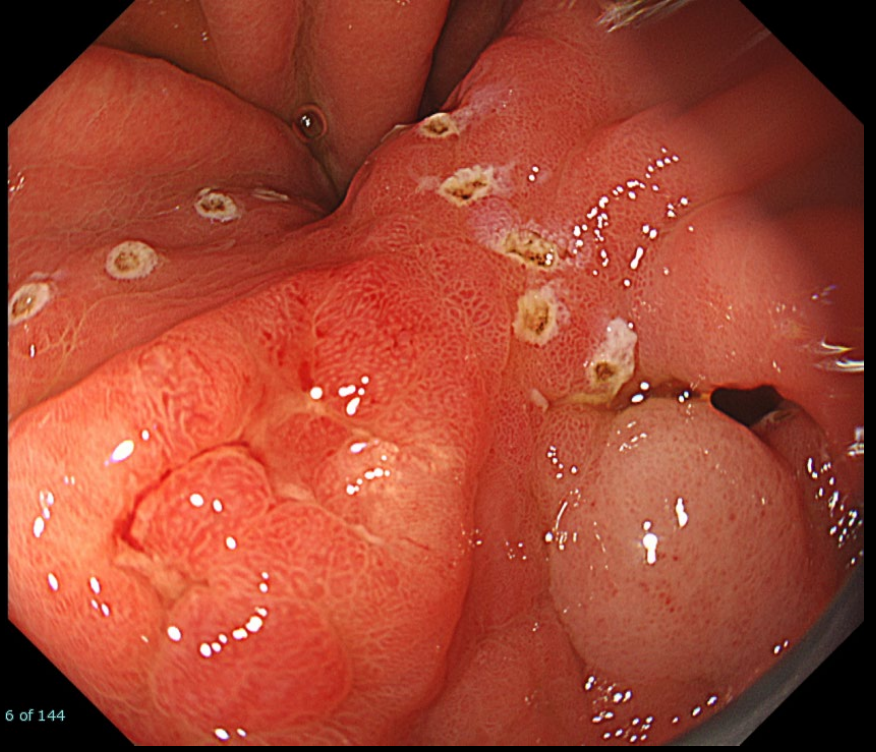
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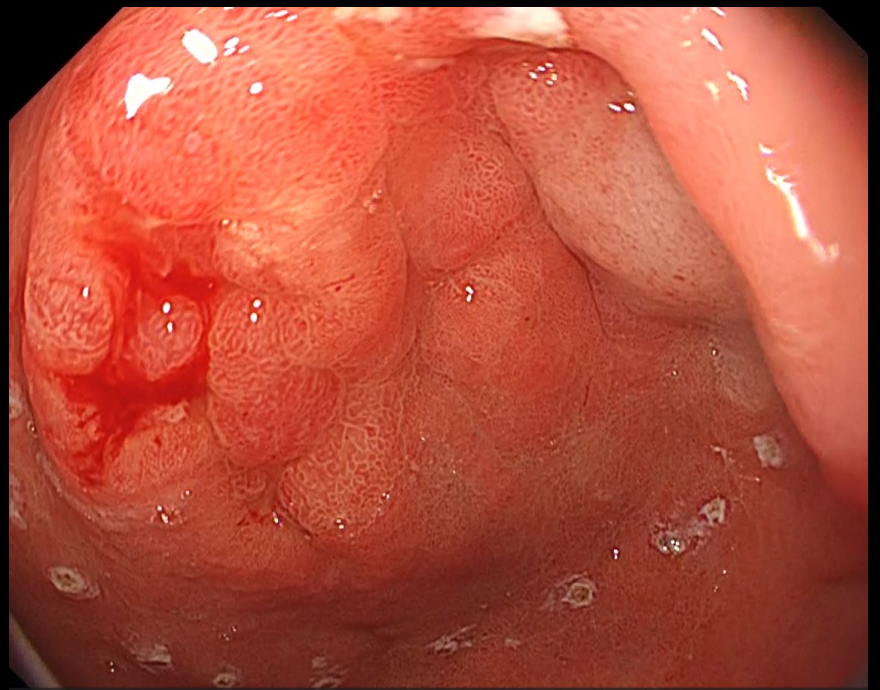

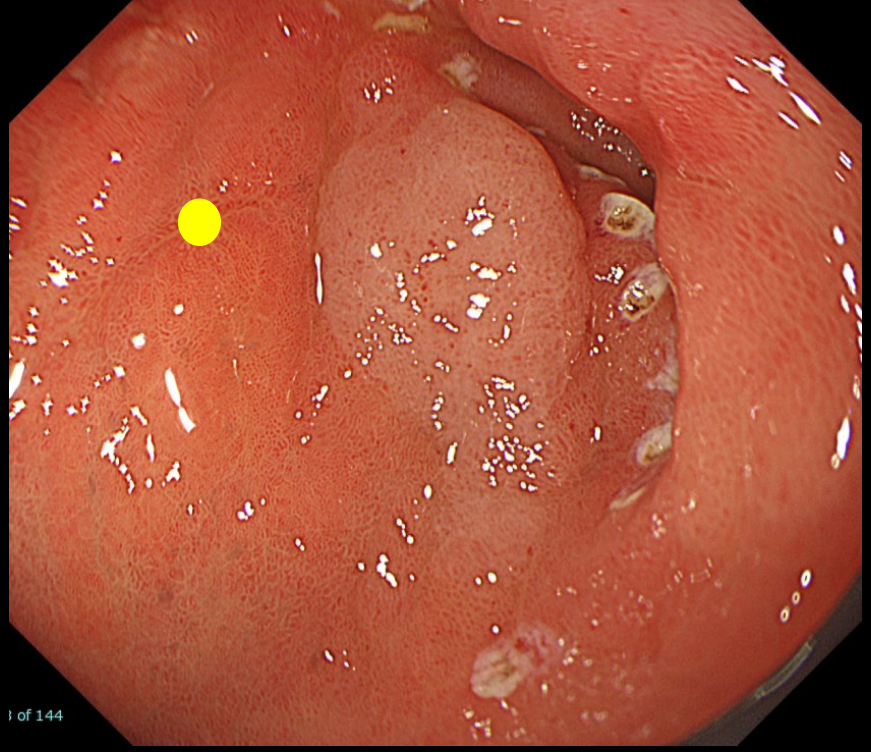
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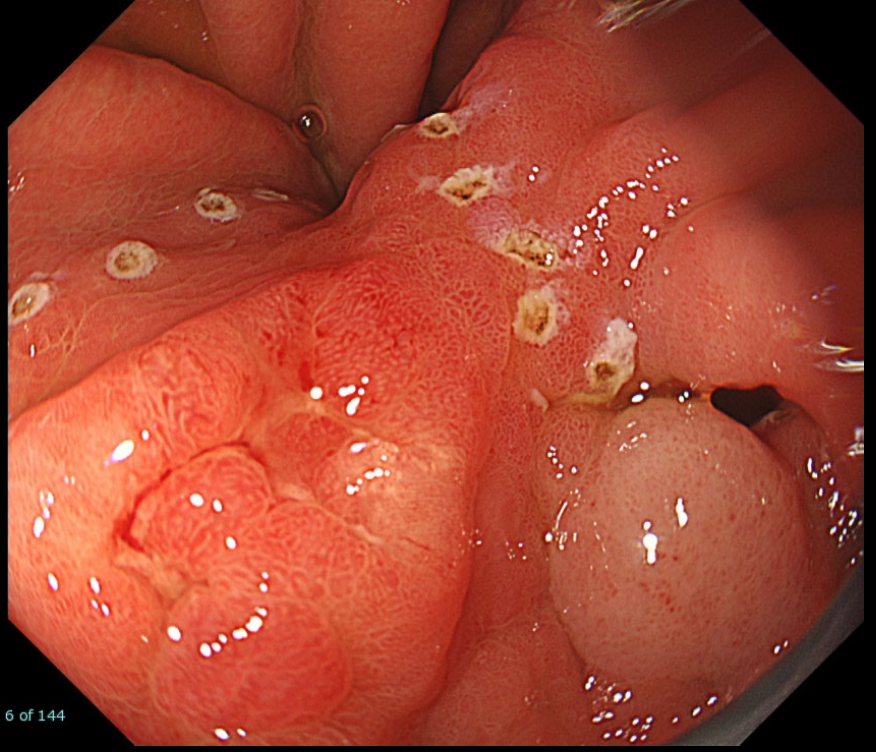
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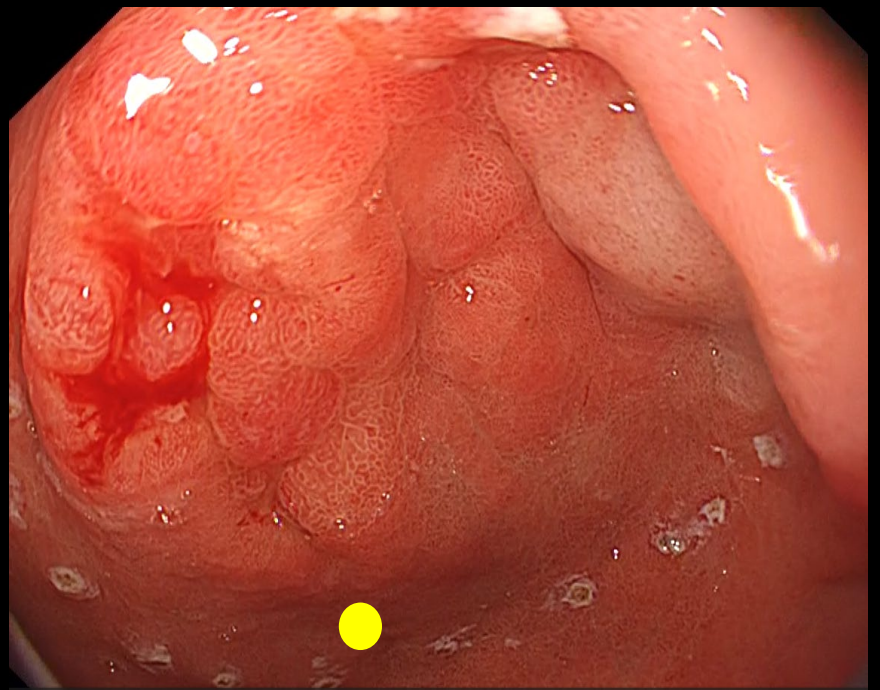

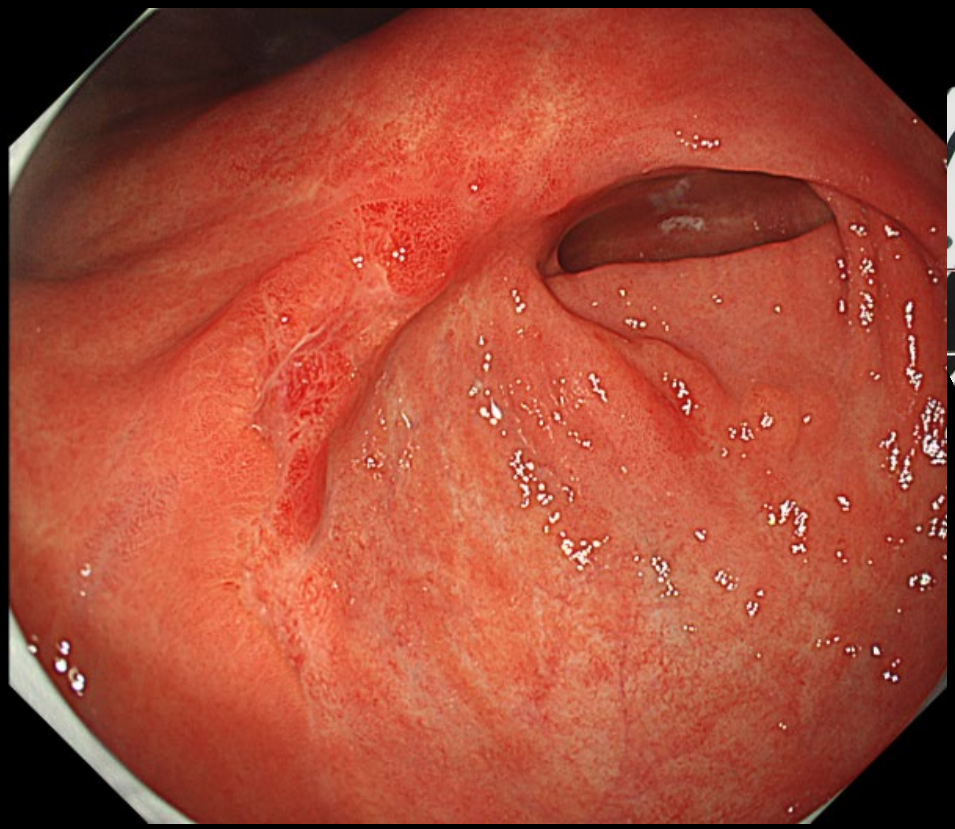

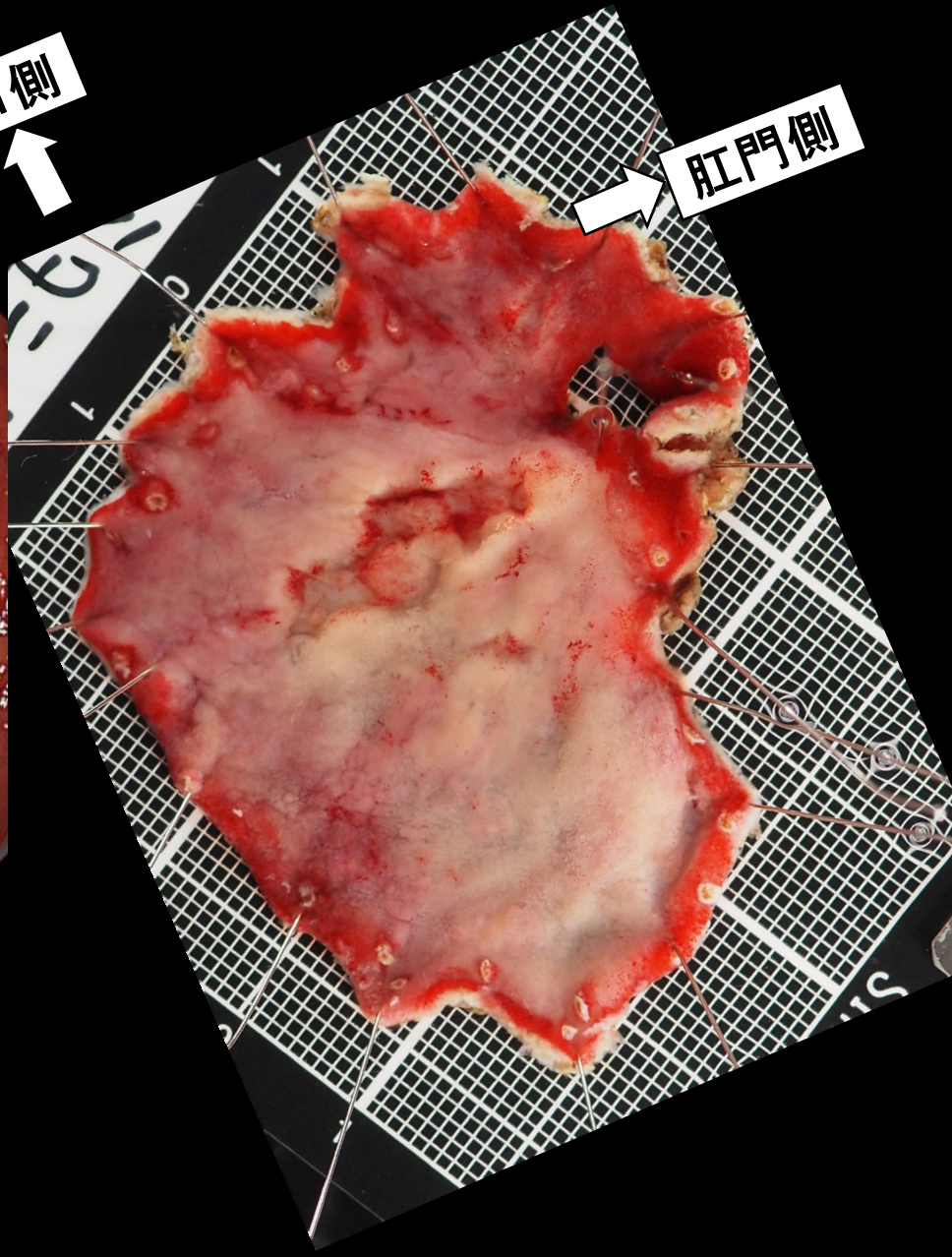
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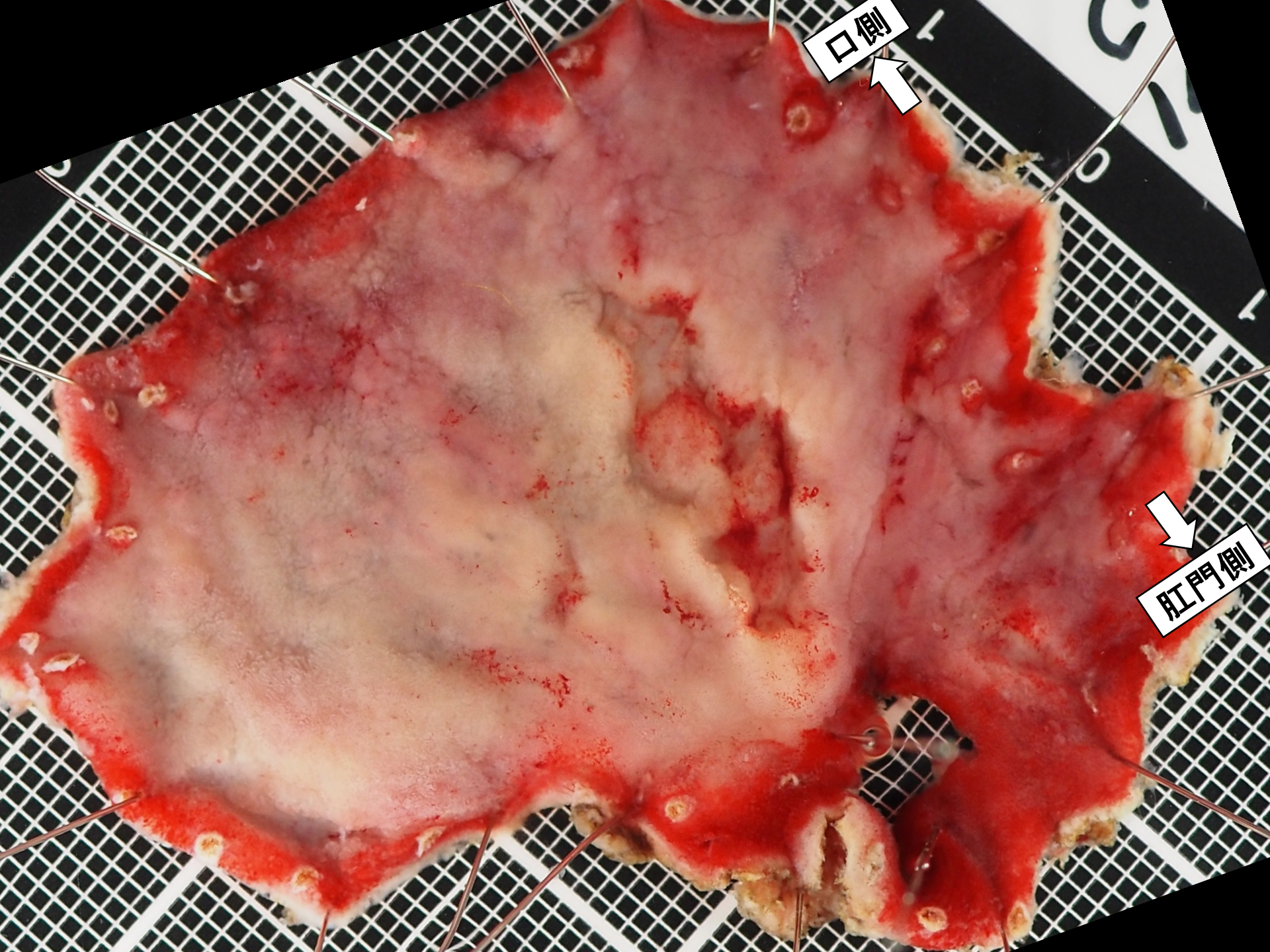
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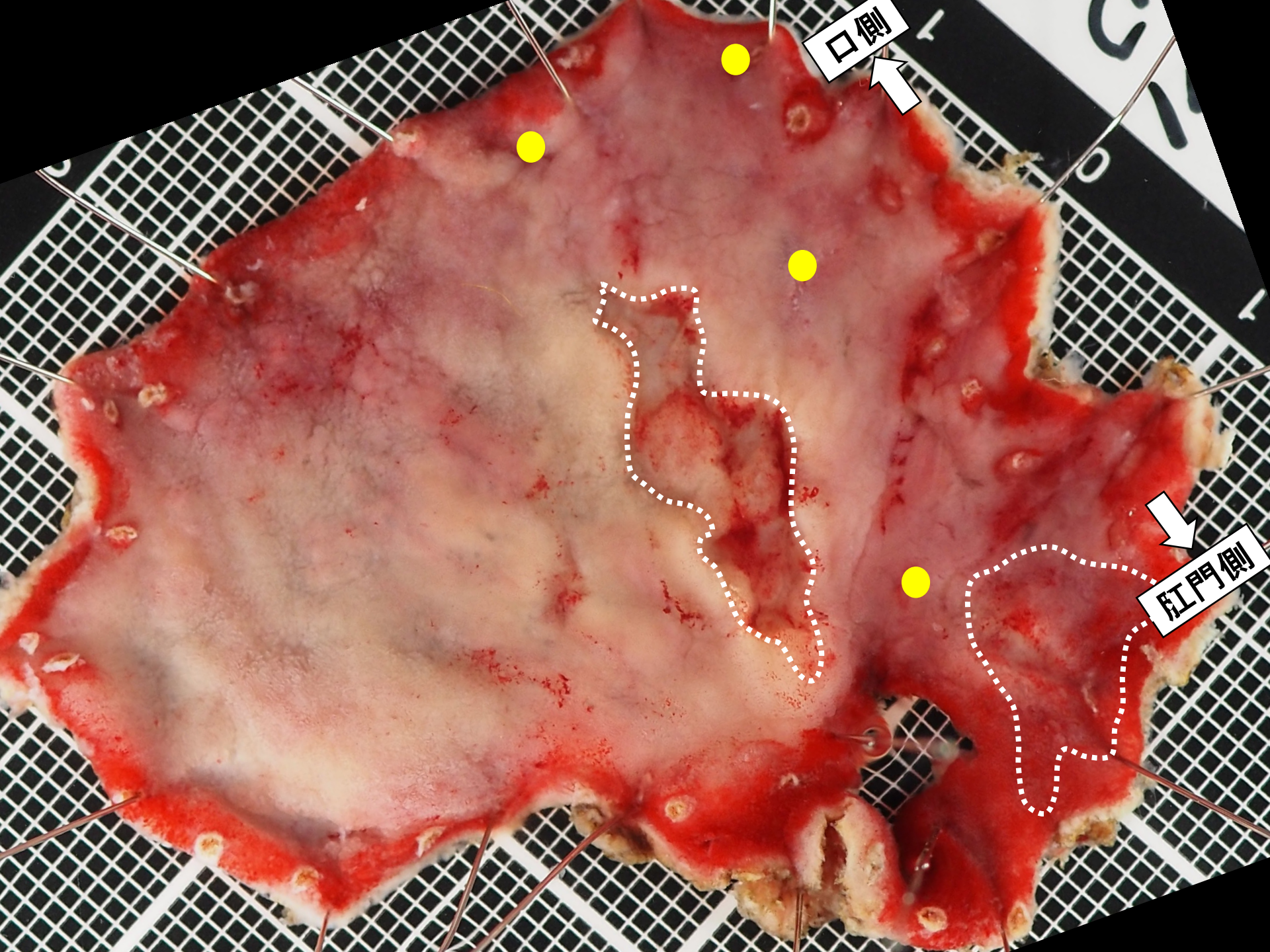
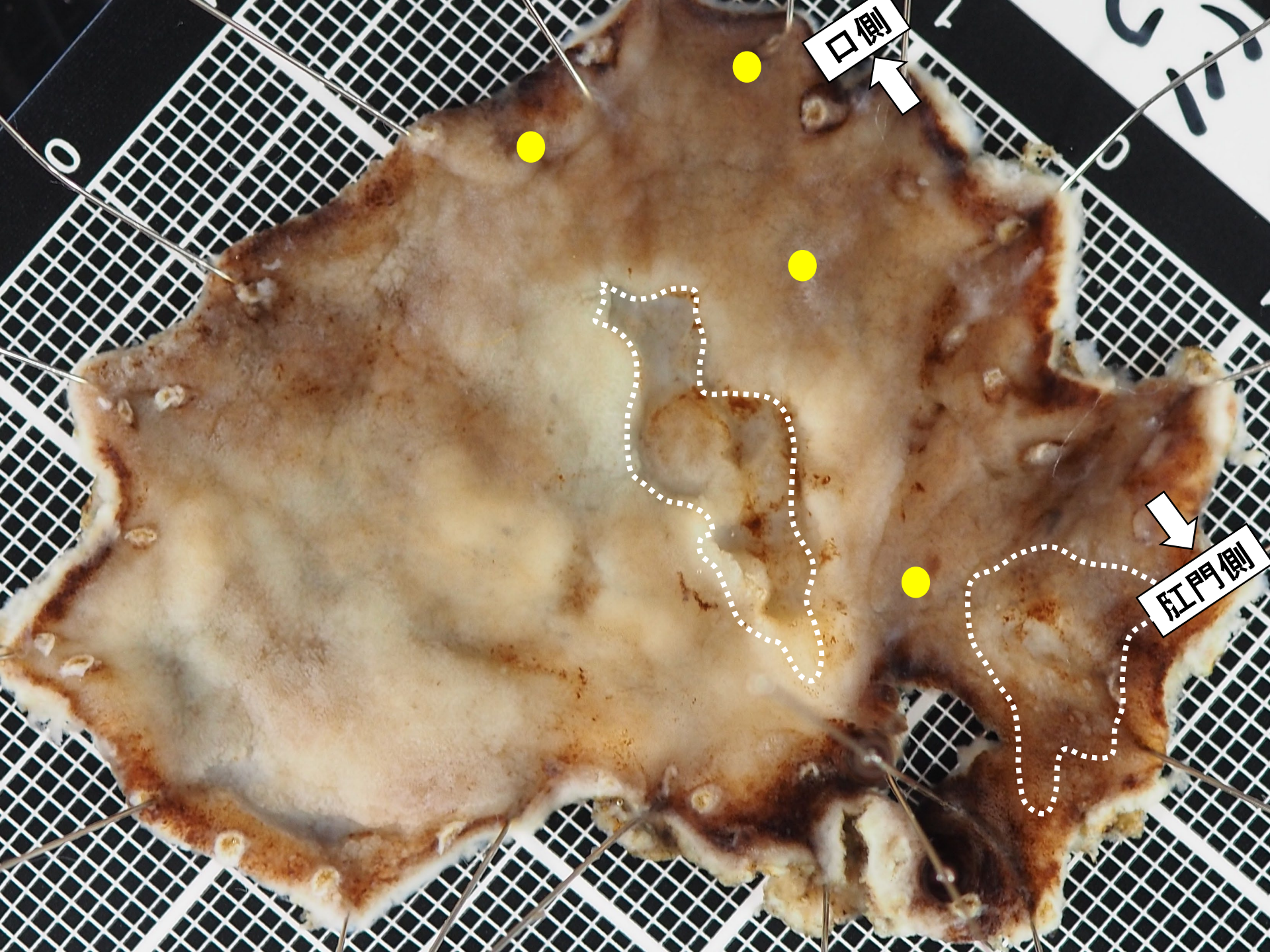

口側
肛門側


口側
肛門側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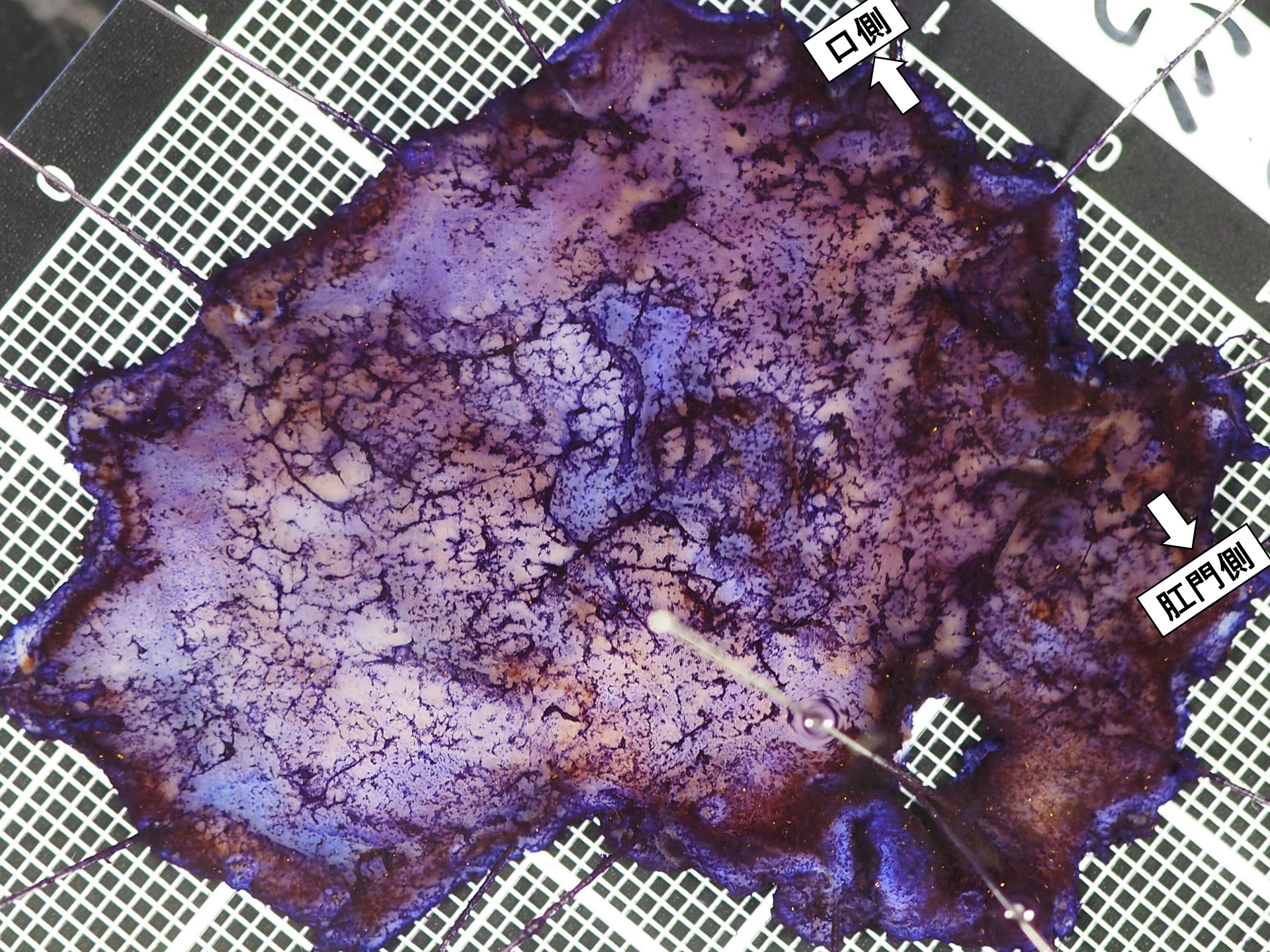
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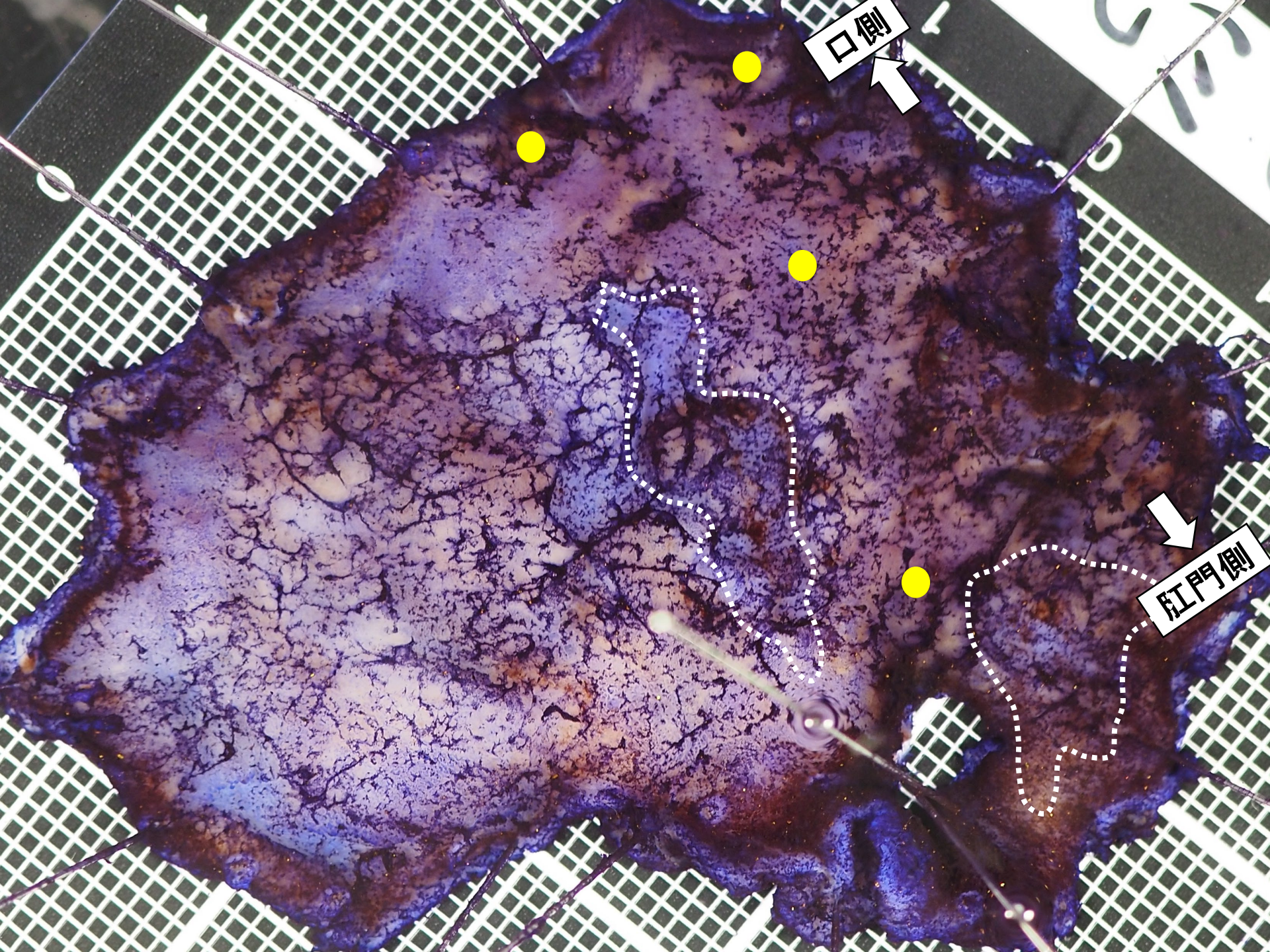
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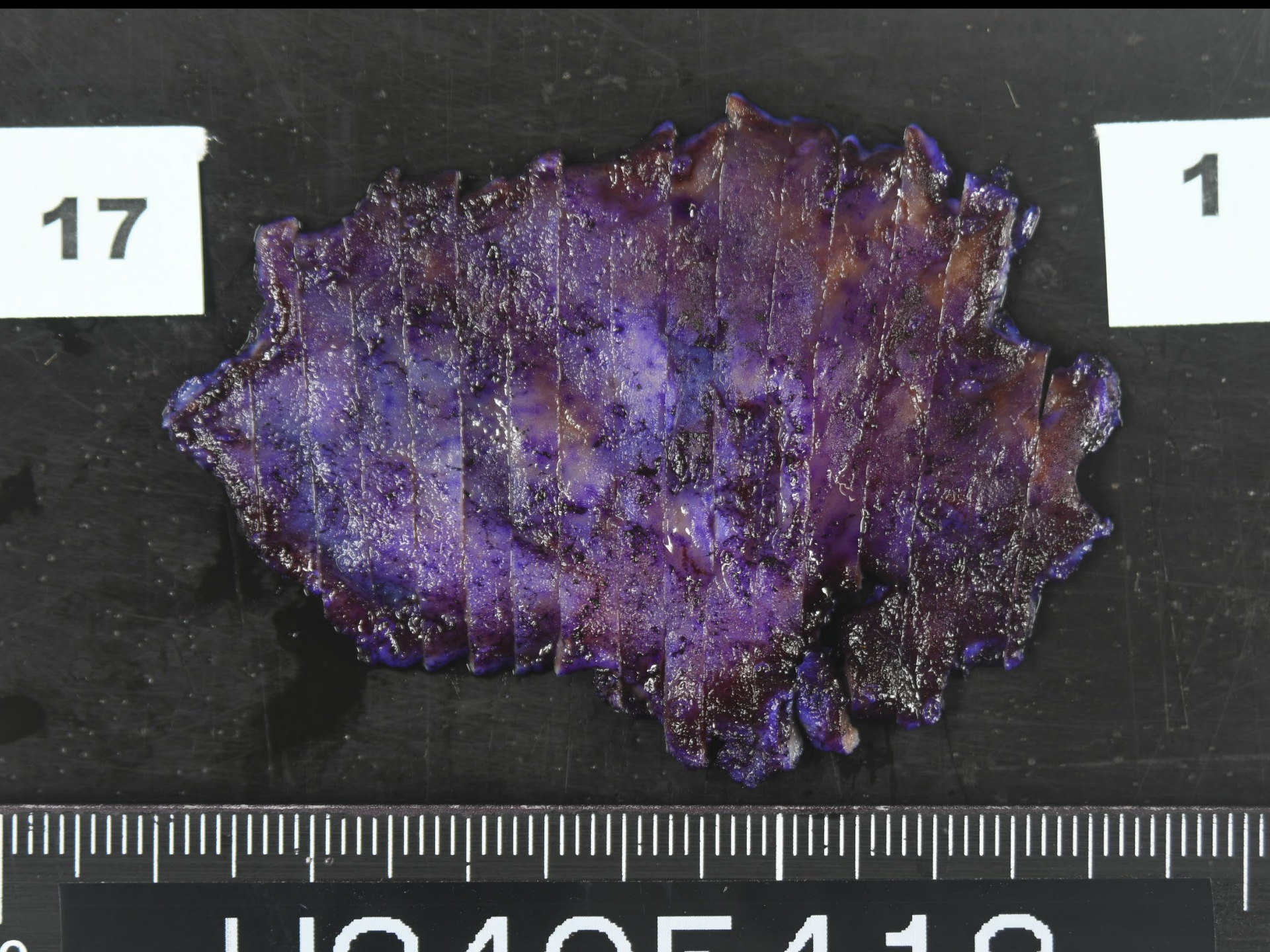
肛門側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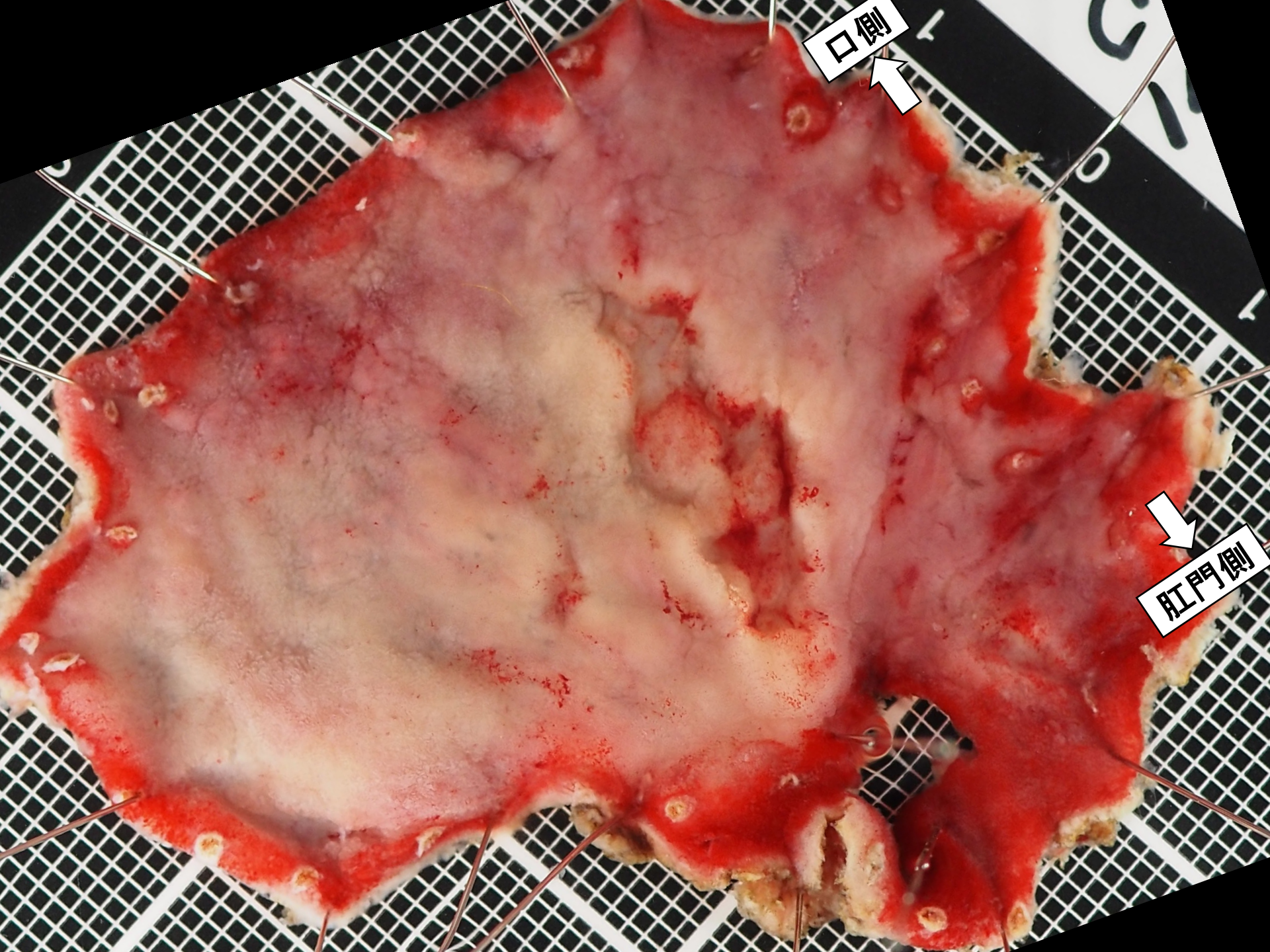
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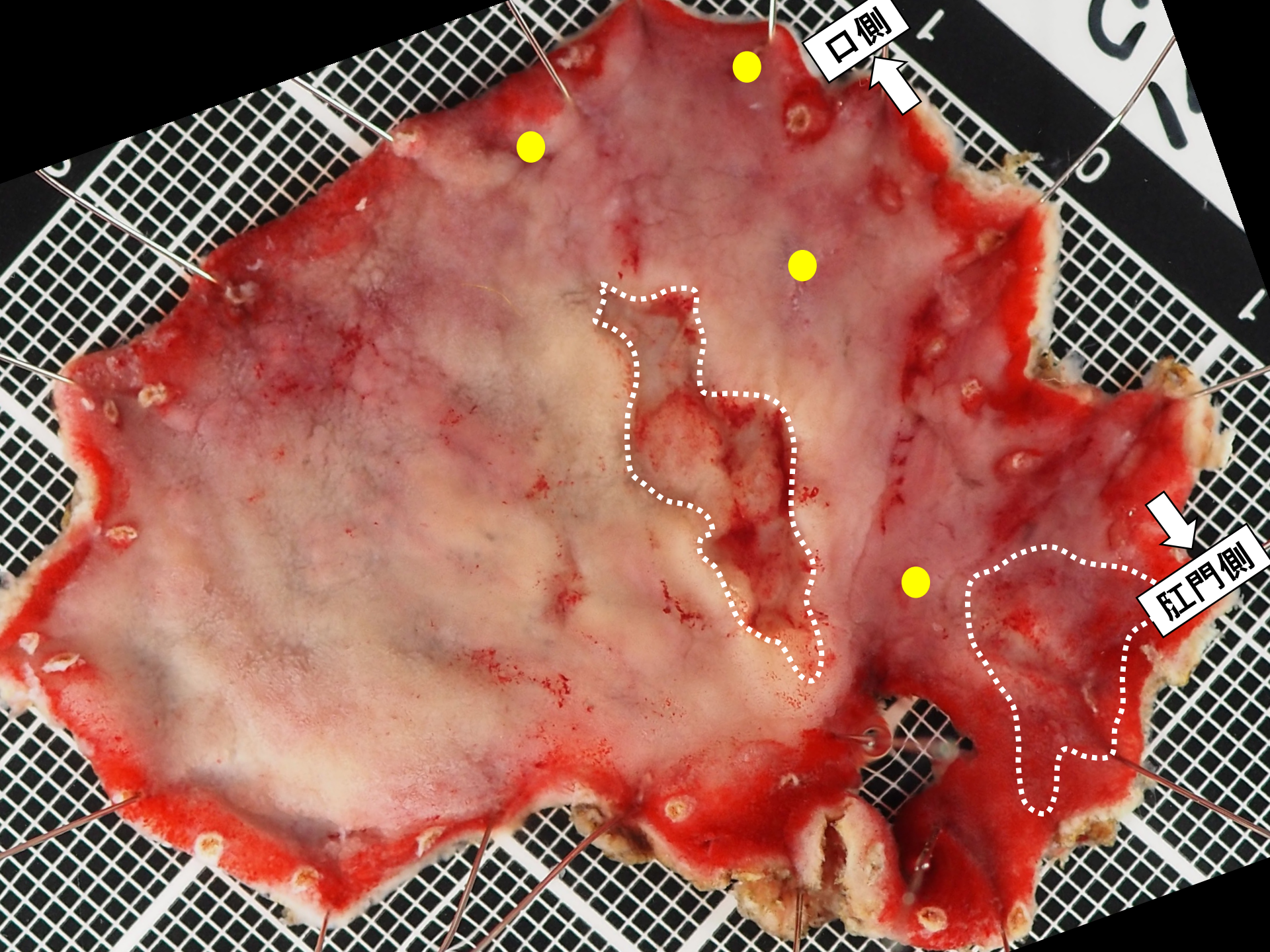
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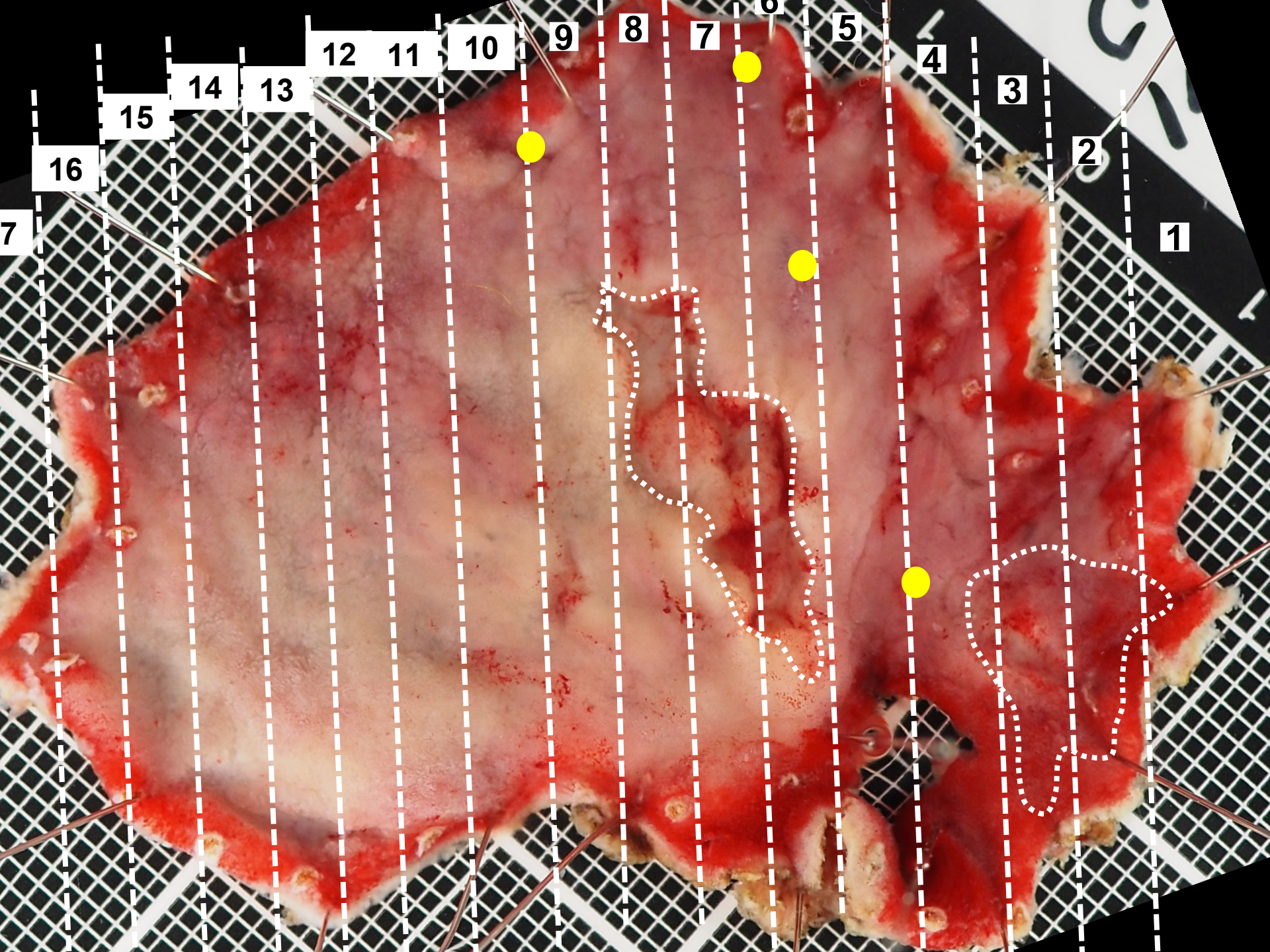
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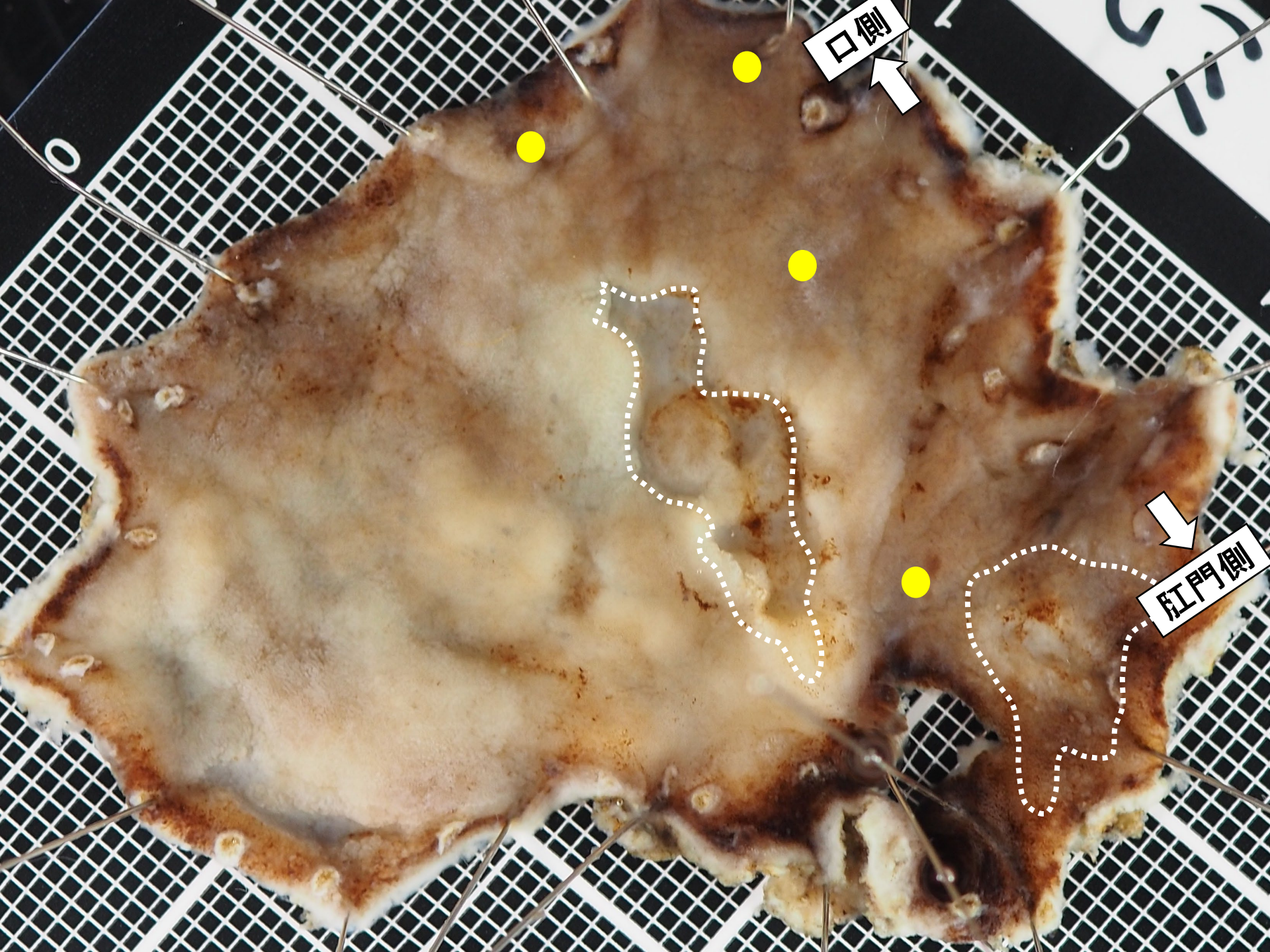
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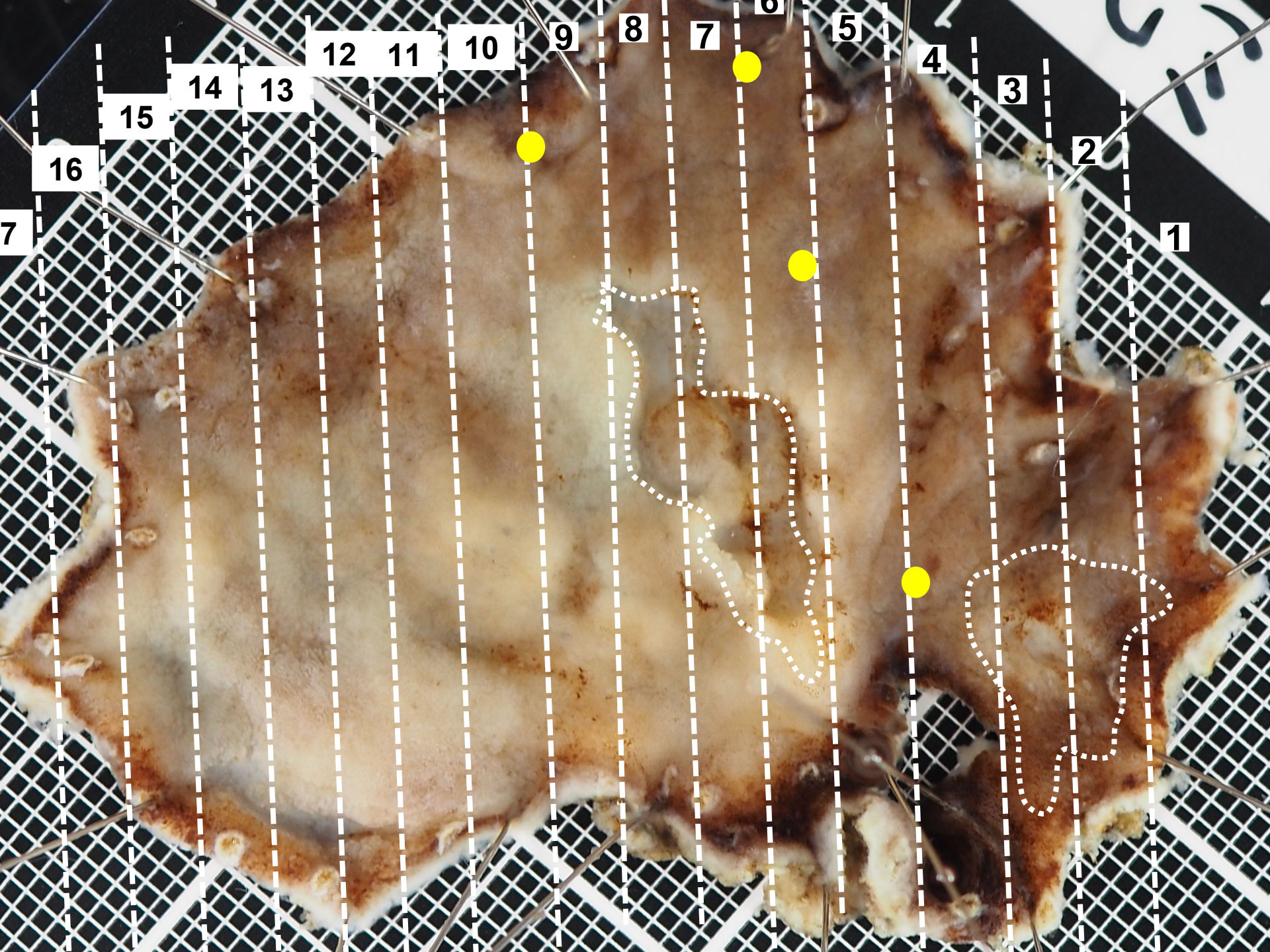
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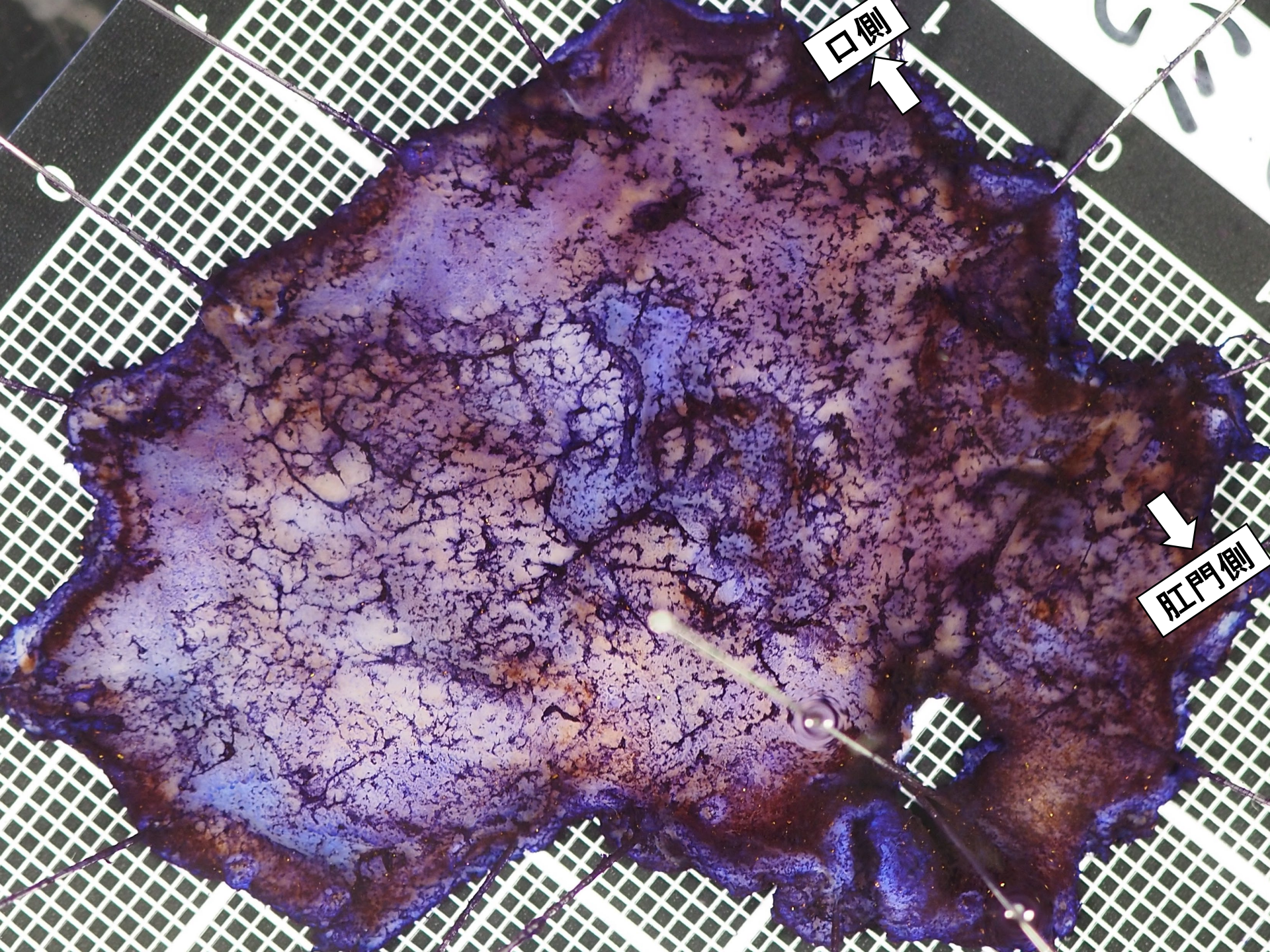
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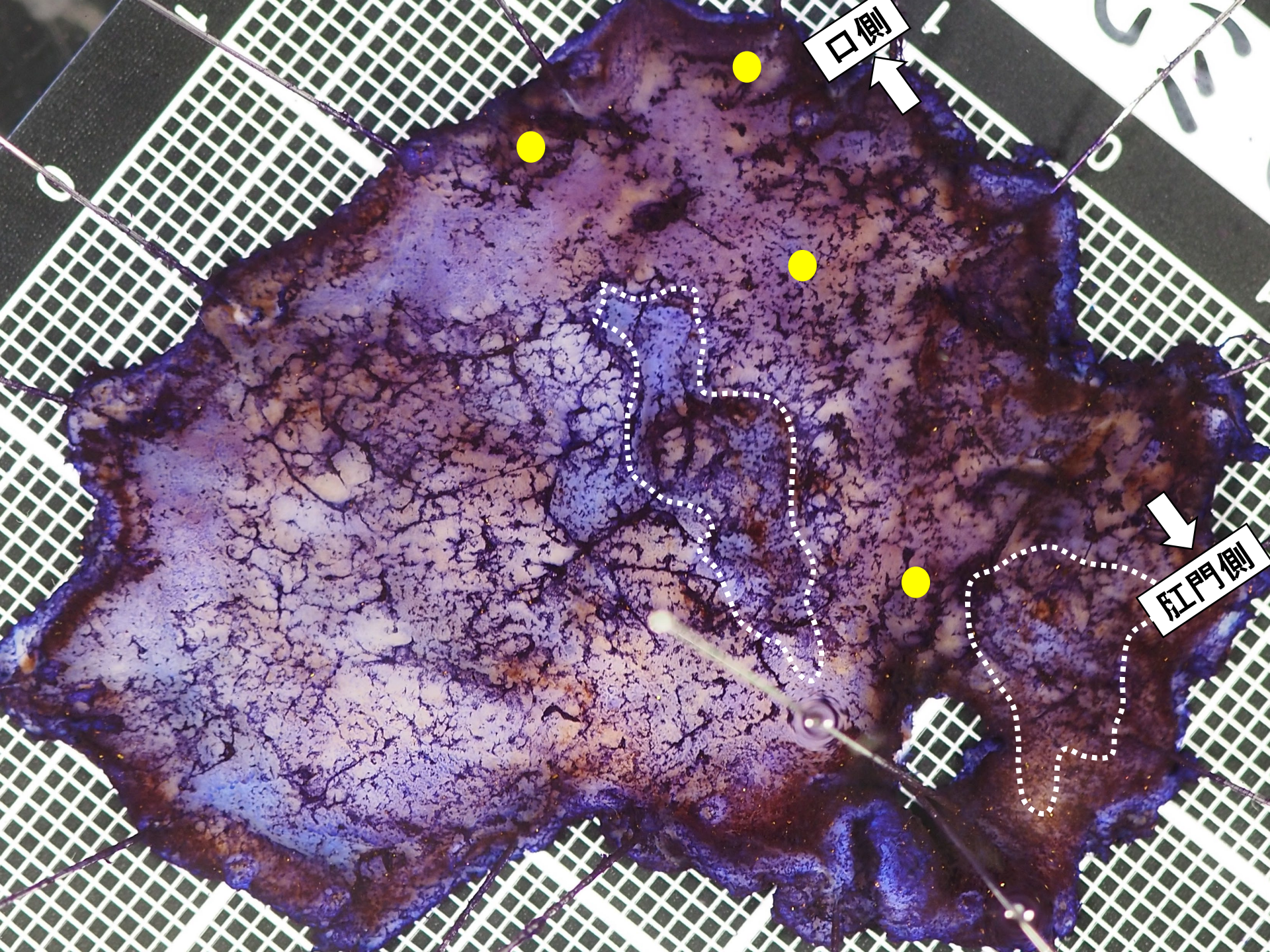
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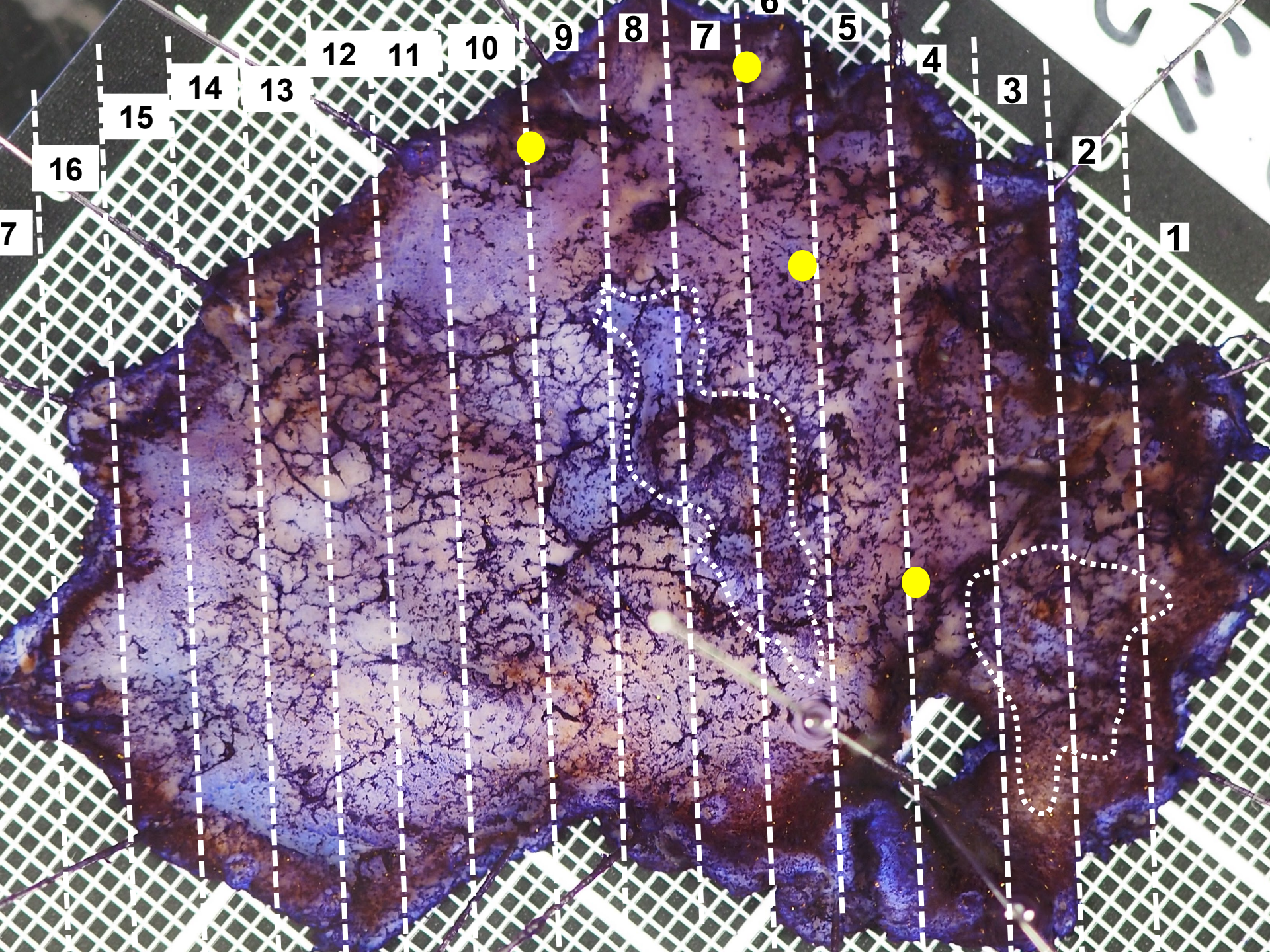
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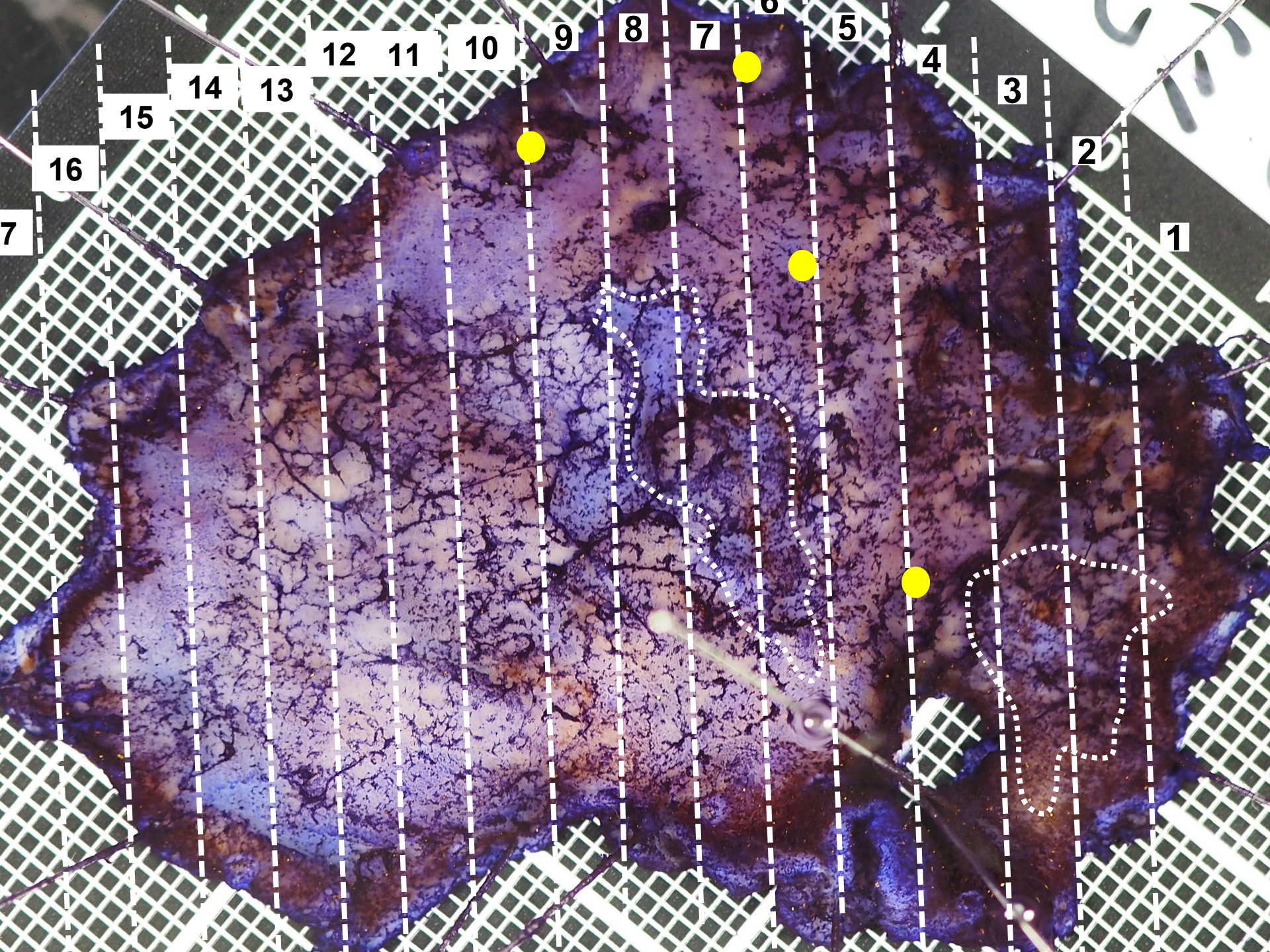
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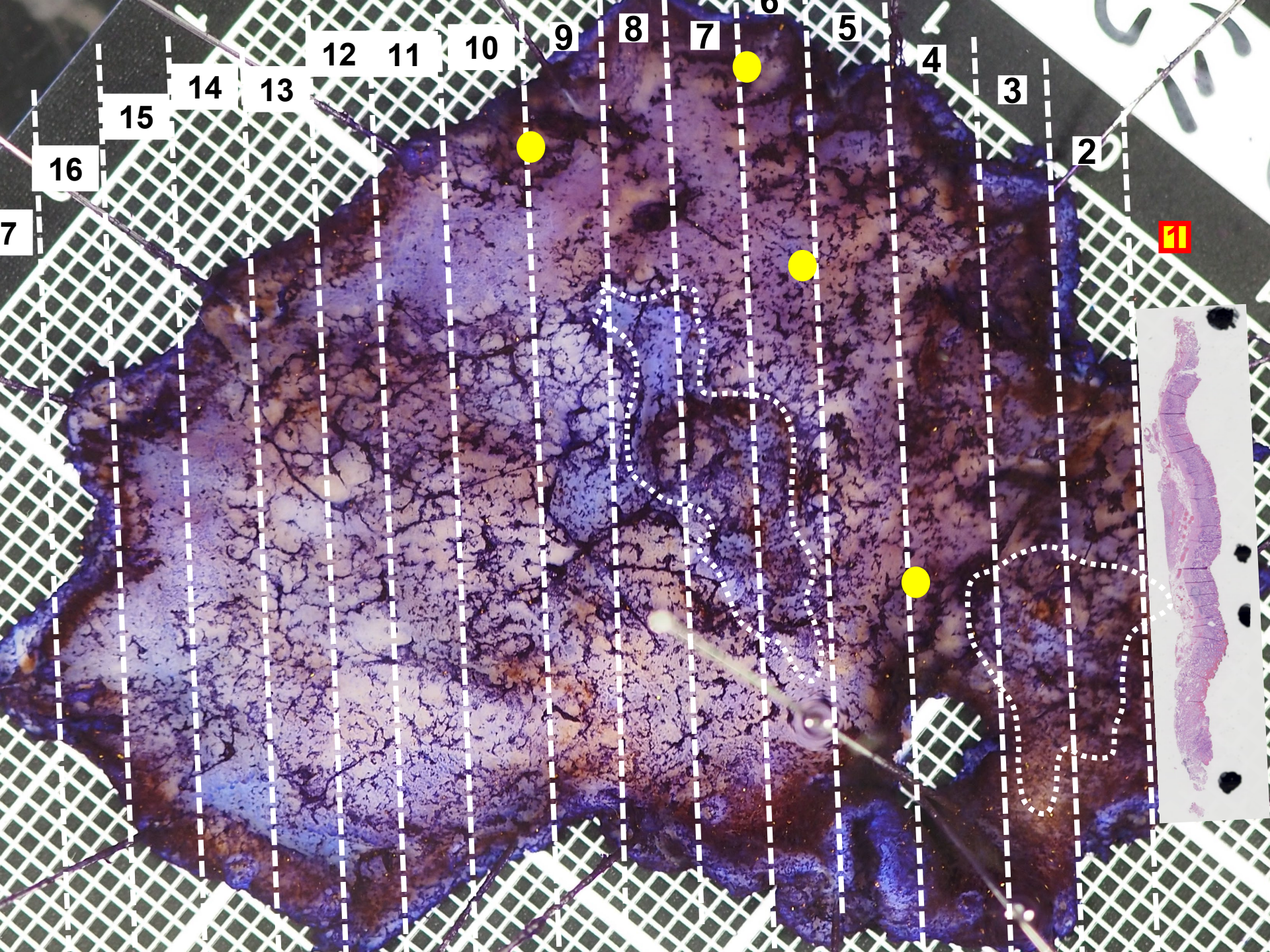
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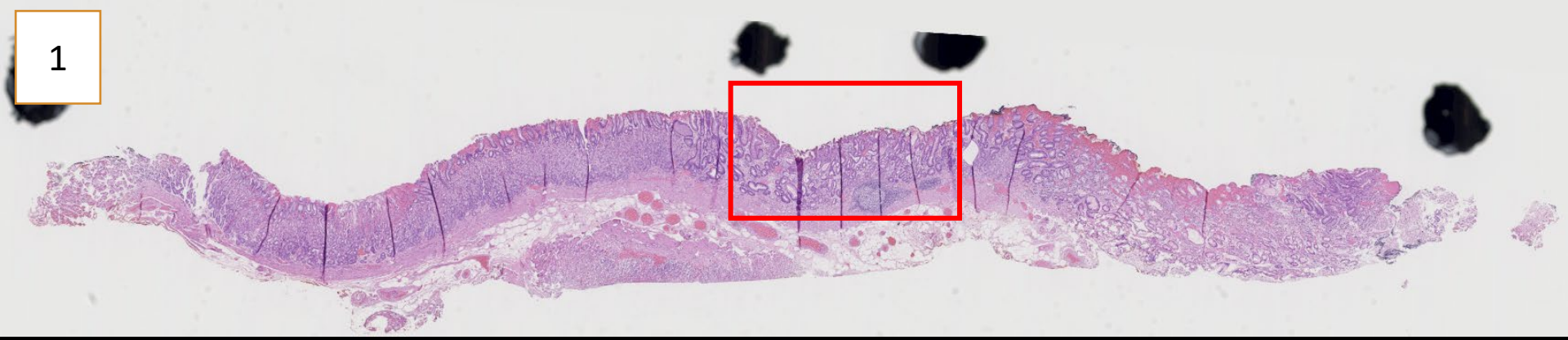
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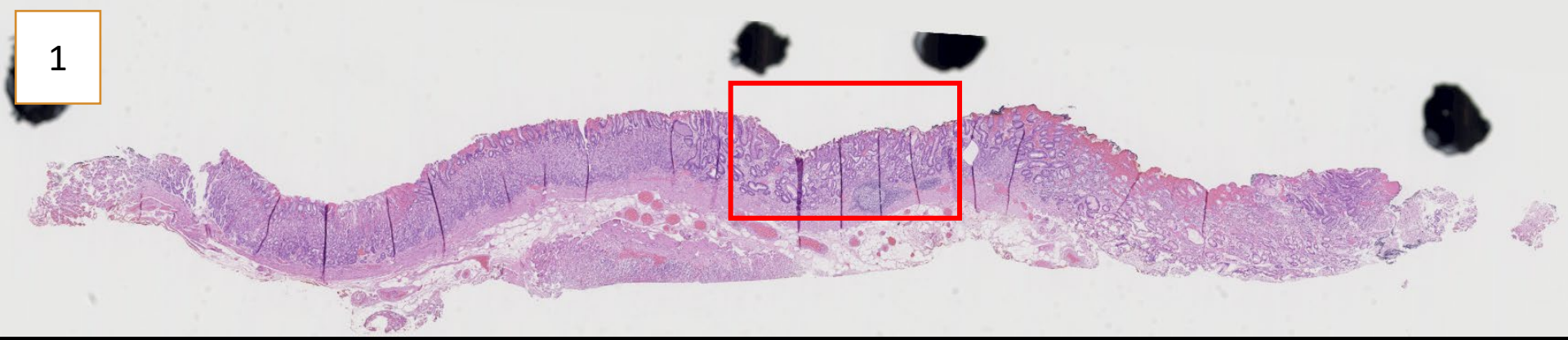

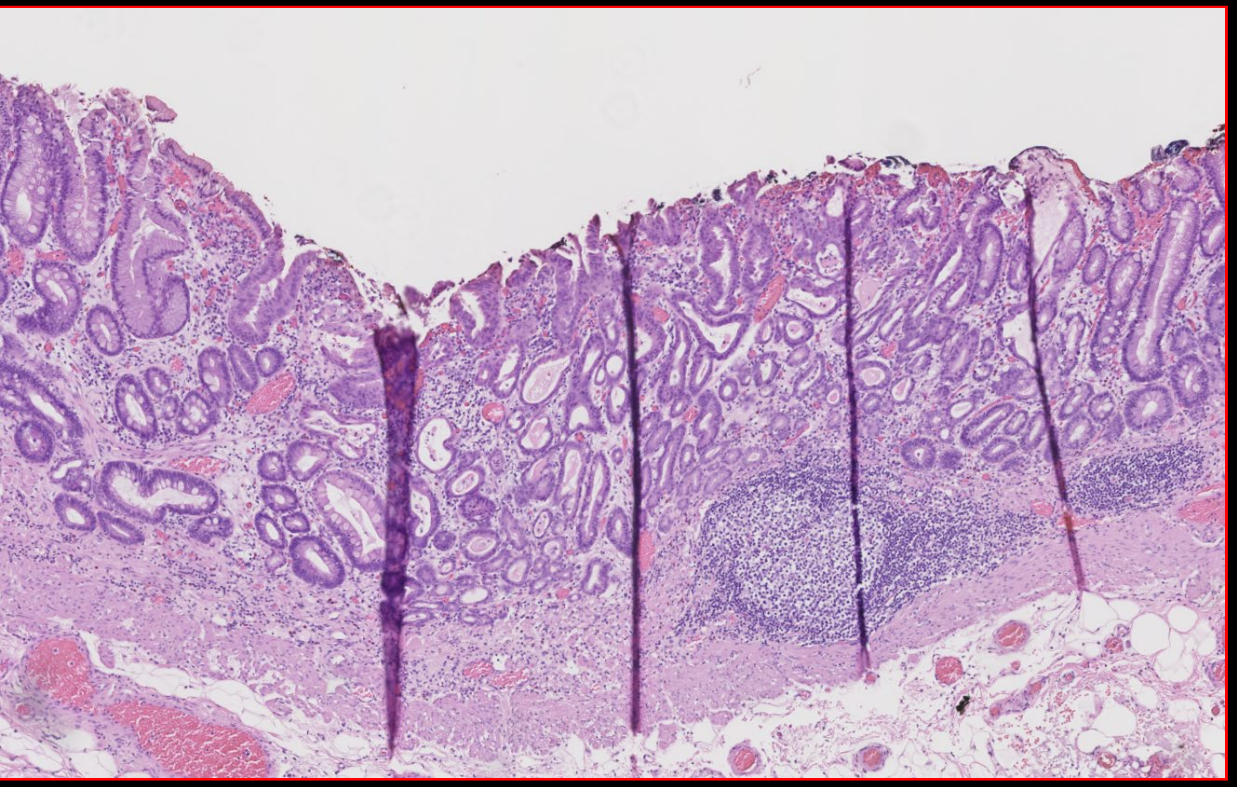

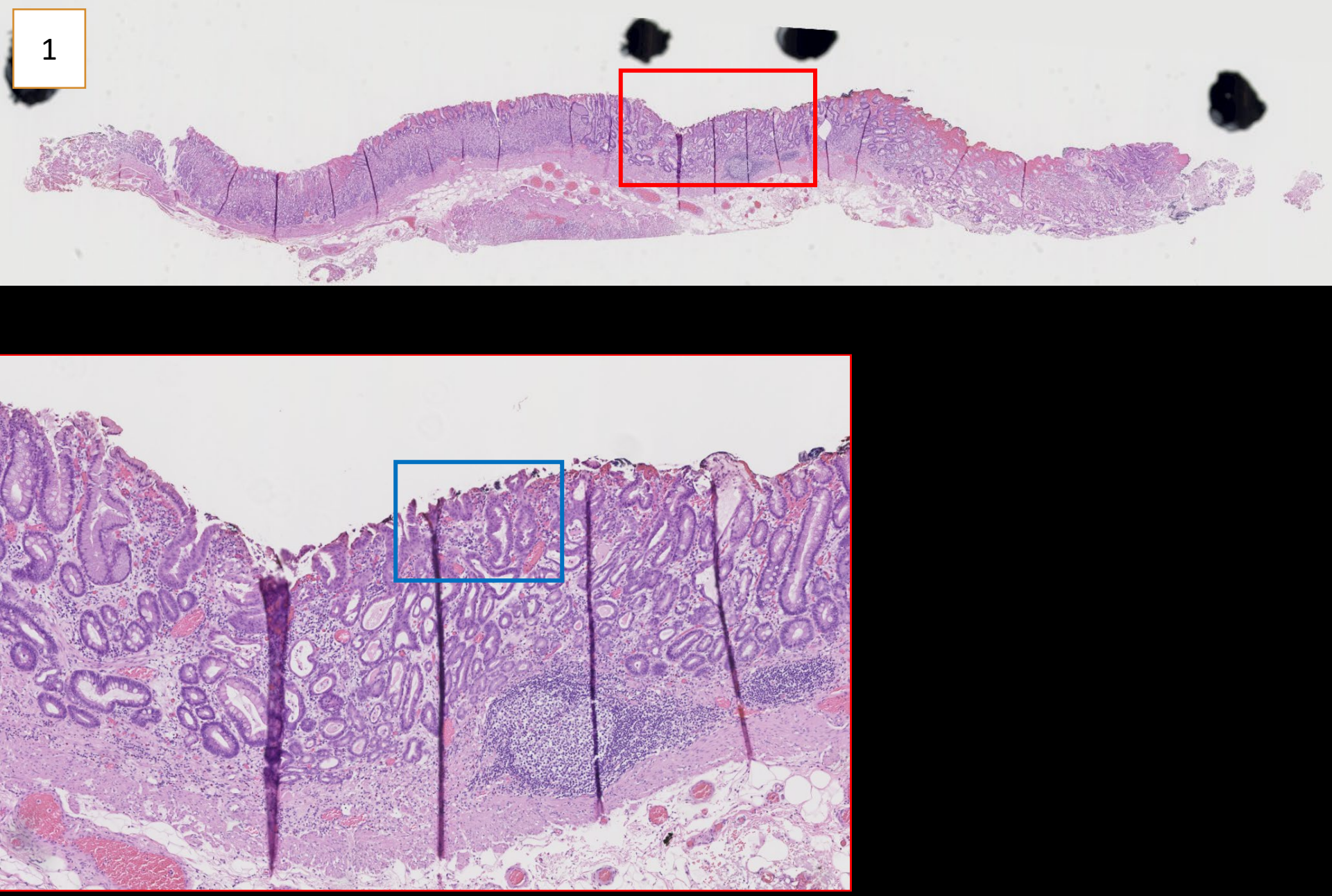
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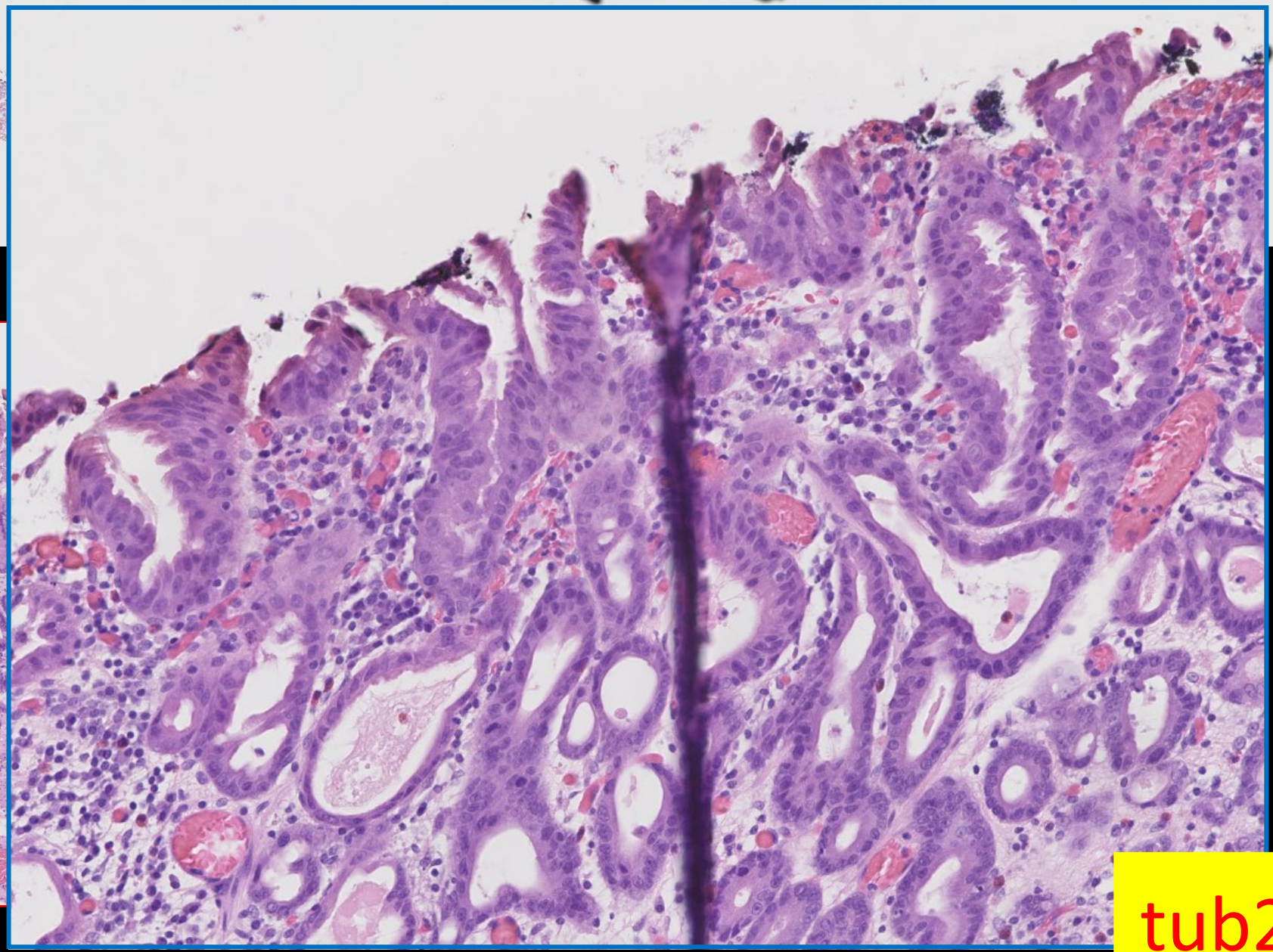

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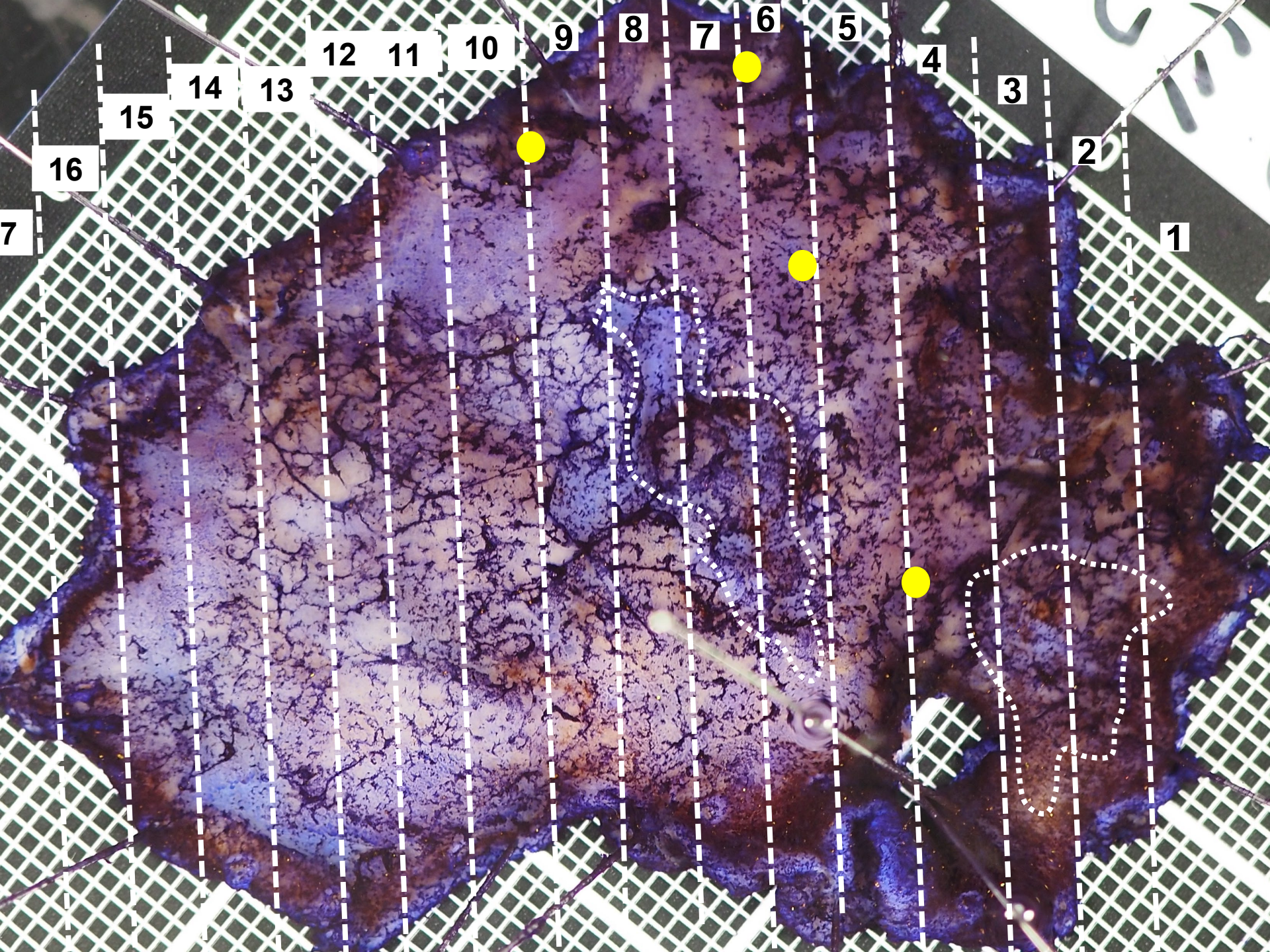
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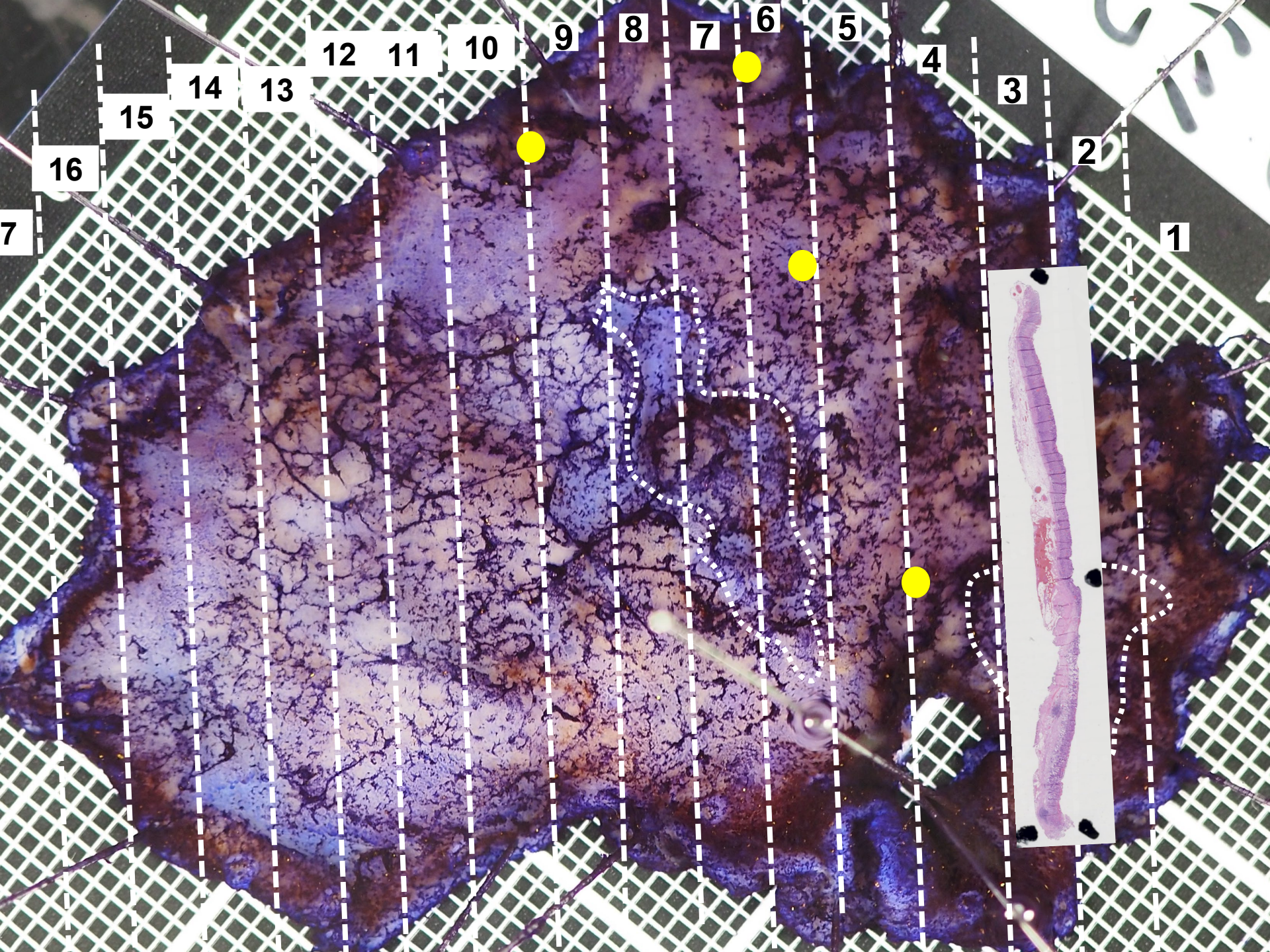
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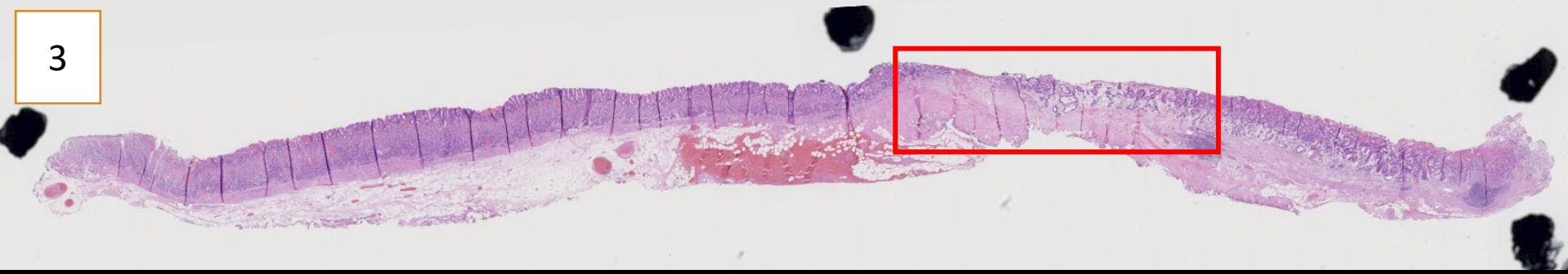
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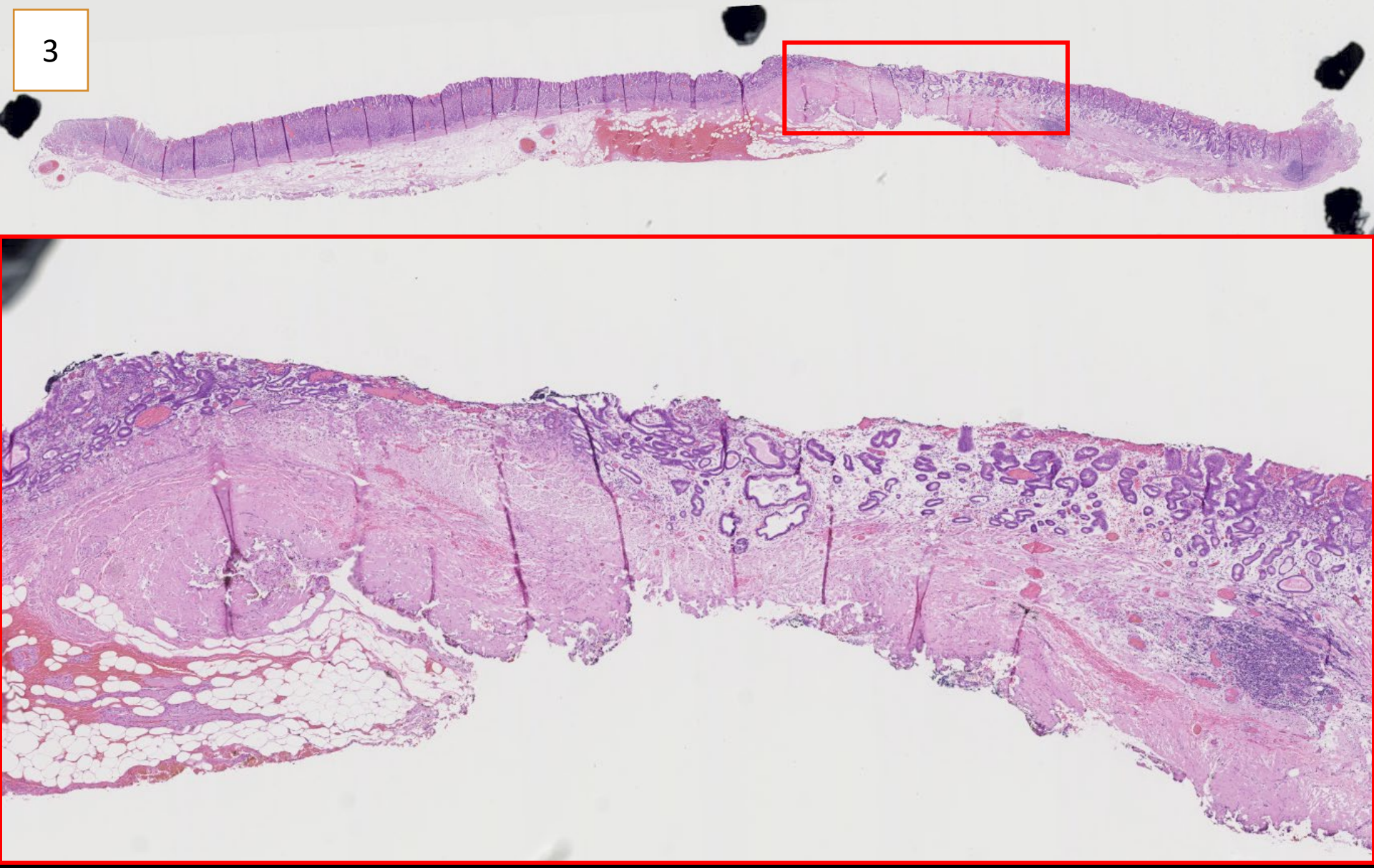

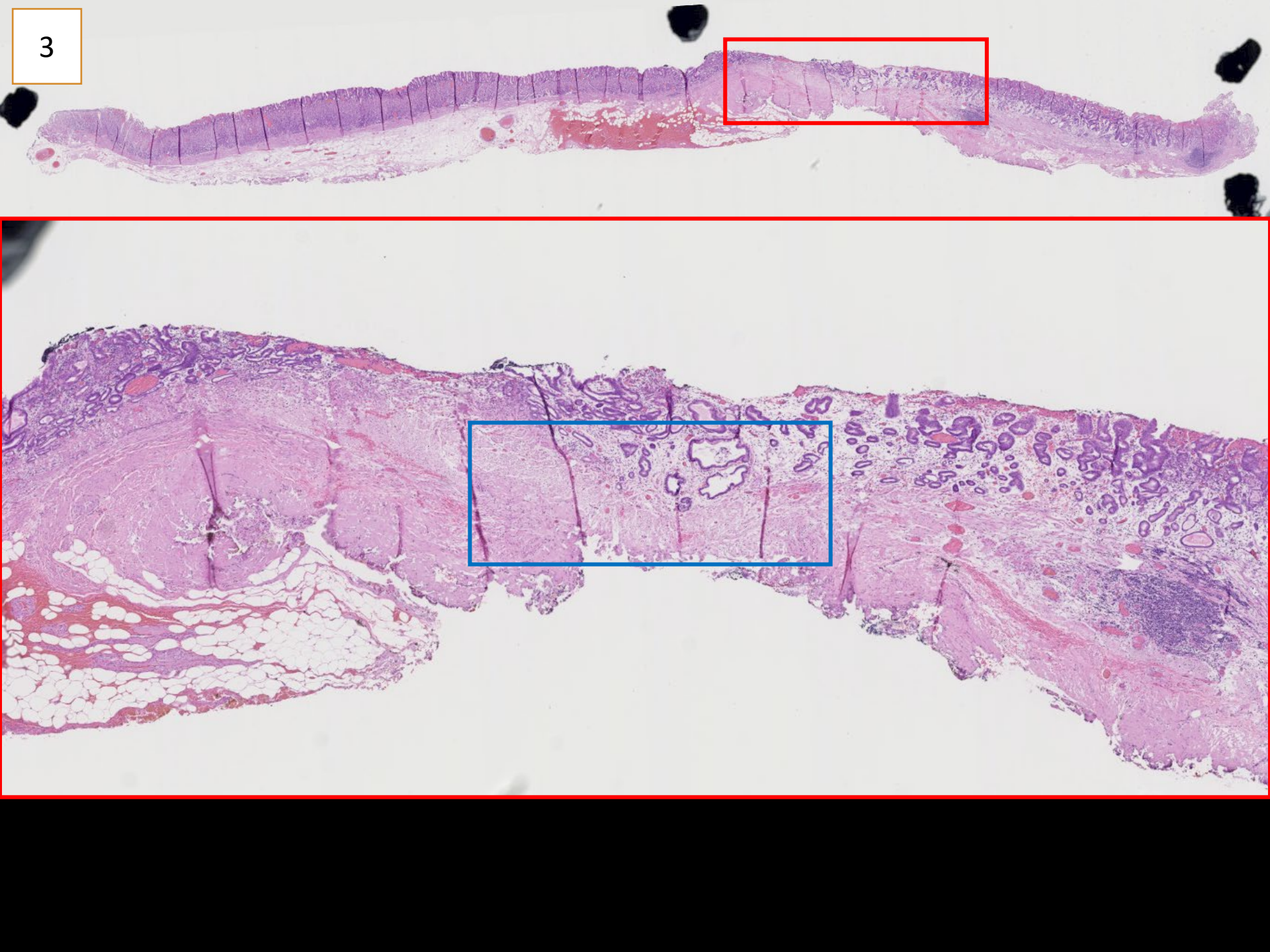
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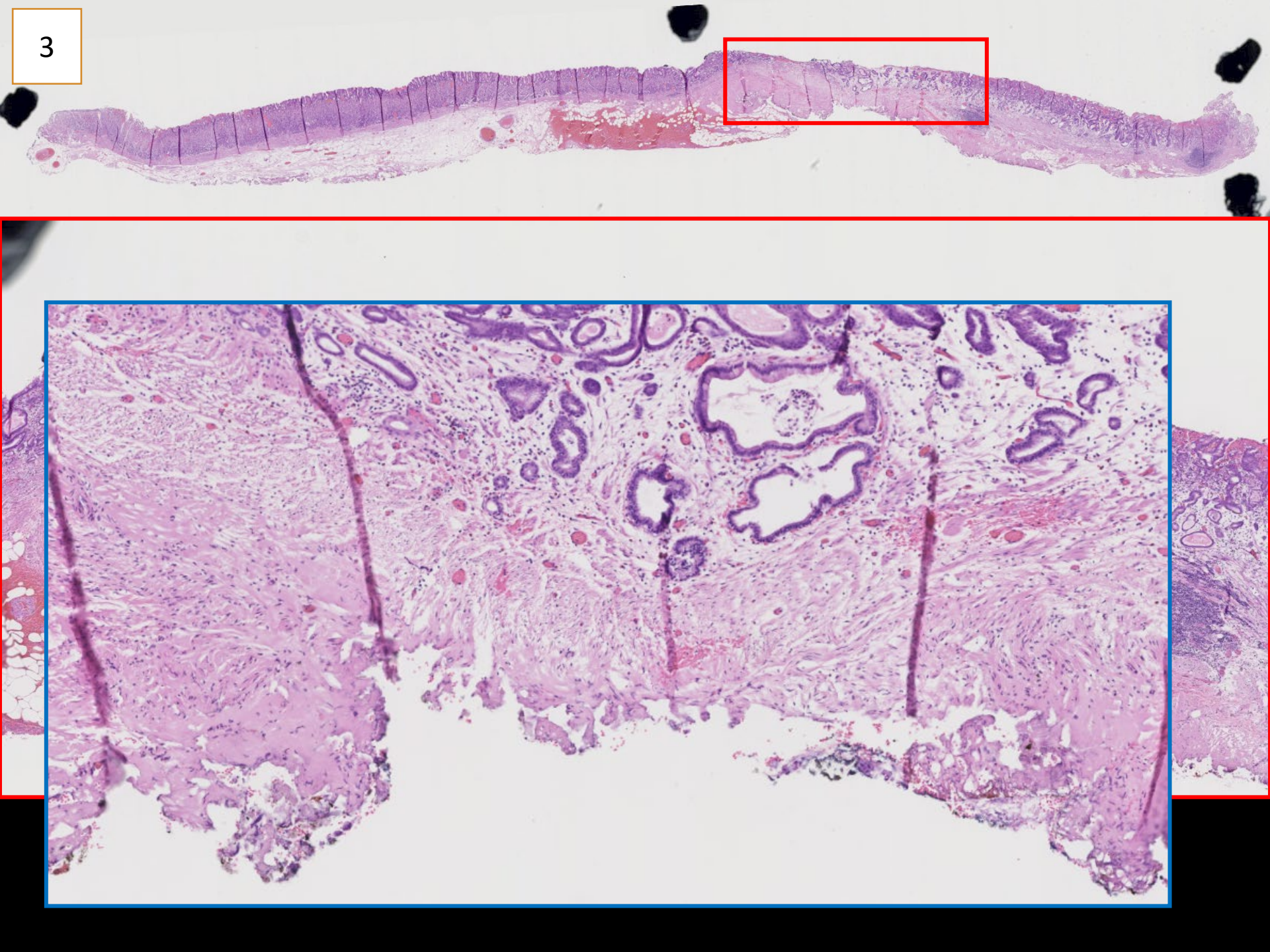
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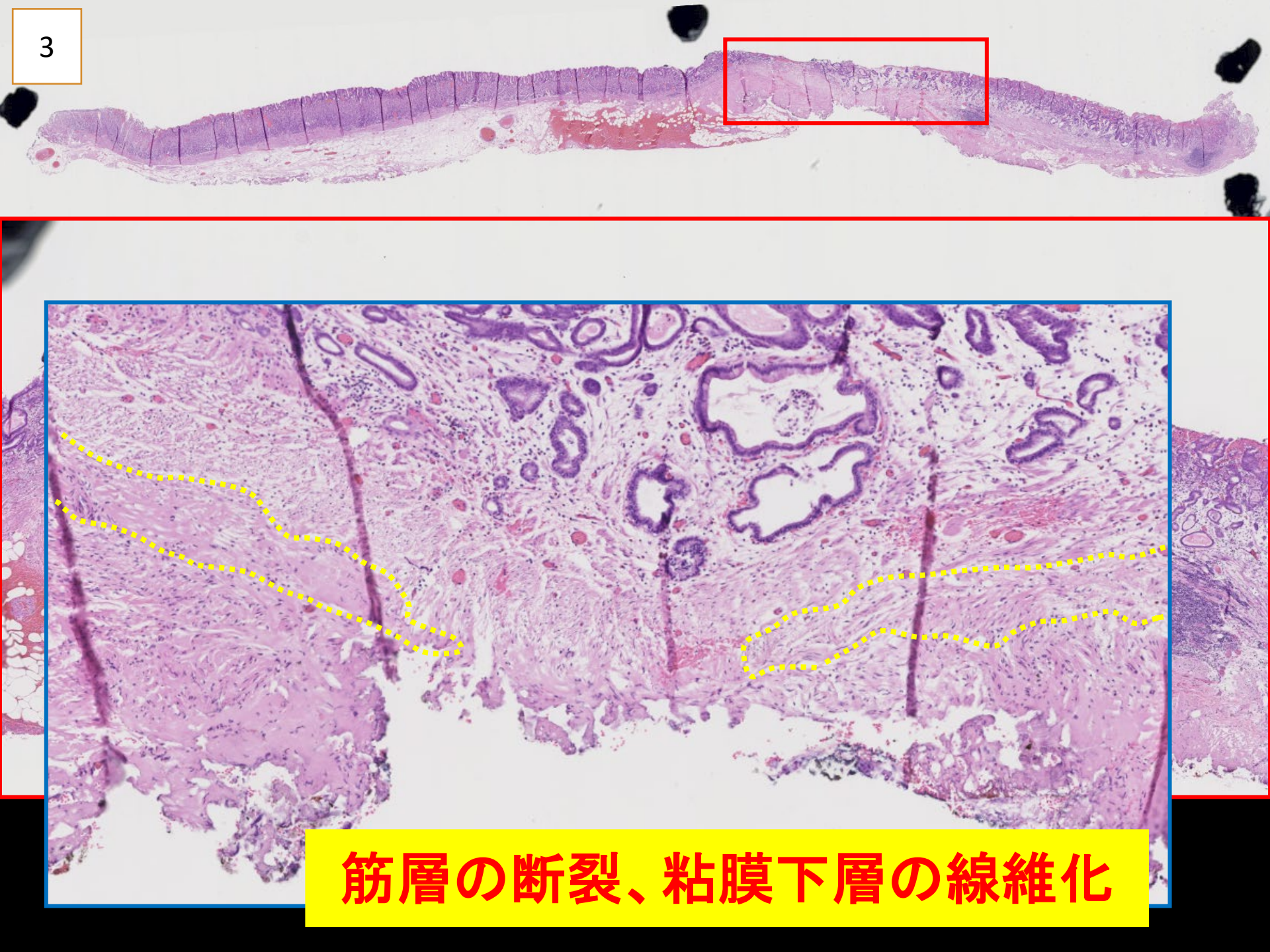

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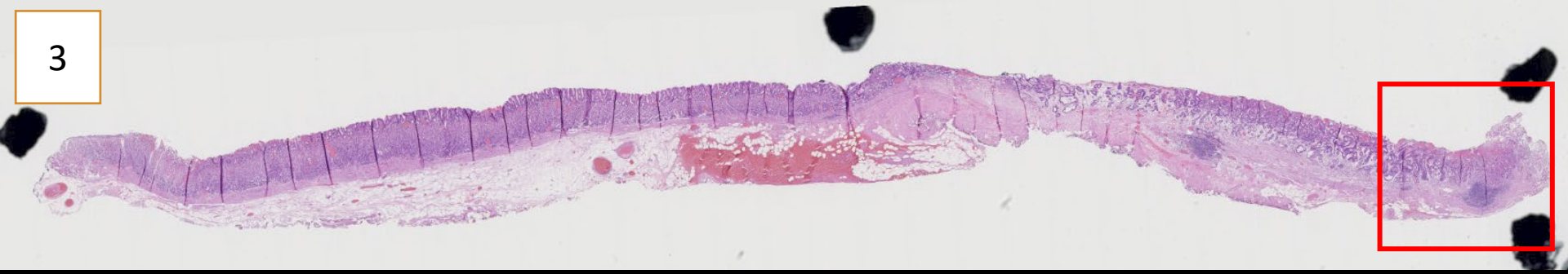
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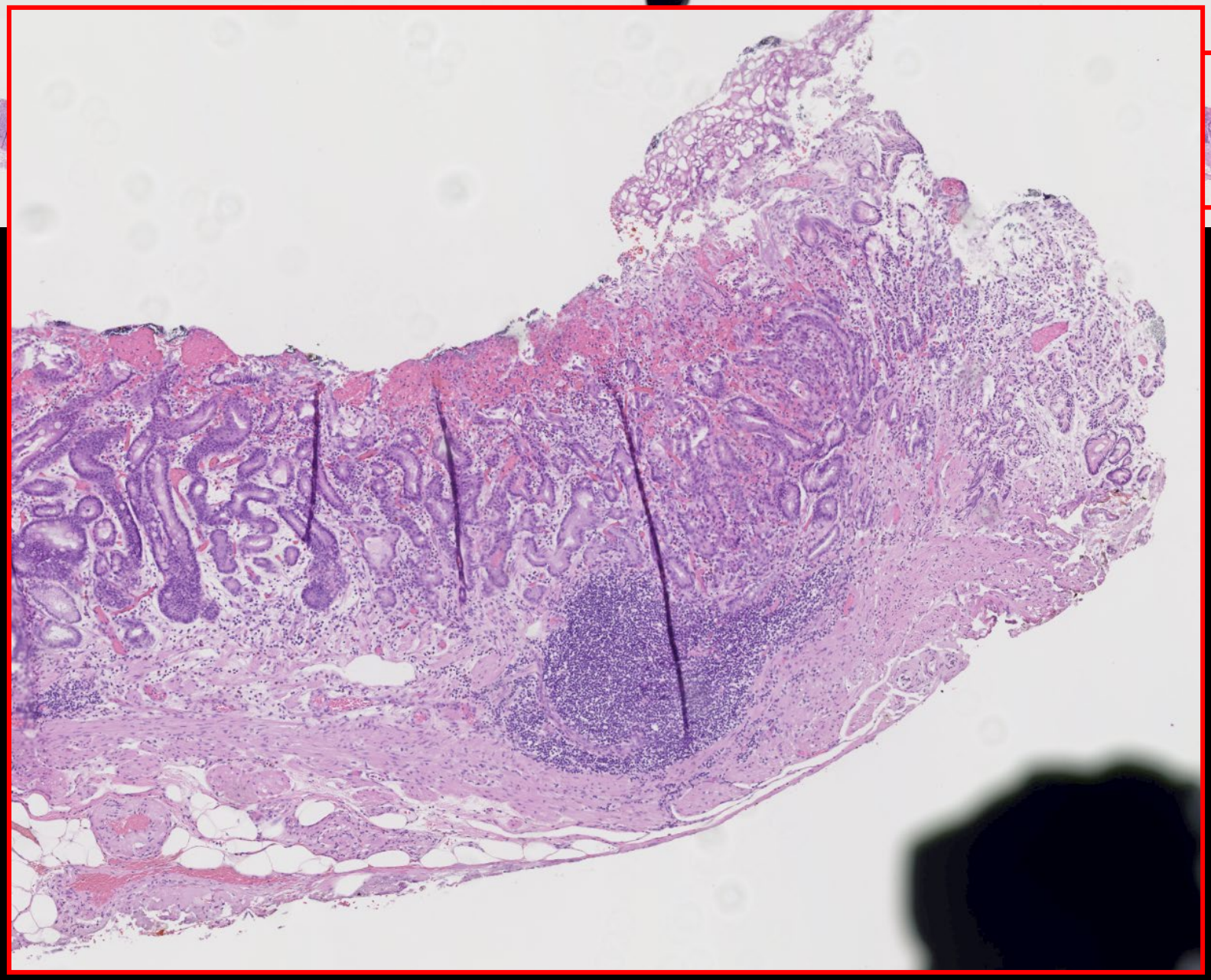

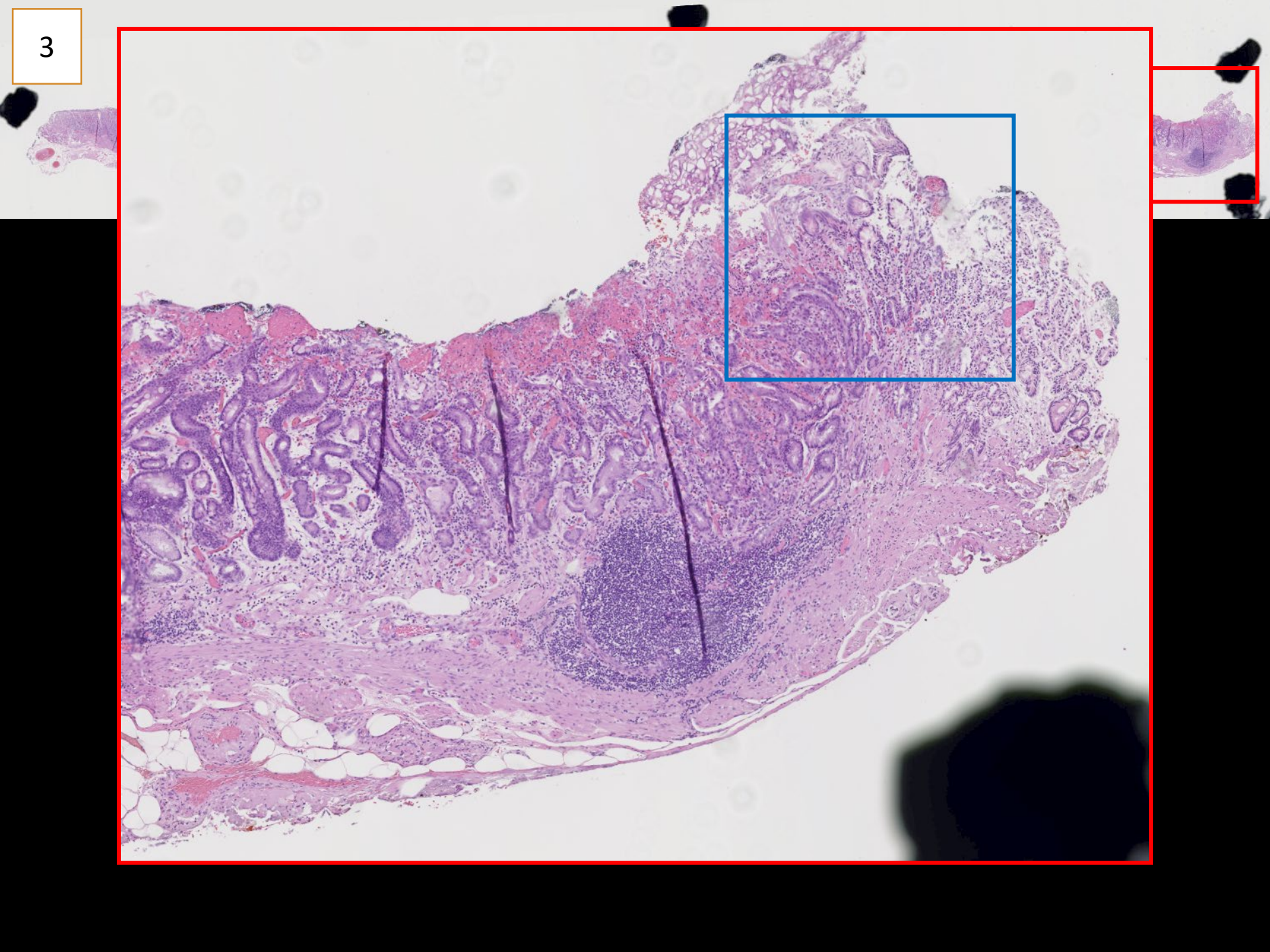
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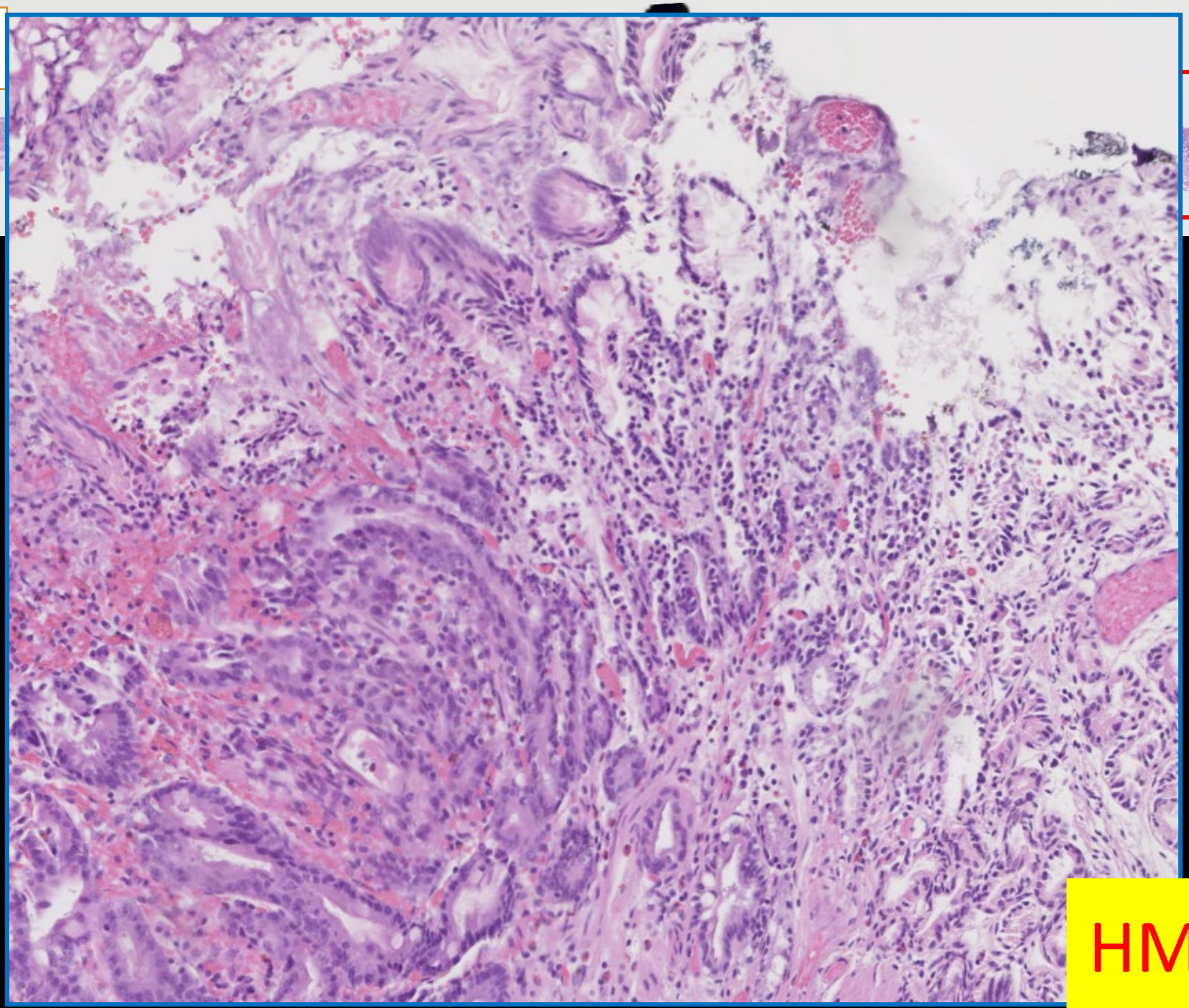

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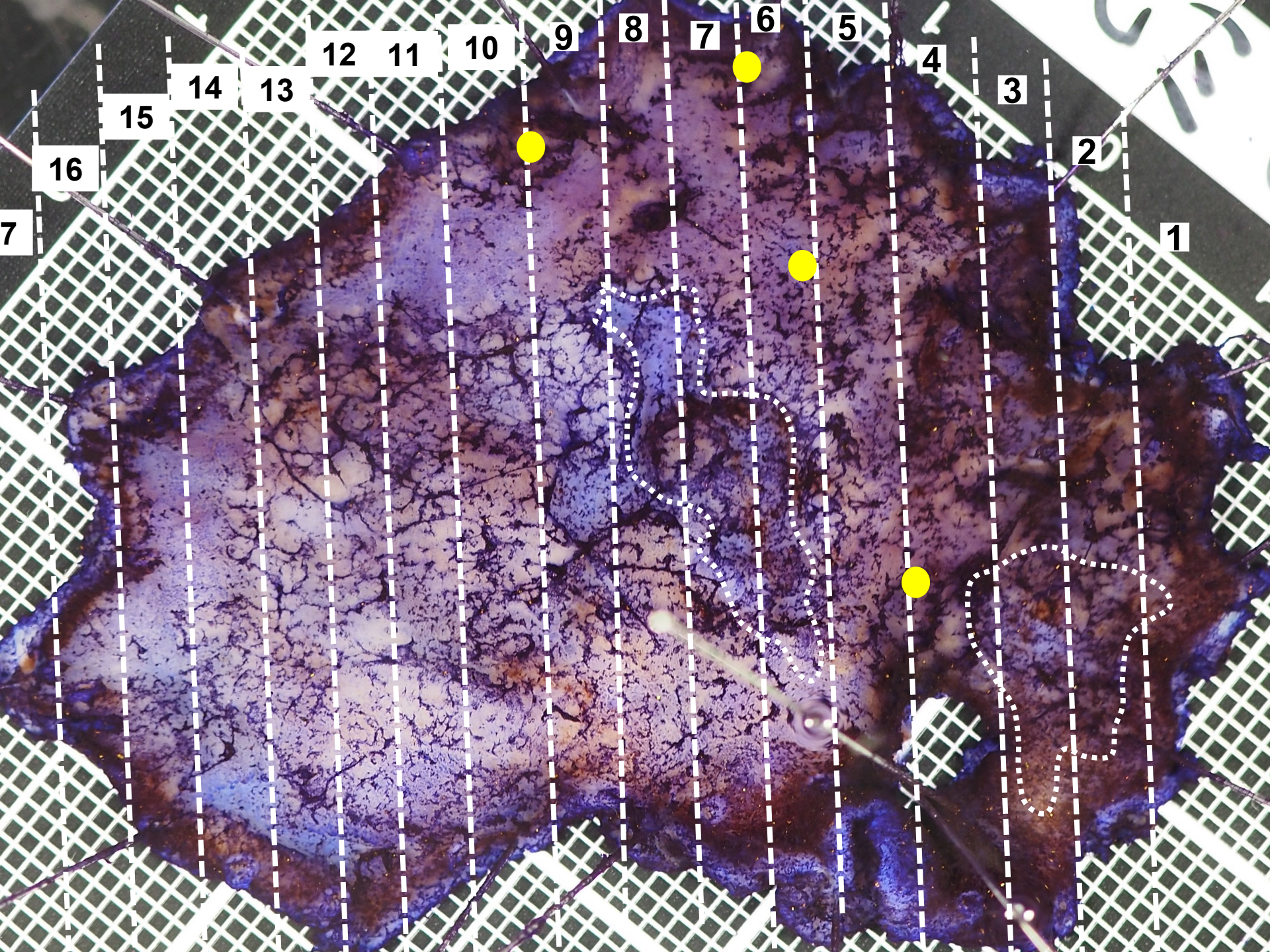
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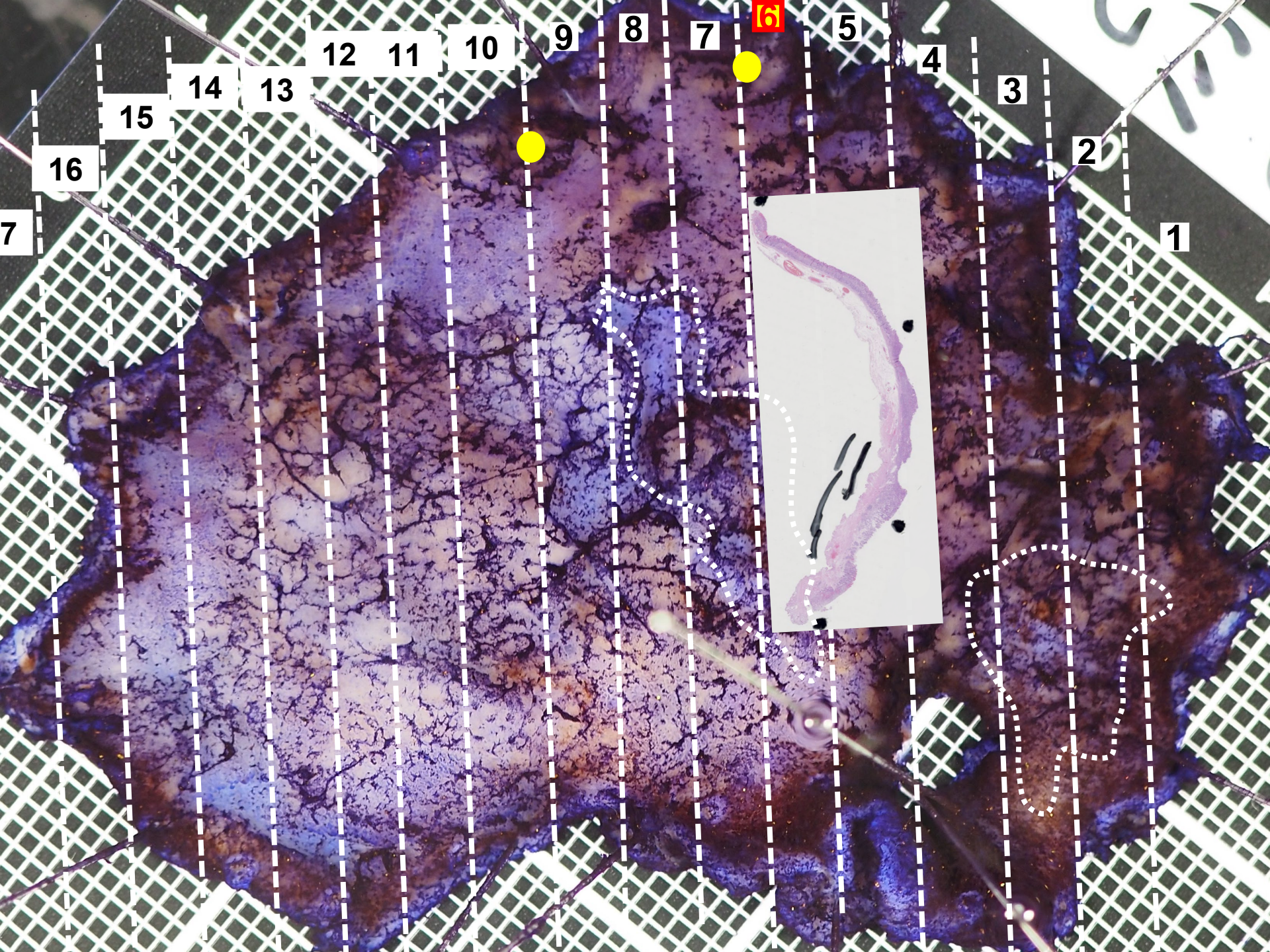
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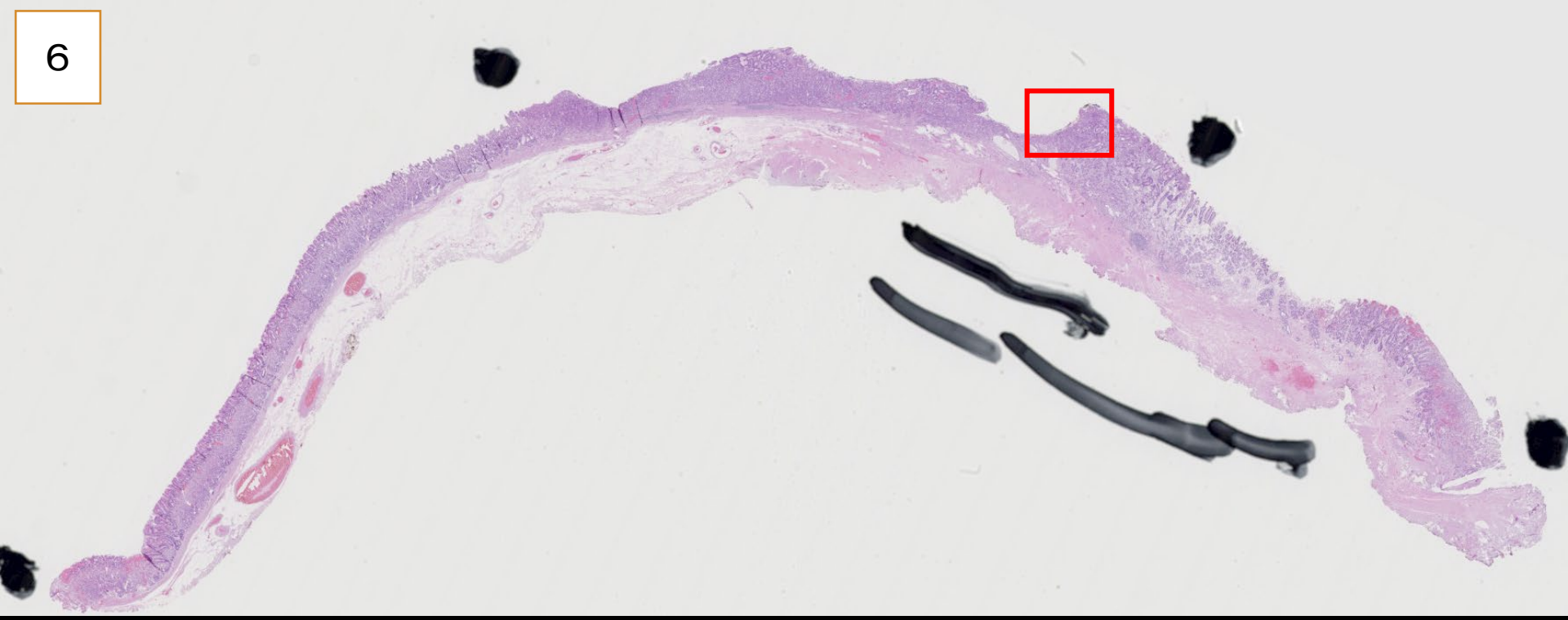
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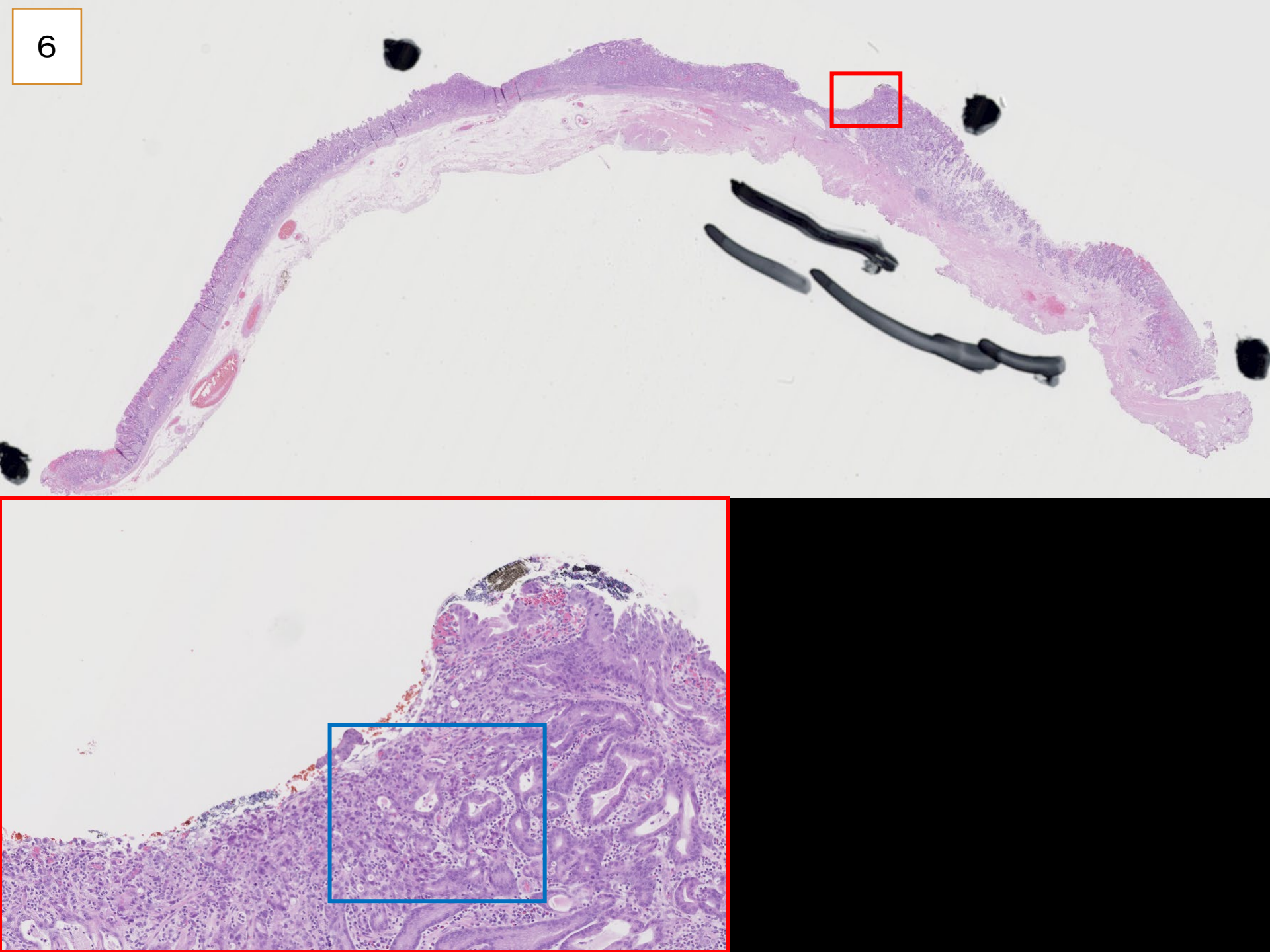

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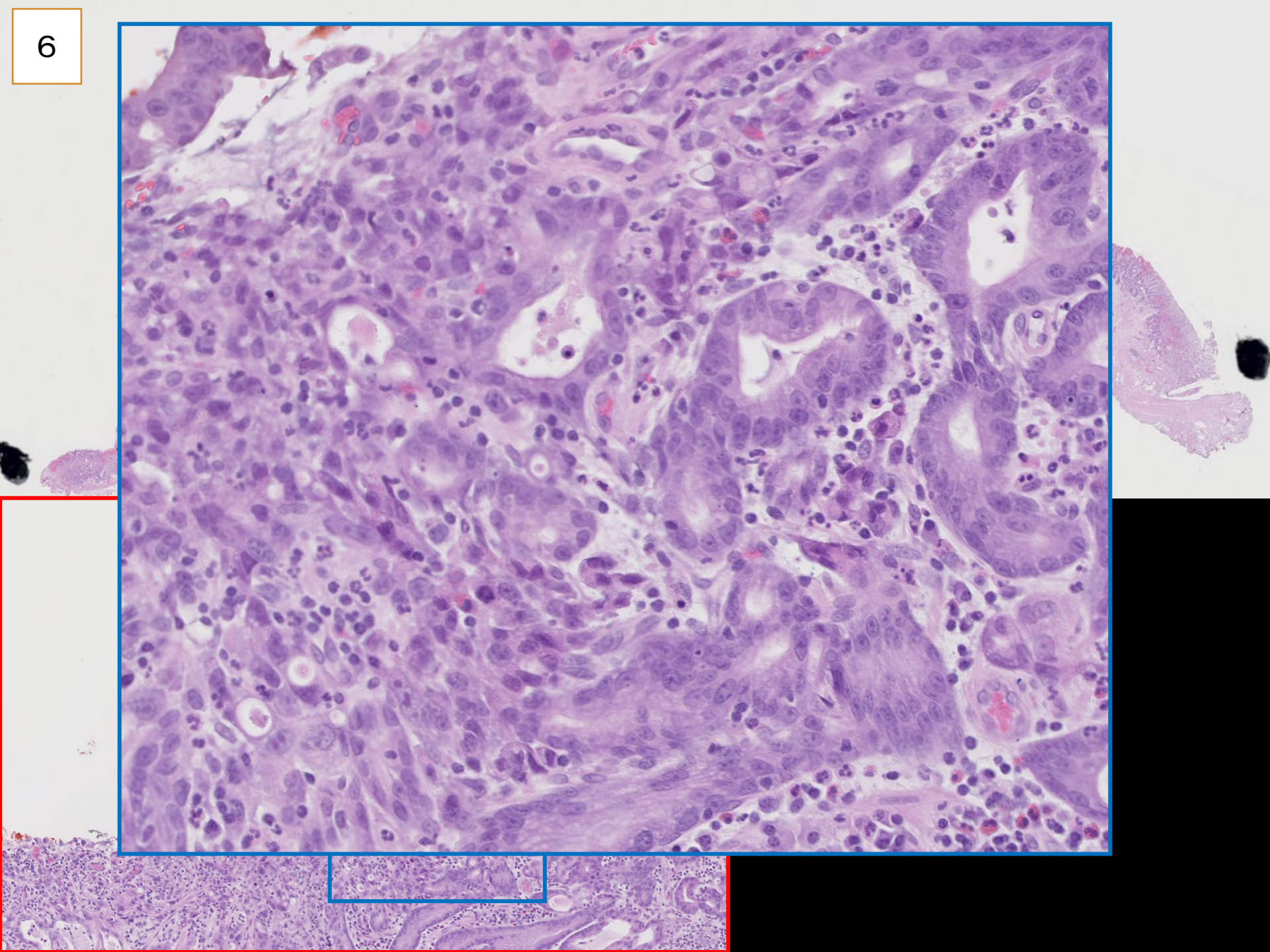

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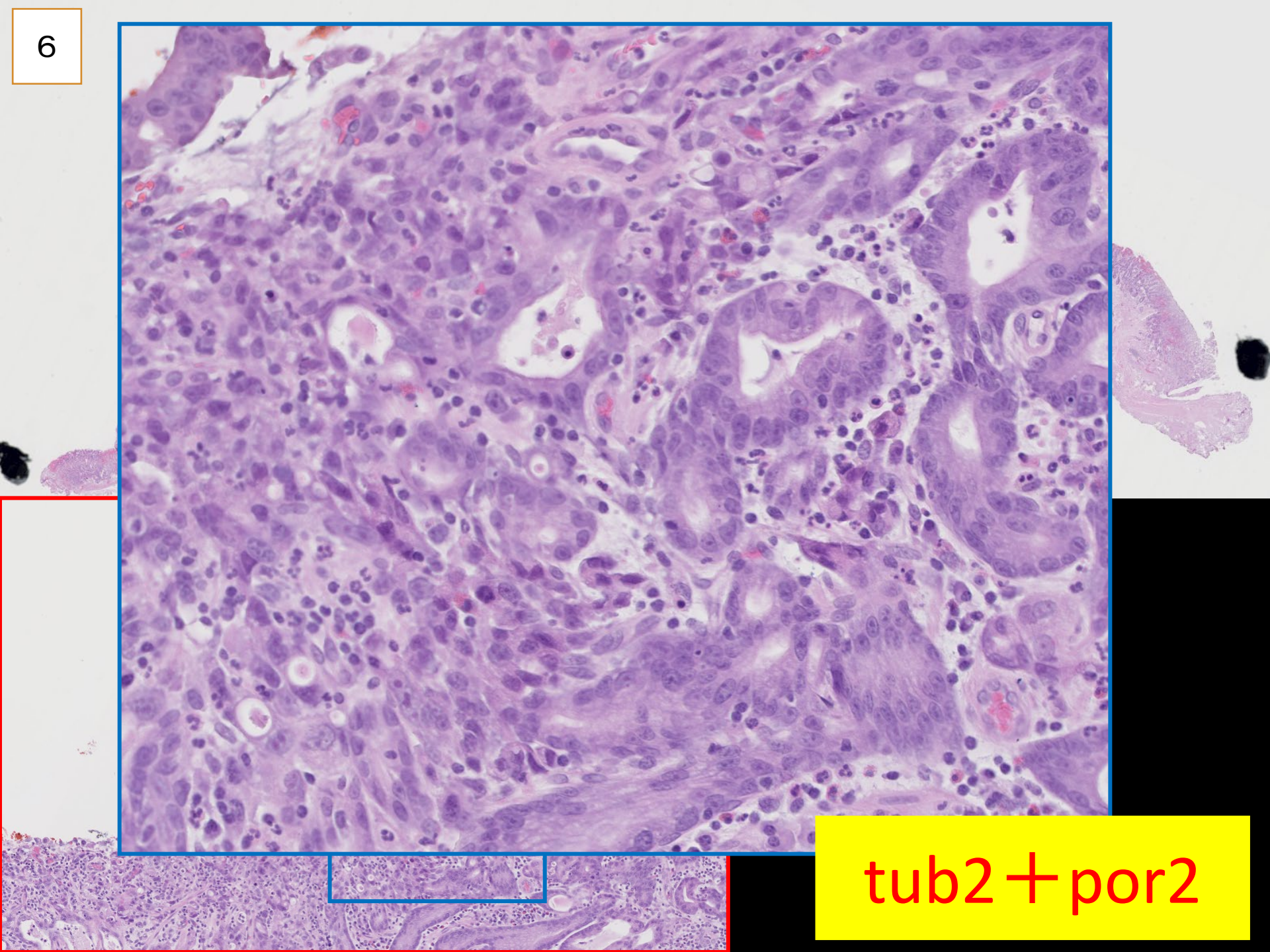

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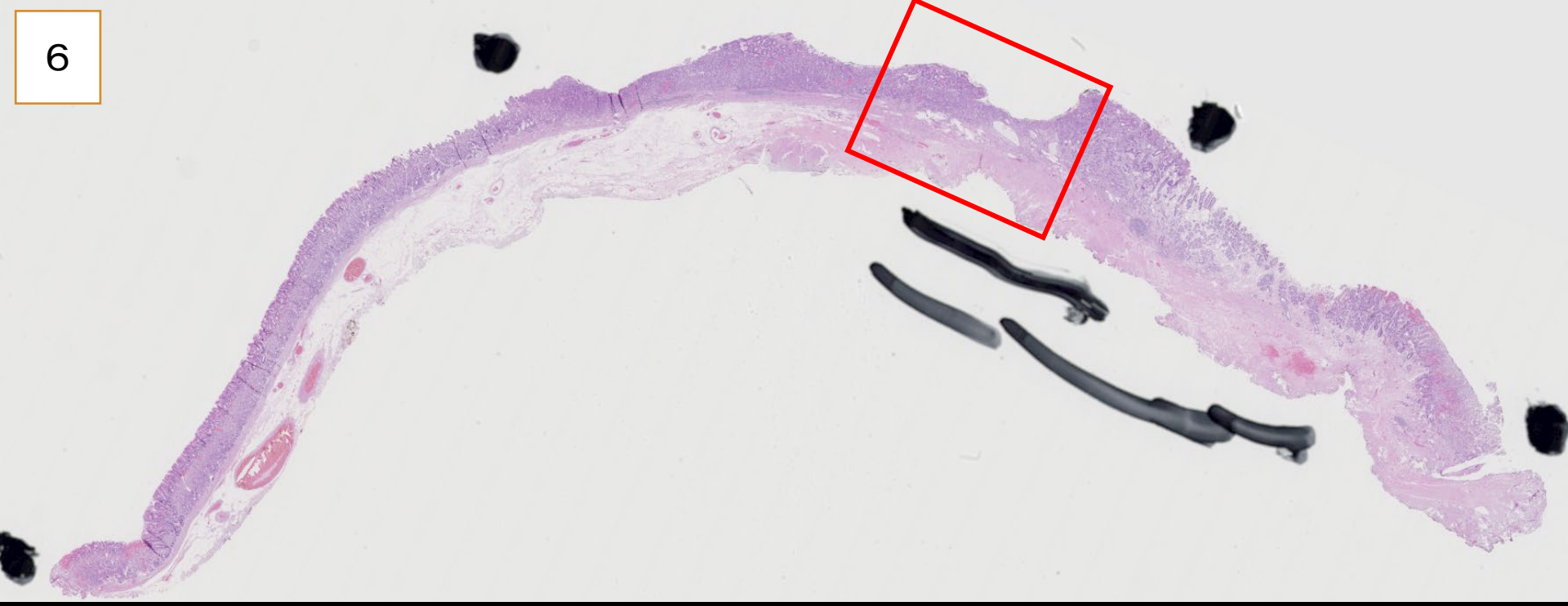
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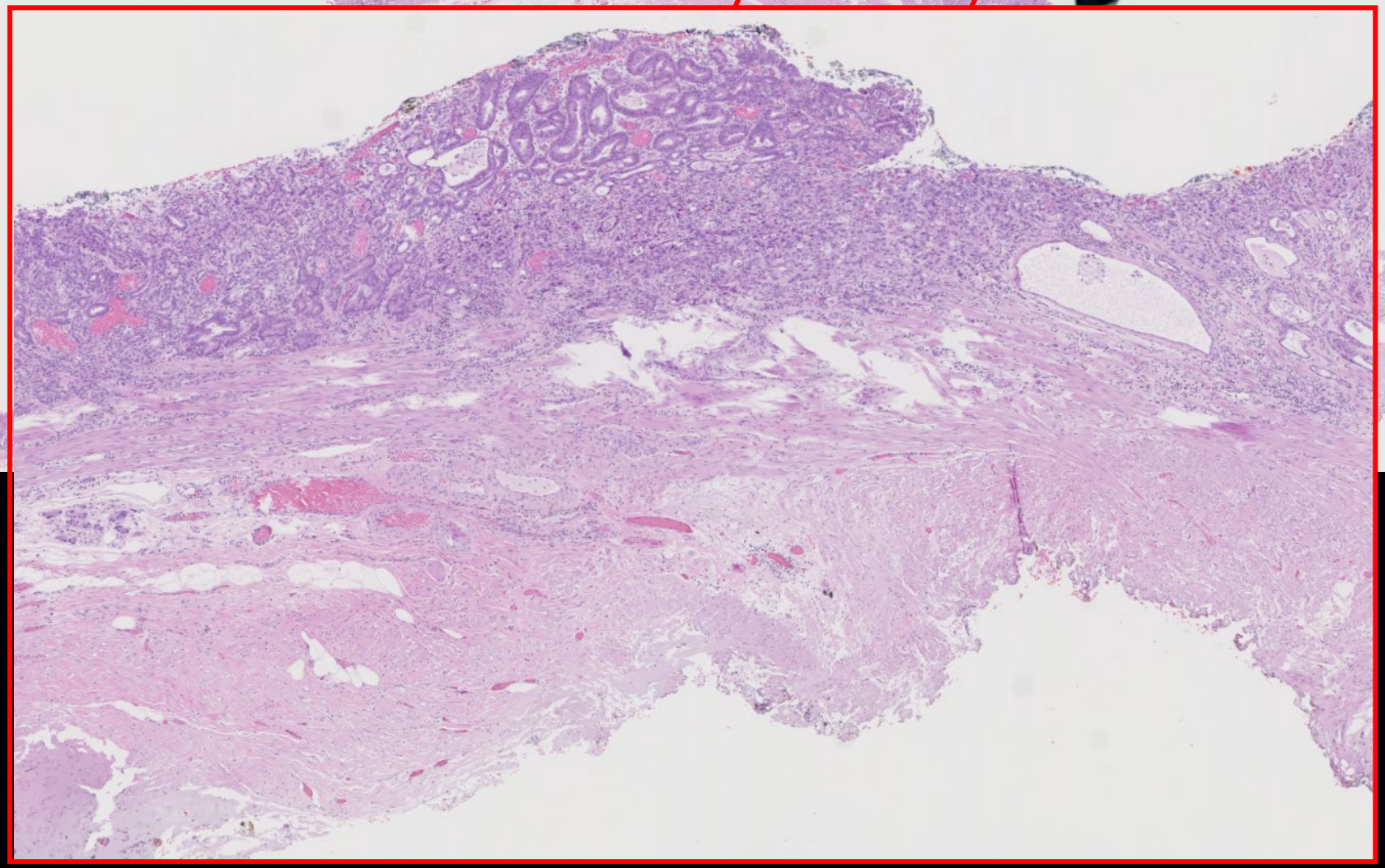

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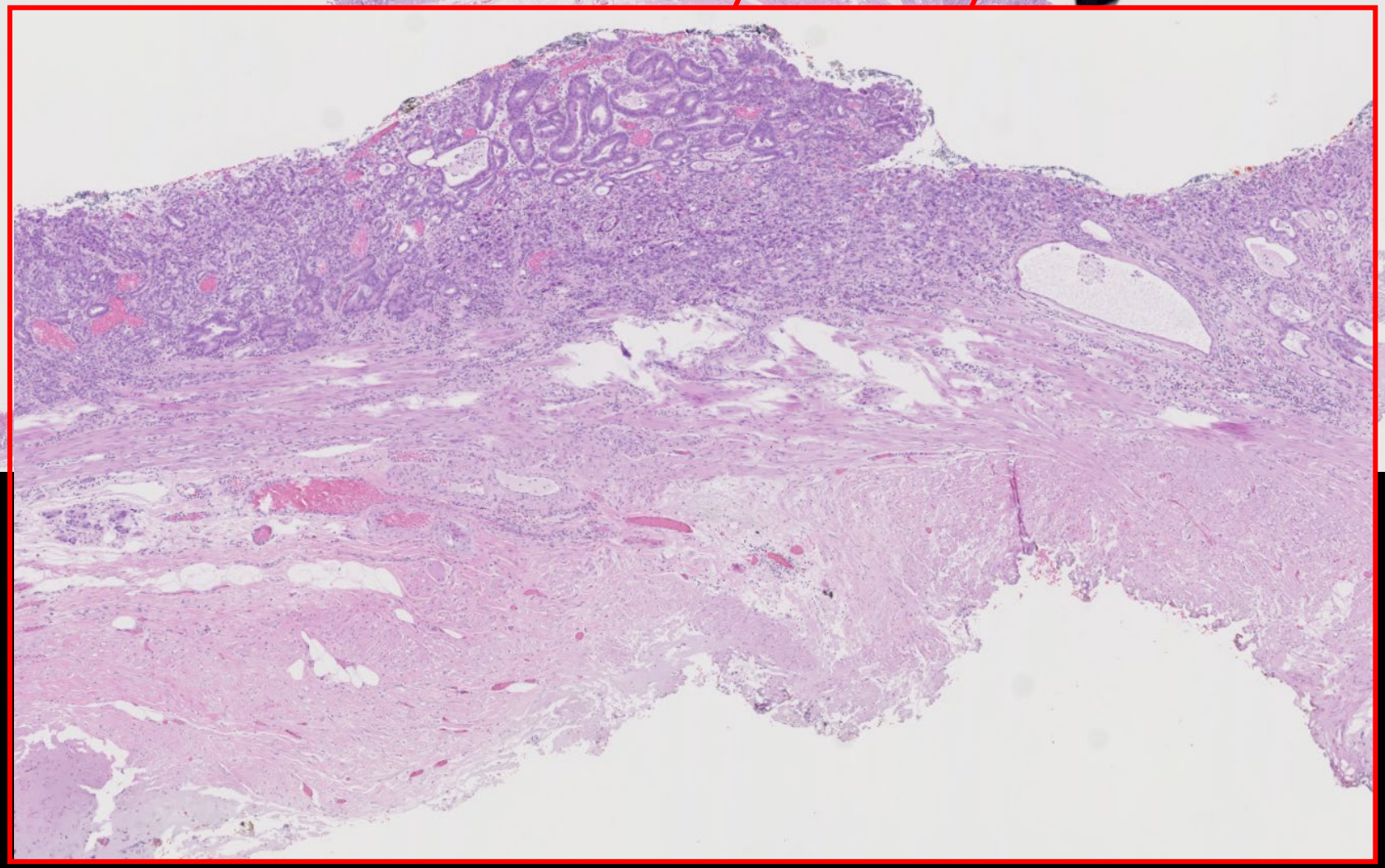

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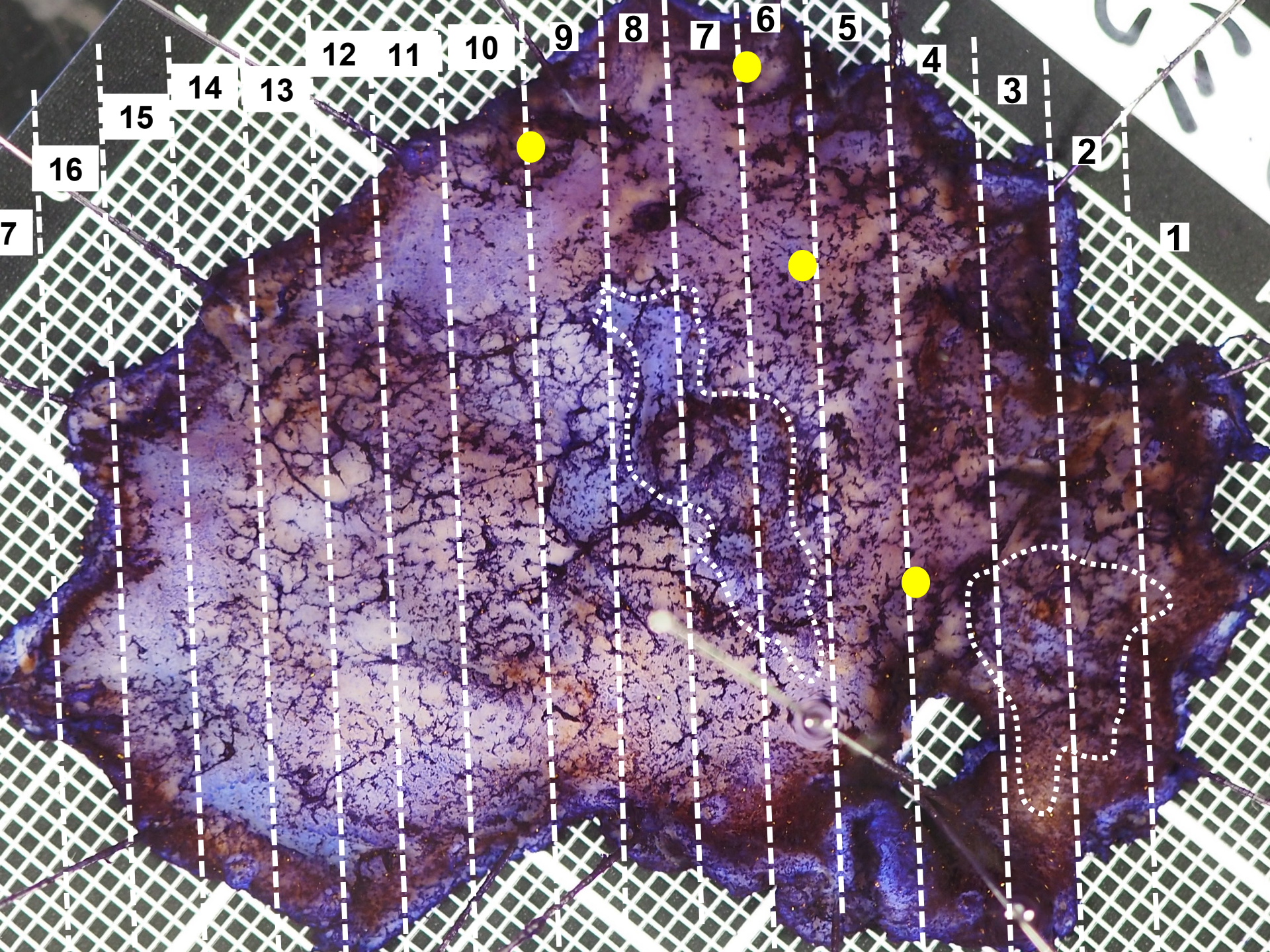
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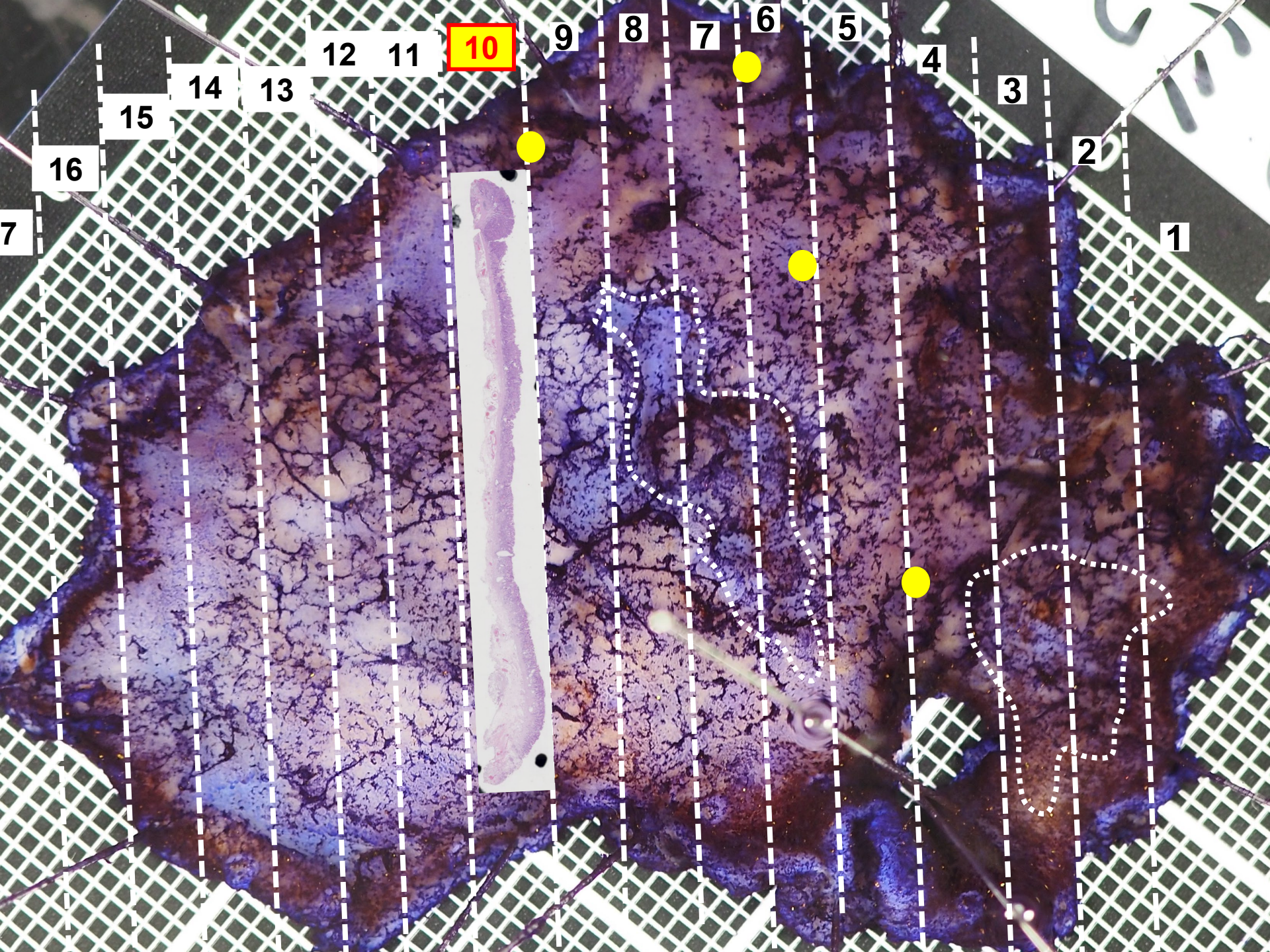
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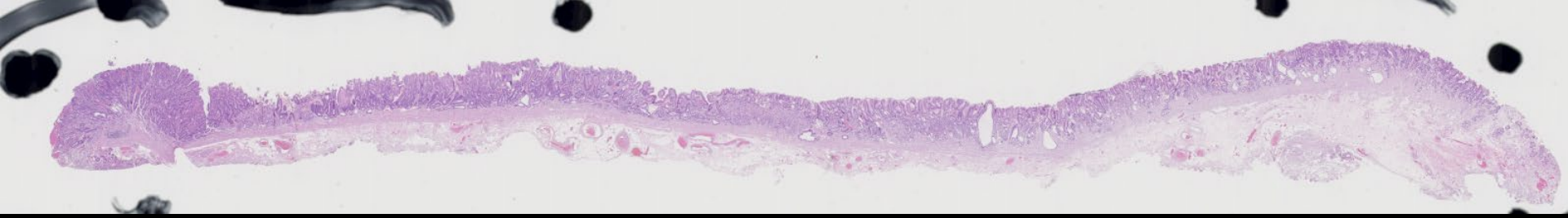

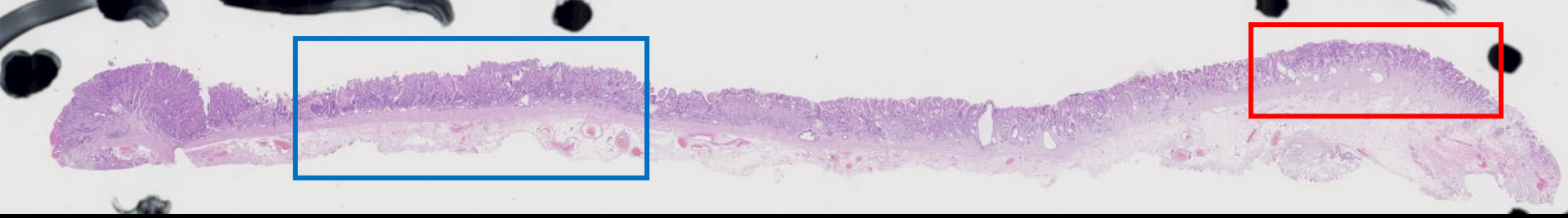

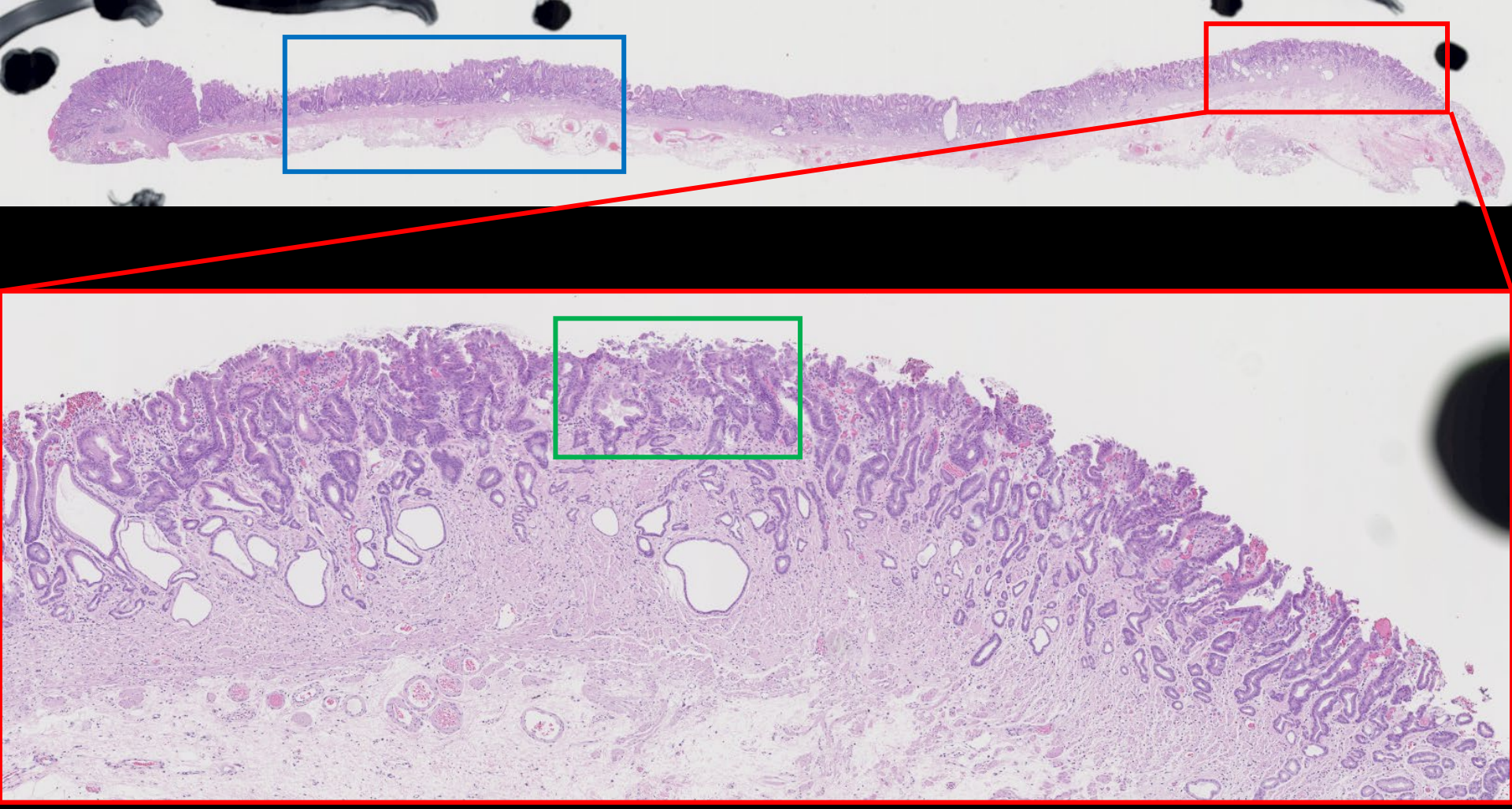

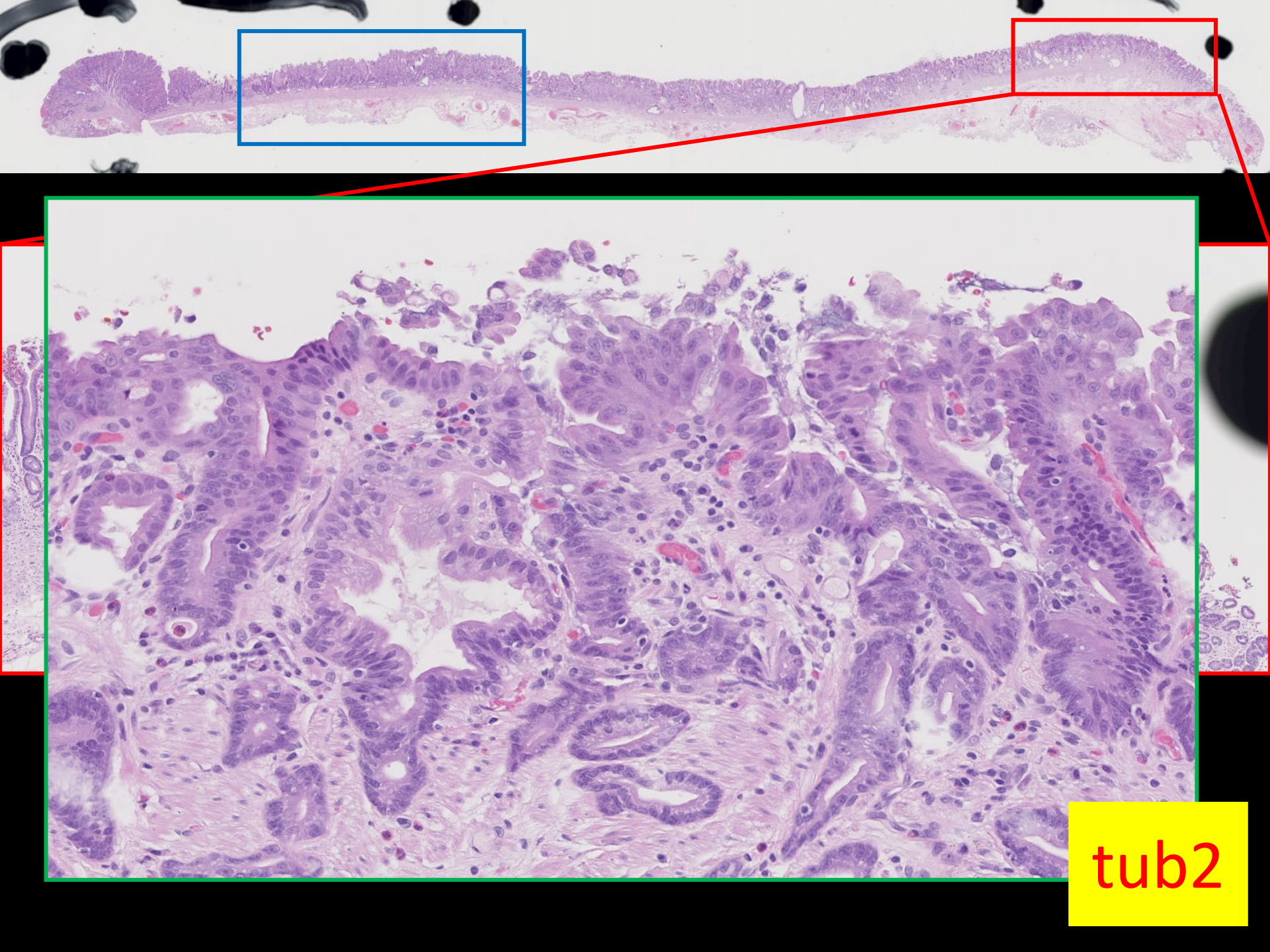
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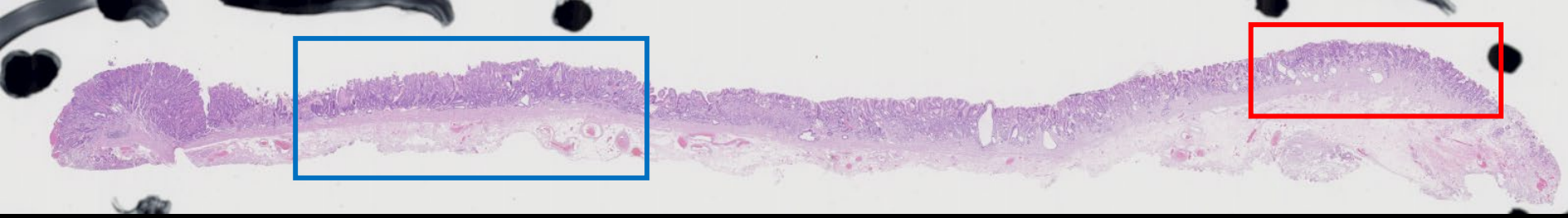
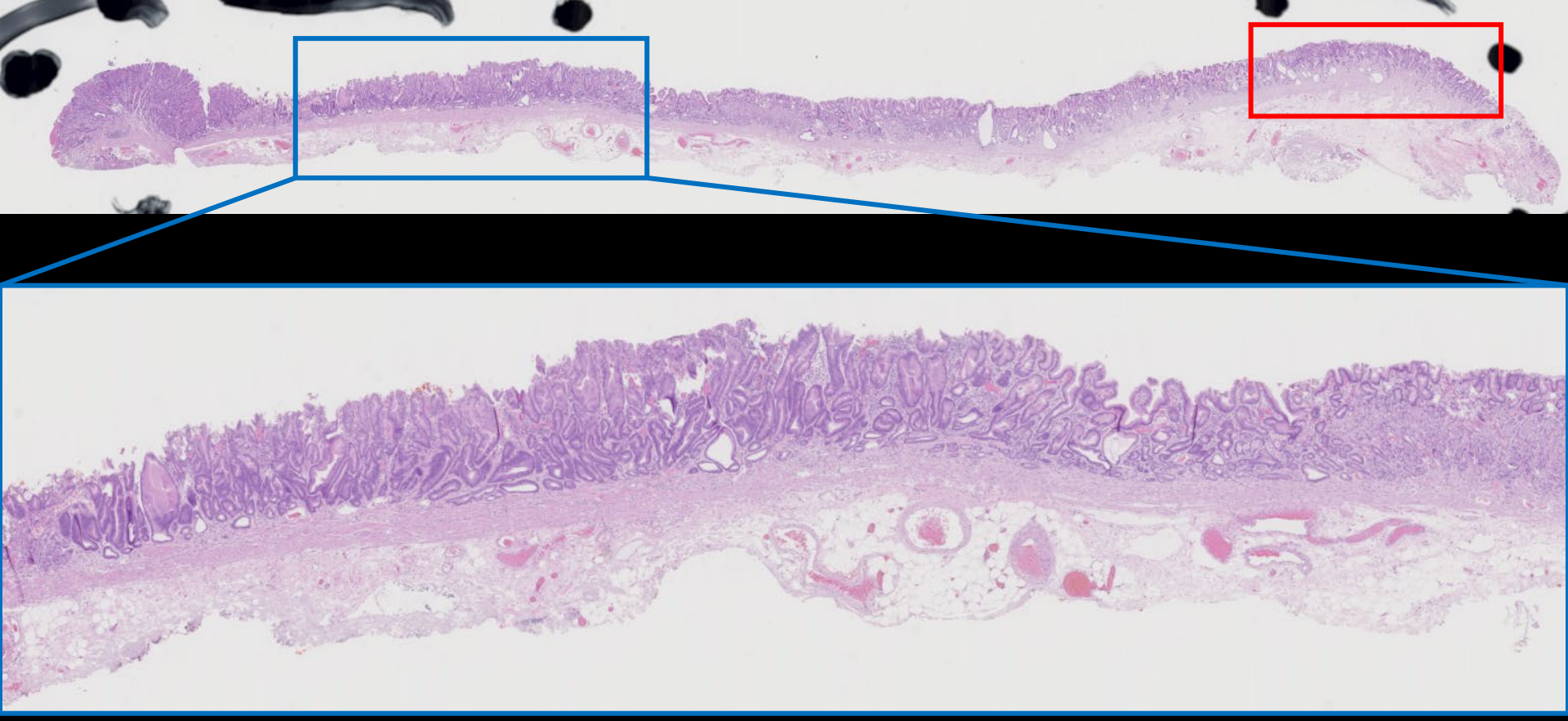
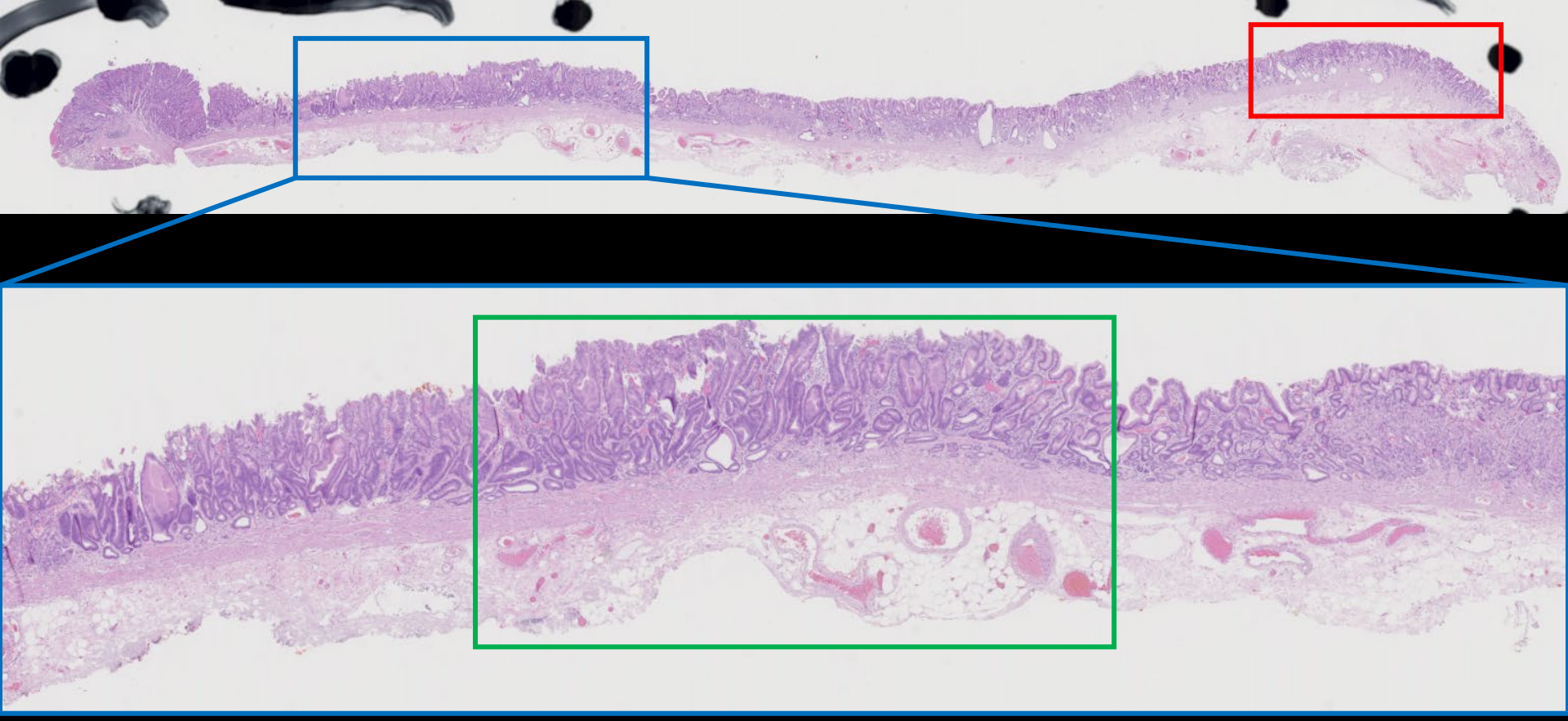
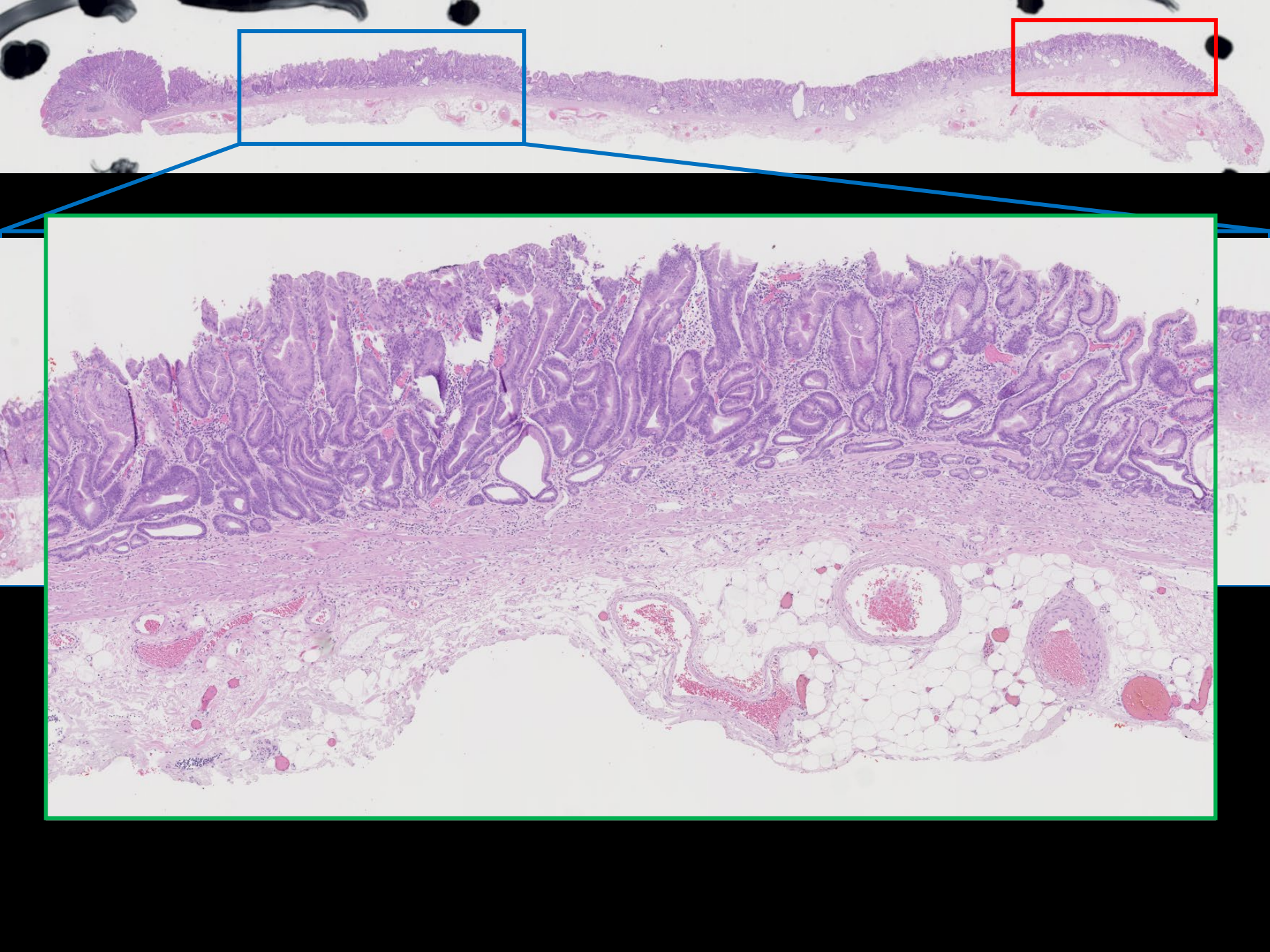
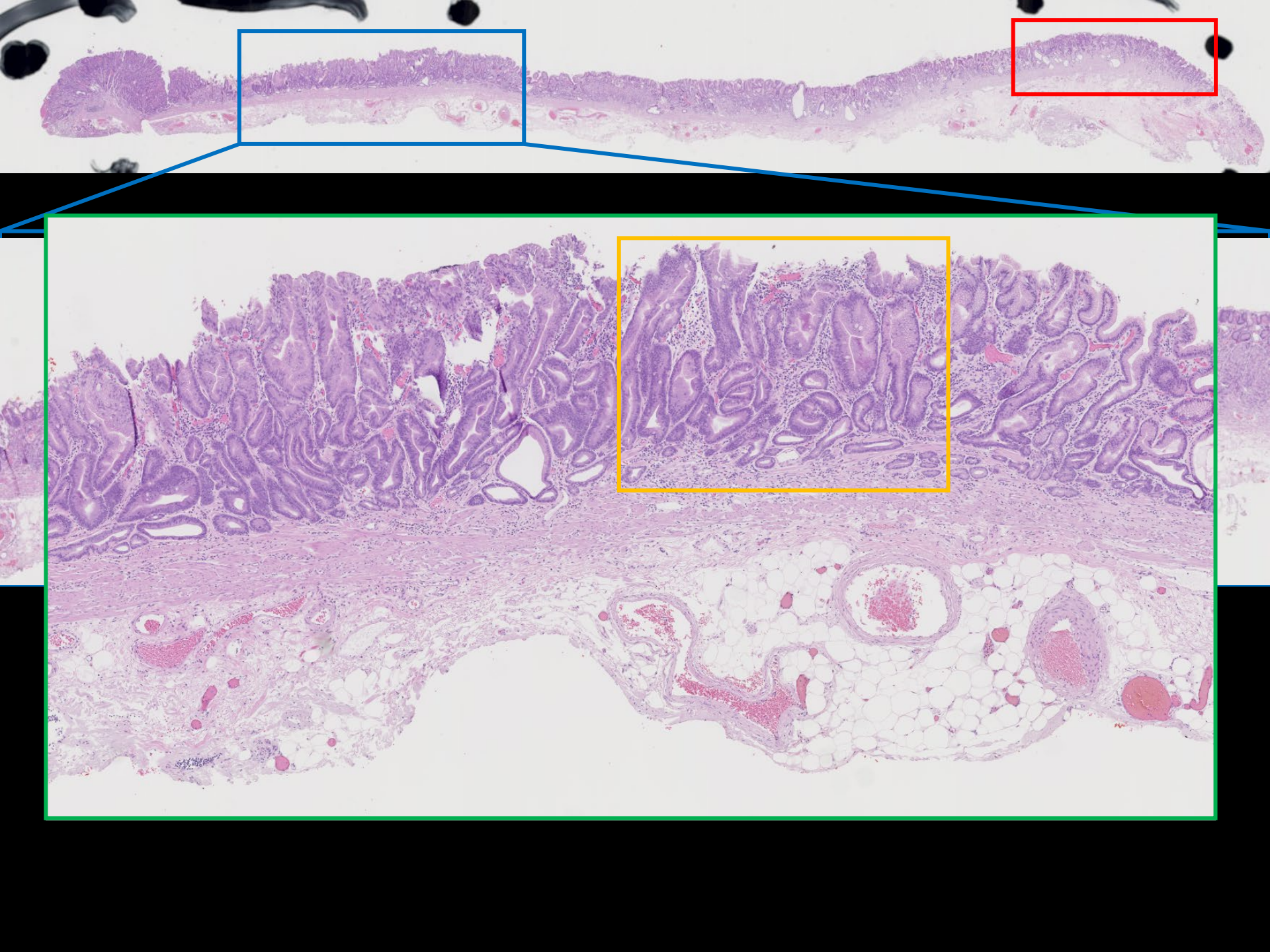
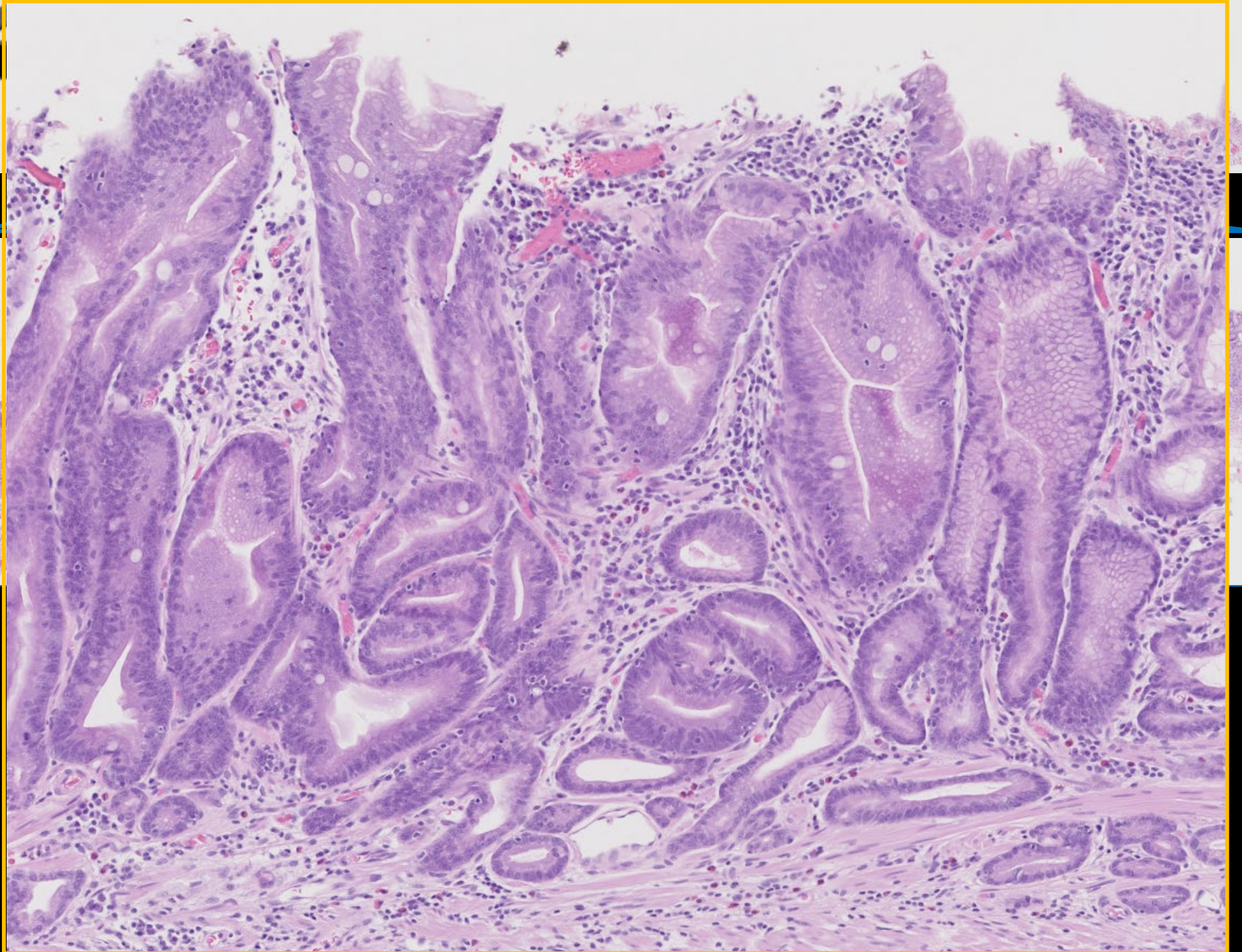


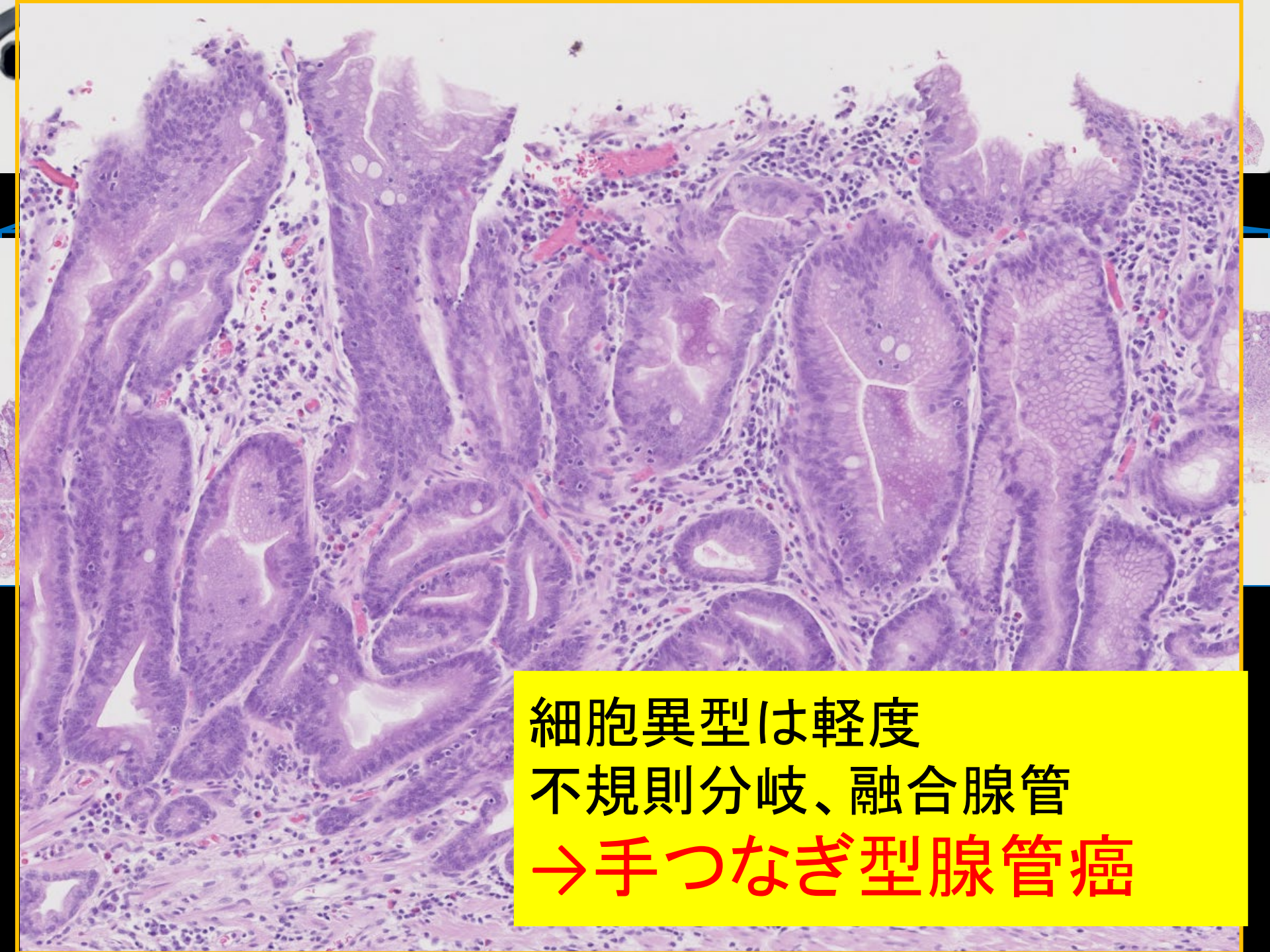


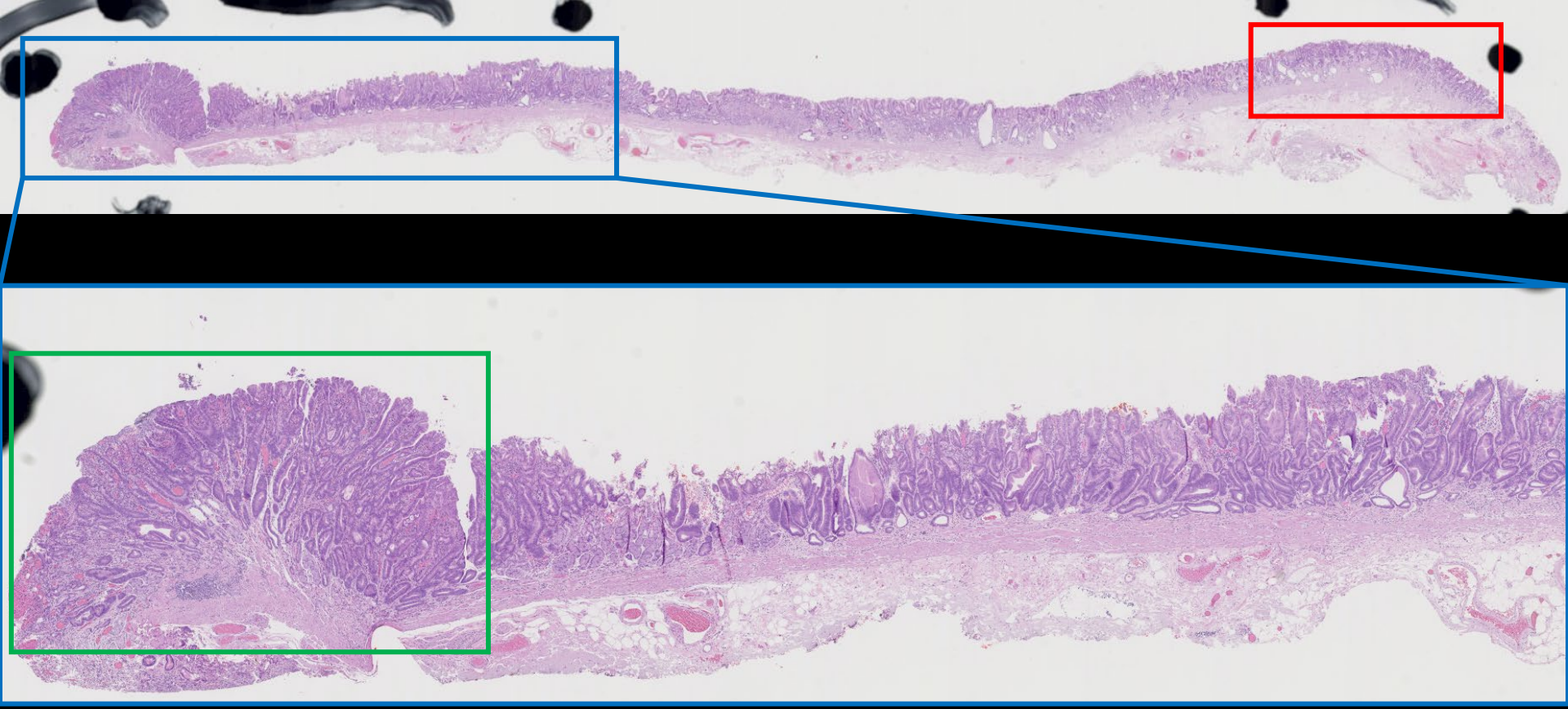


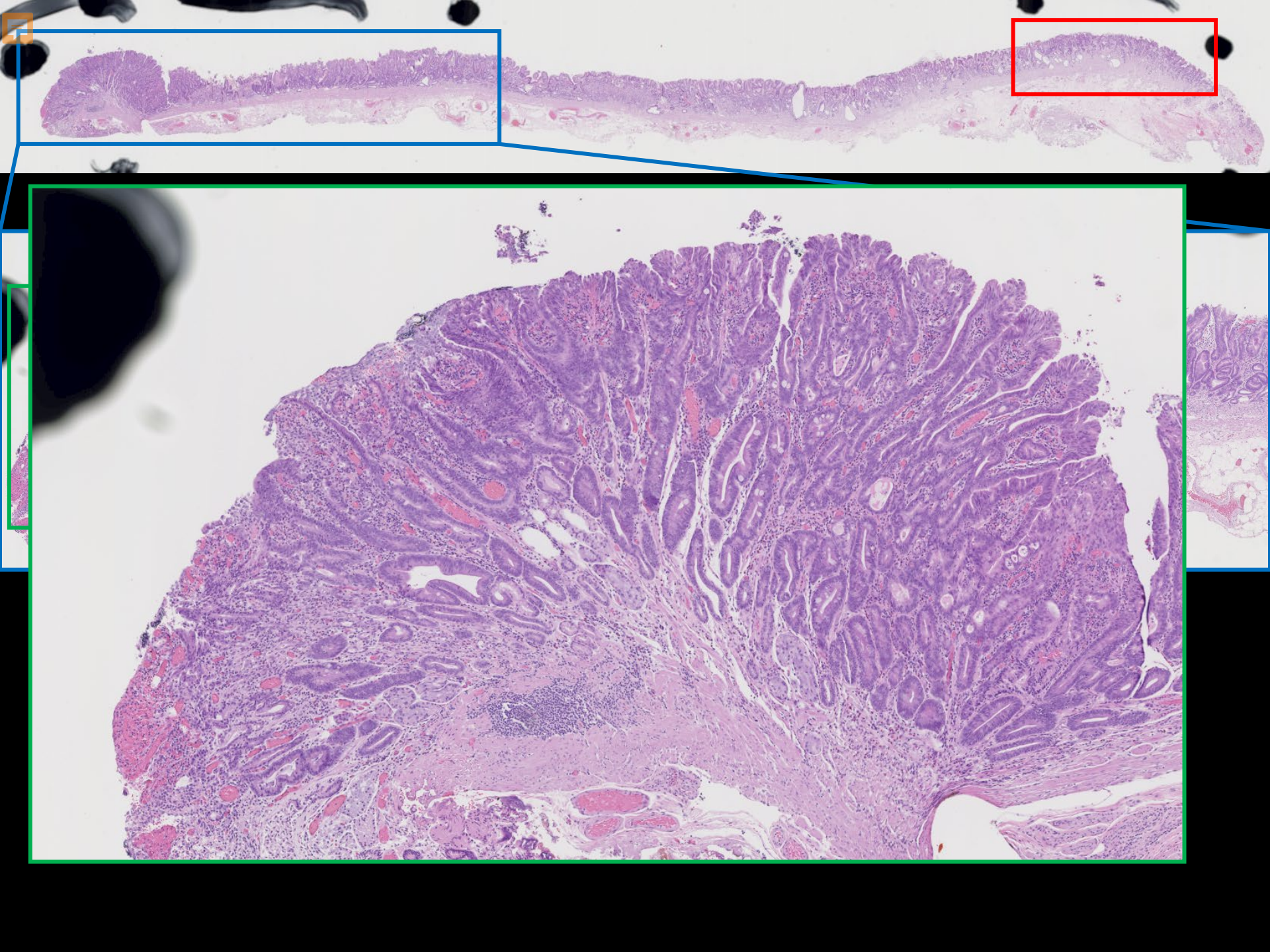


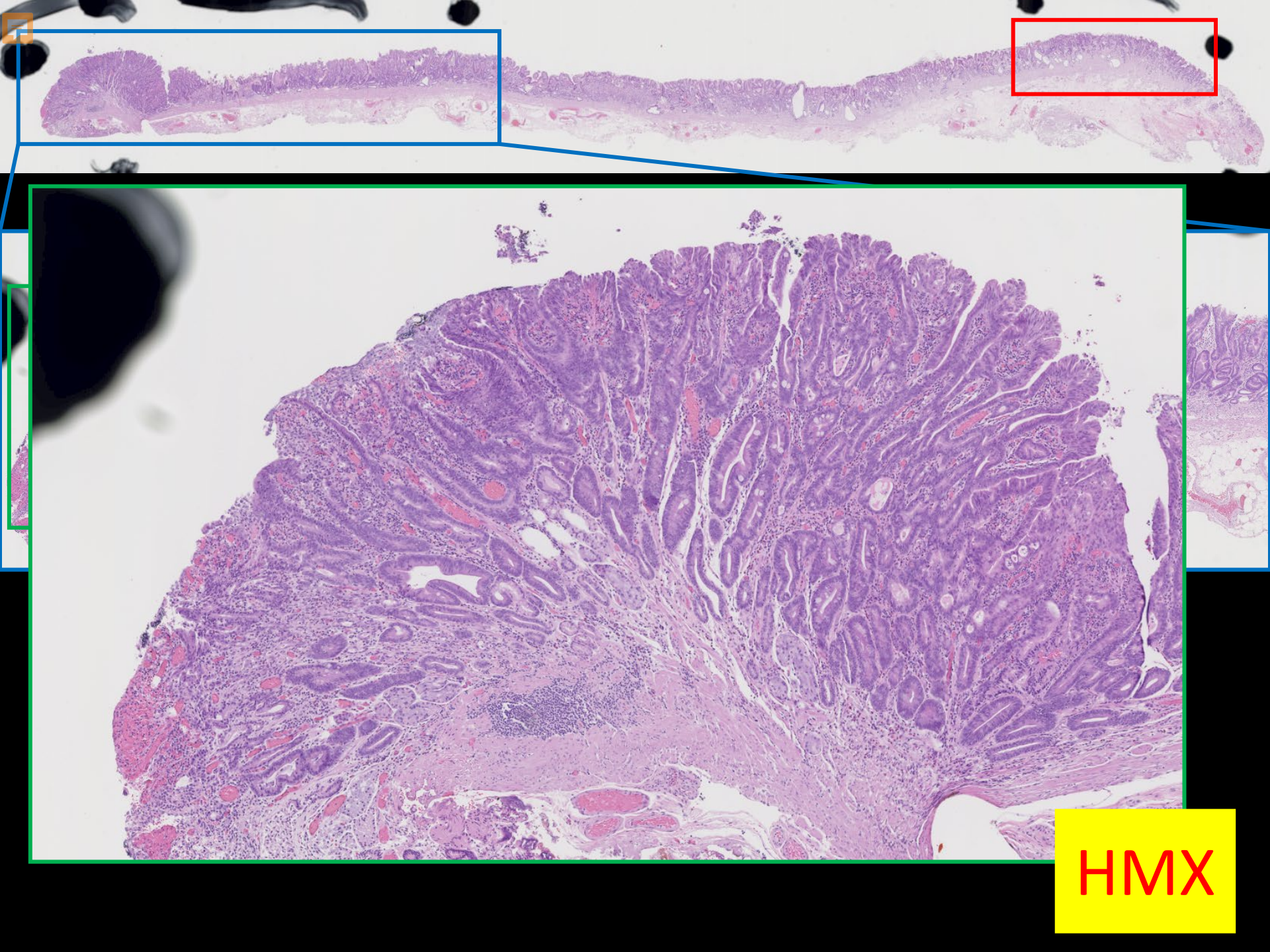





細胞異型は軽度
不規則分岐、融合腺管
→手つなぎ型腺管癌



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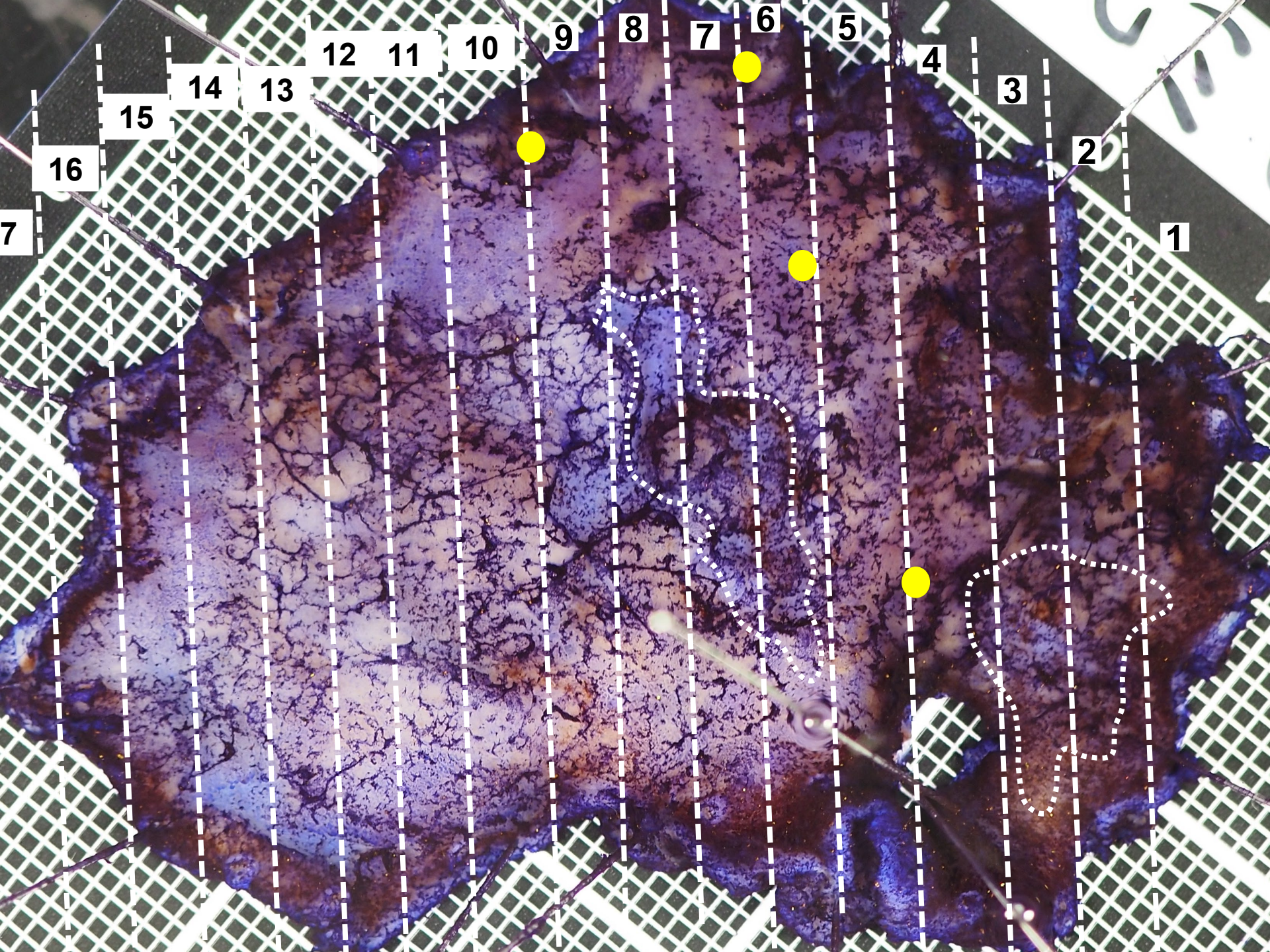
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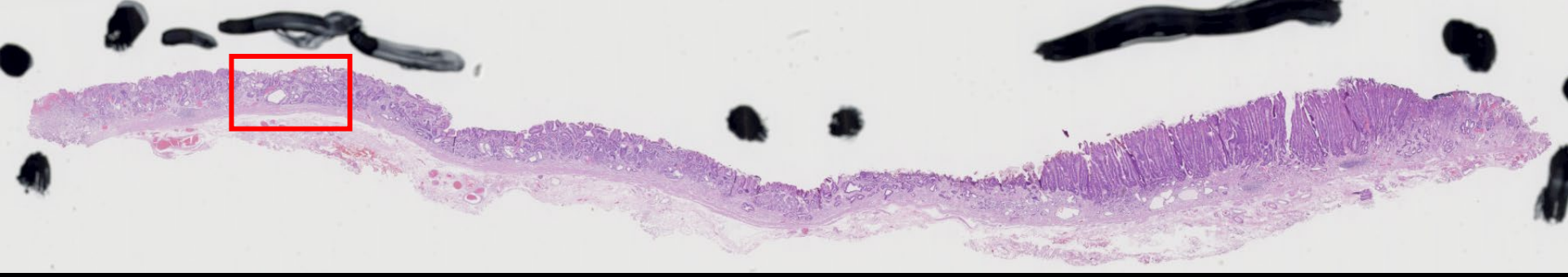
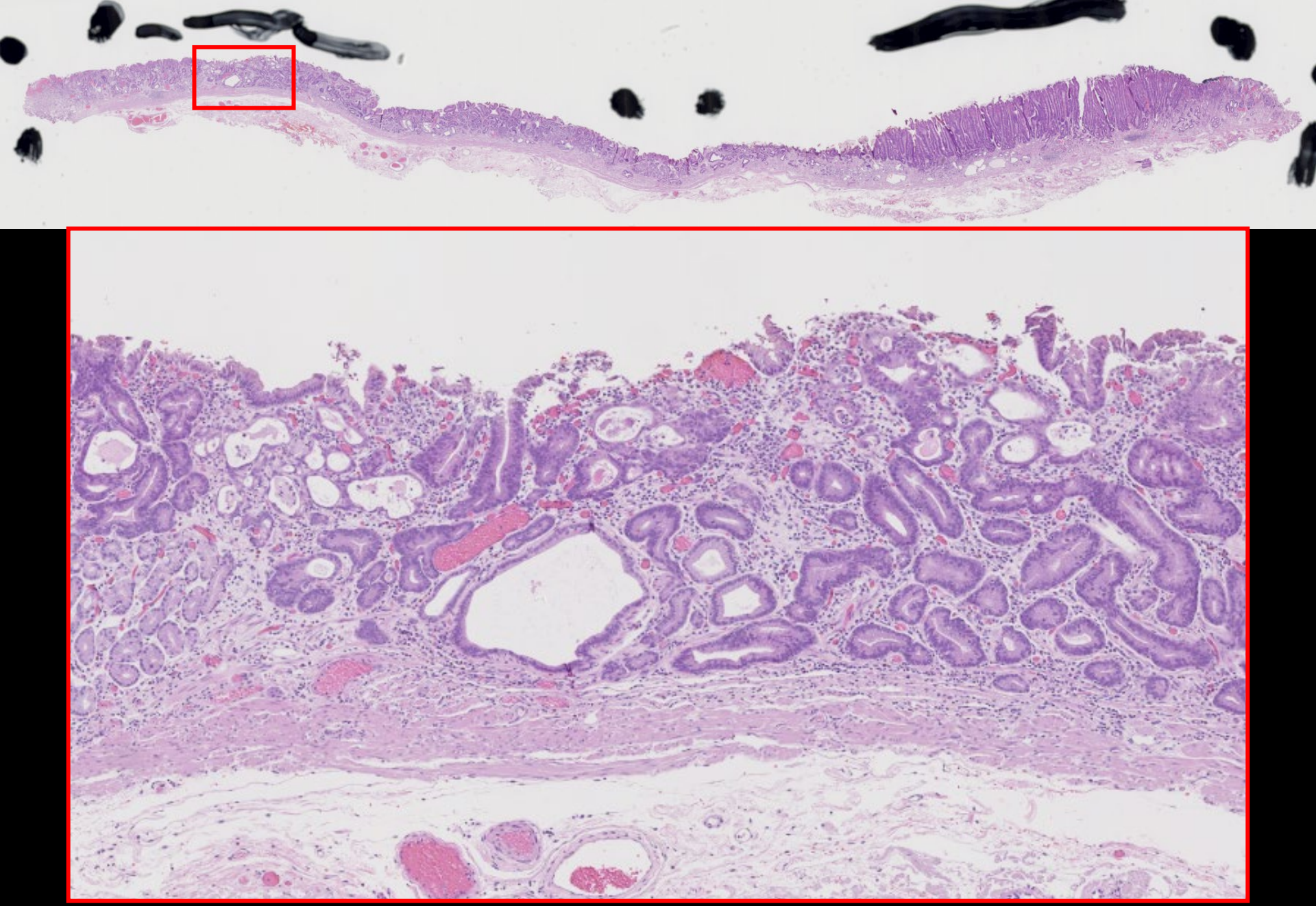
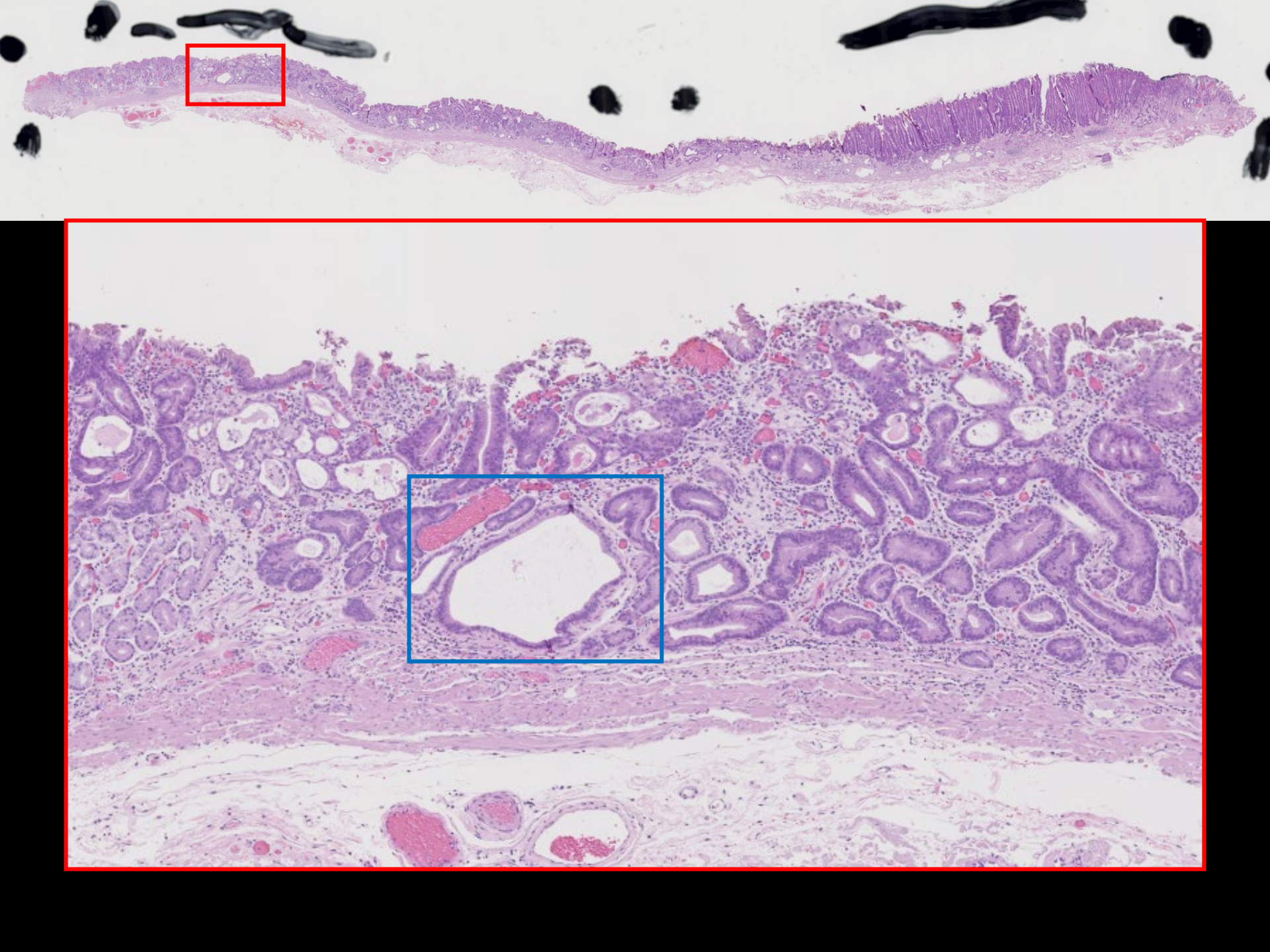
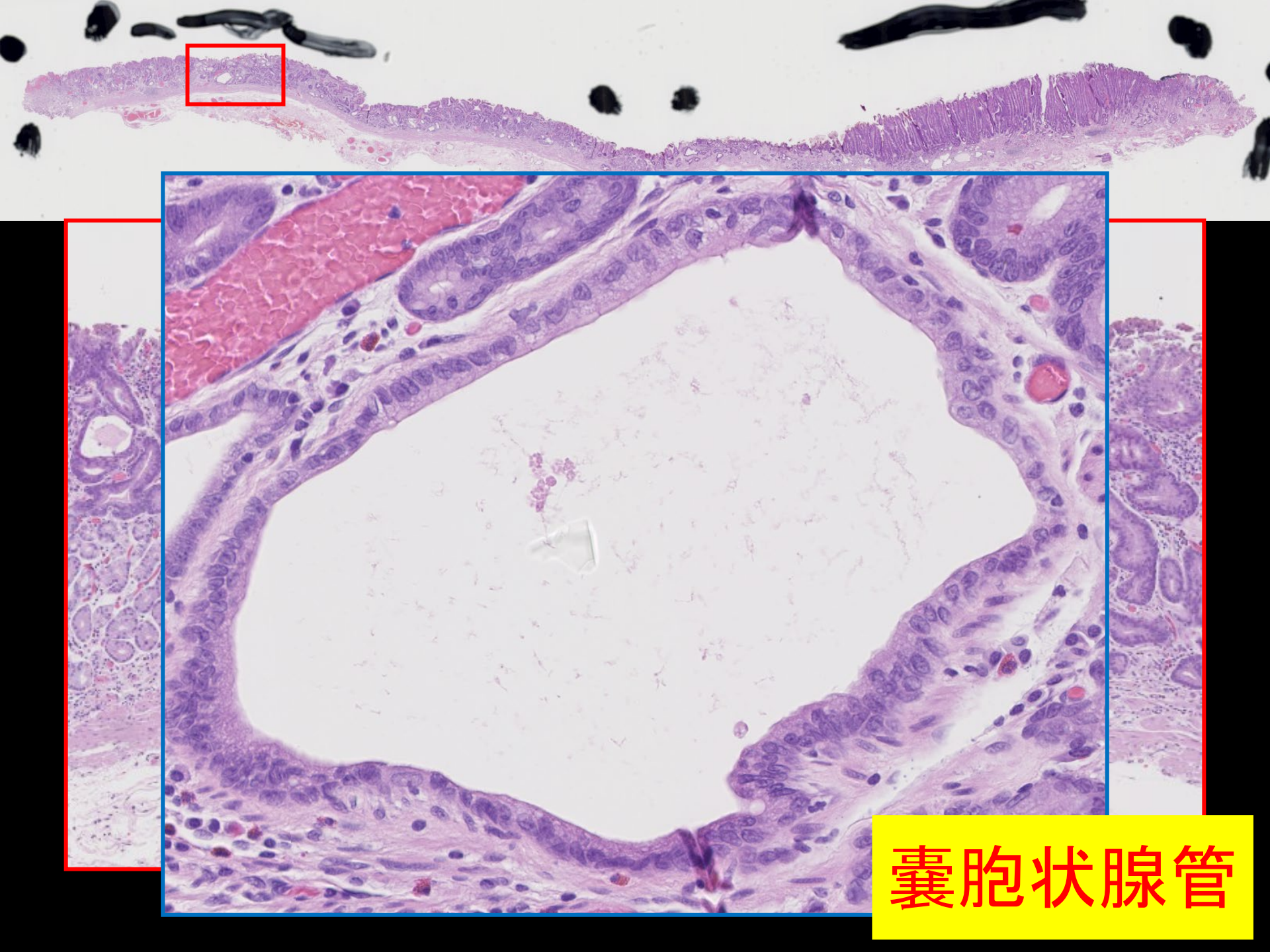
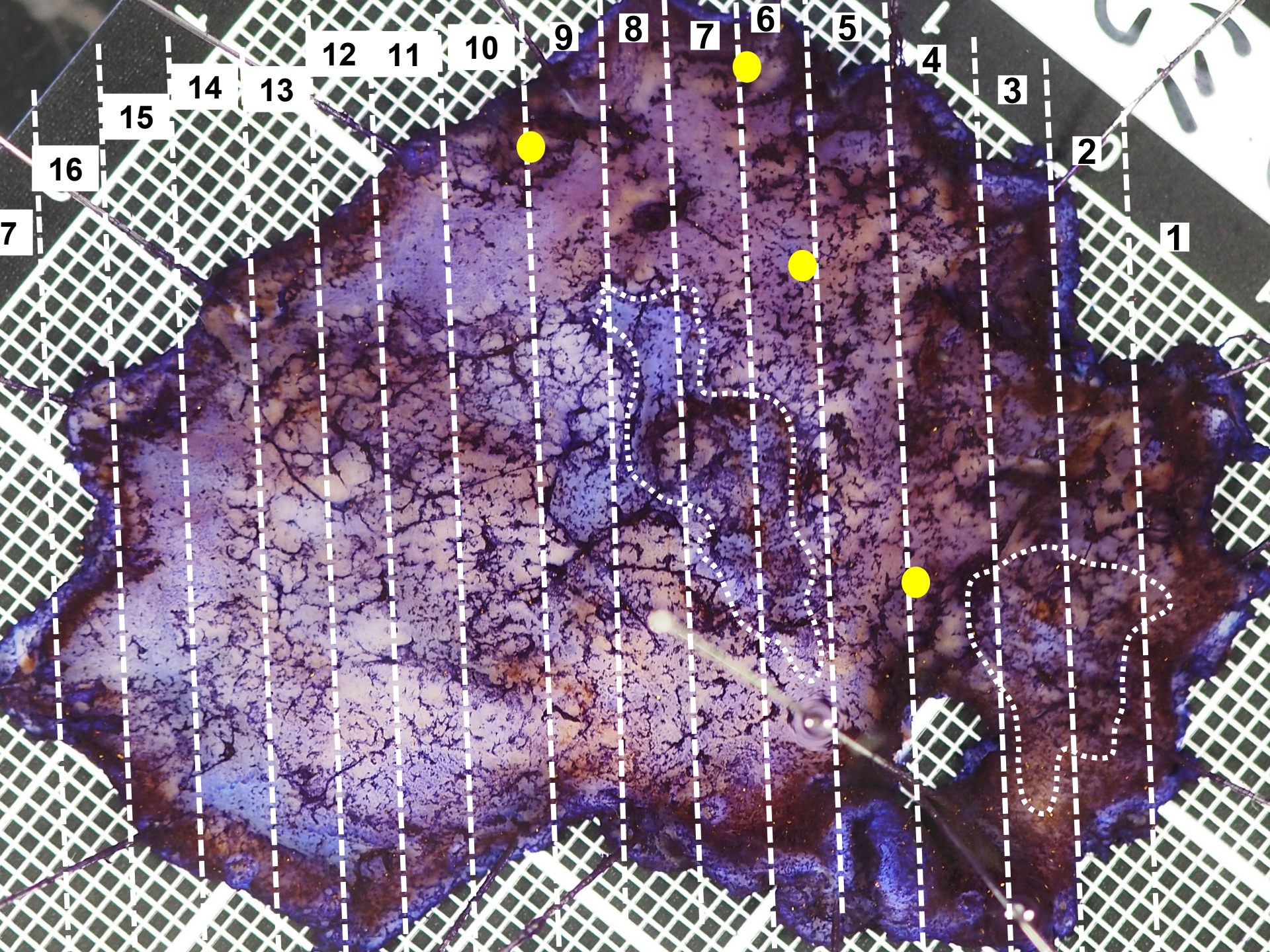







囊胞状腺管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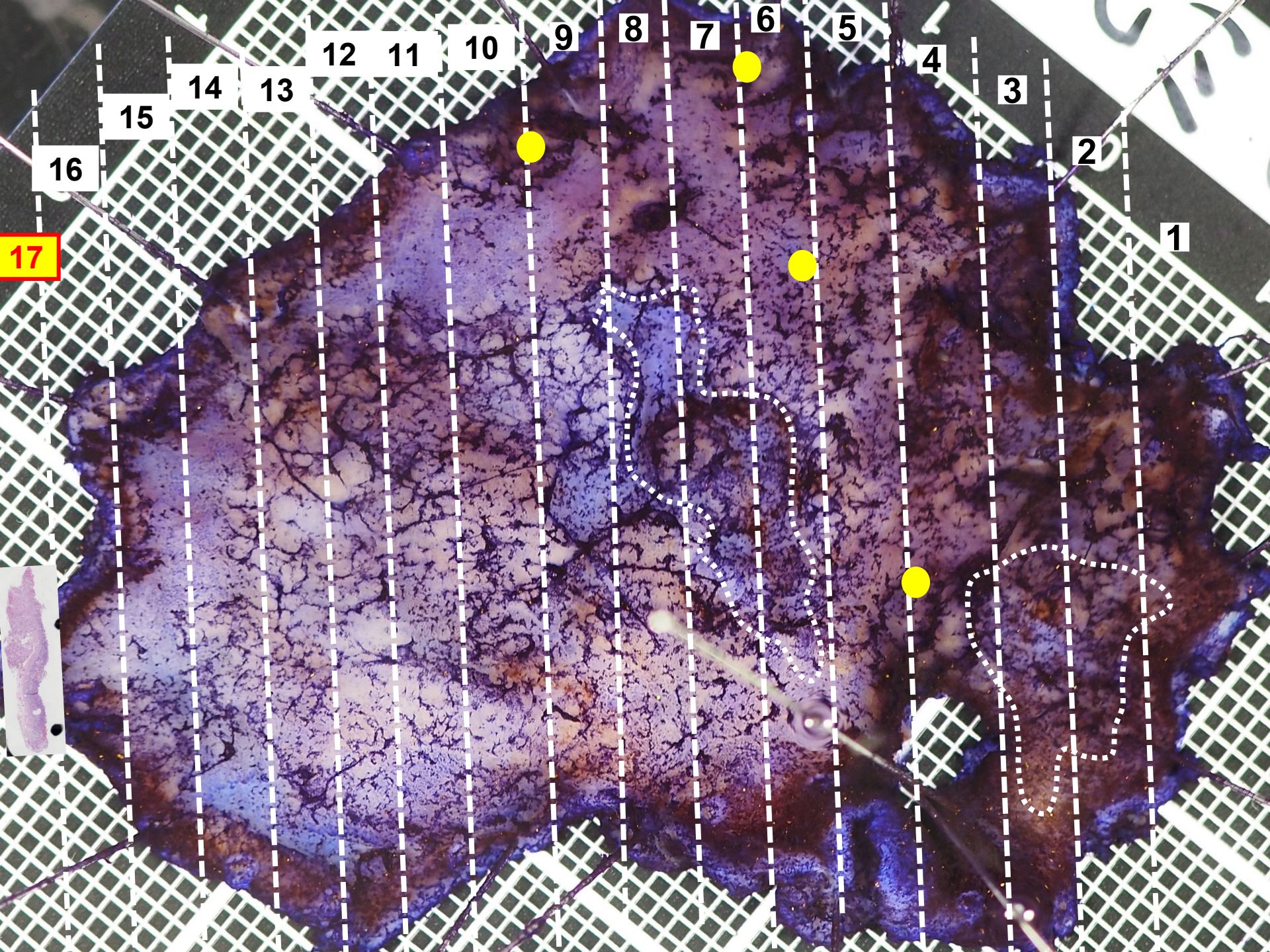
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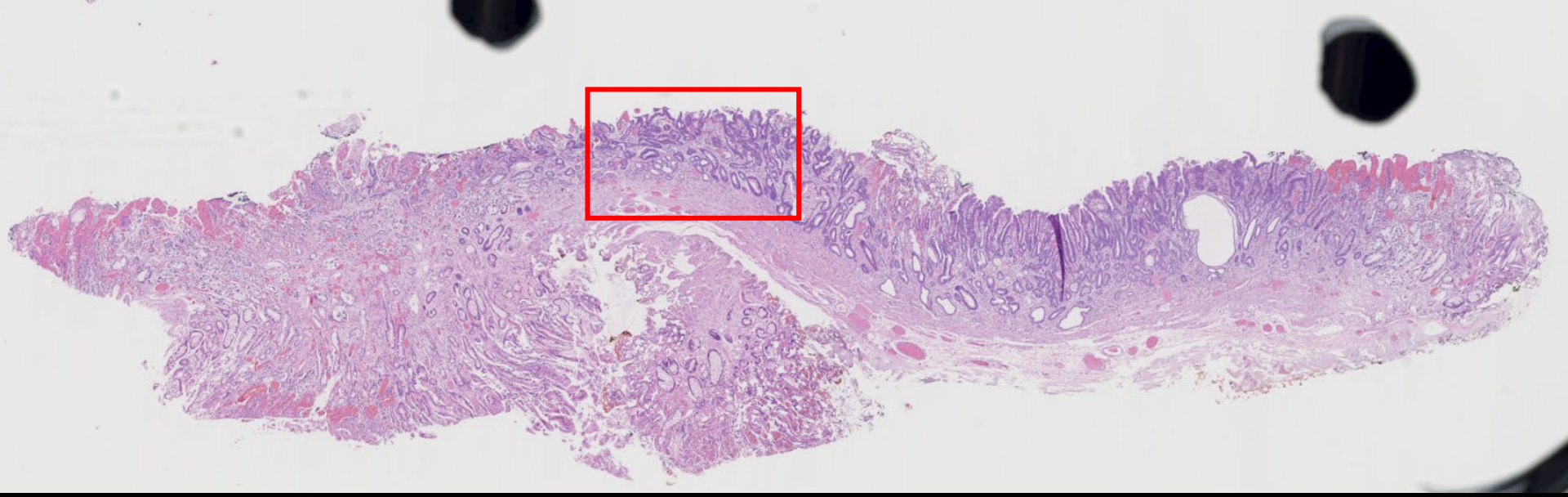
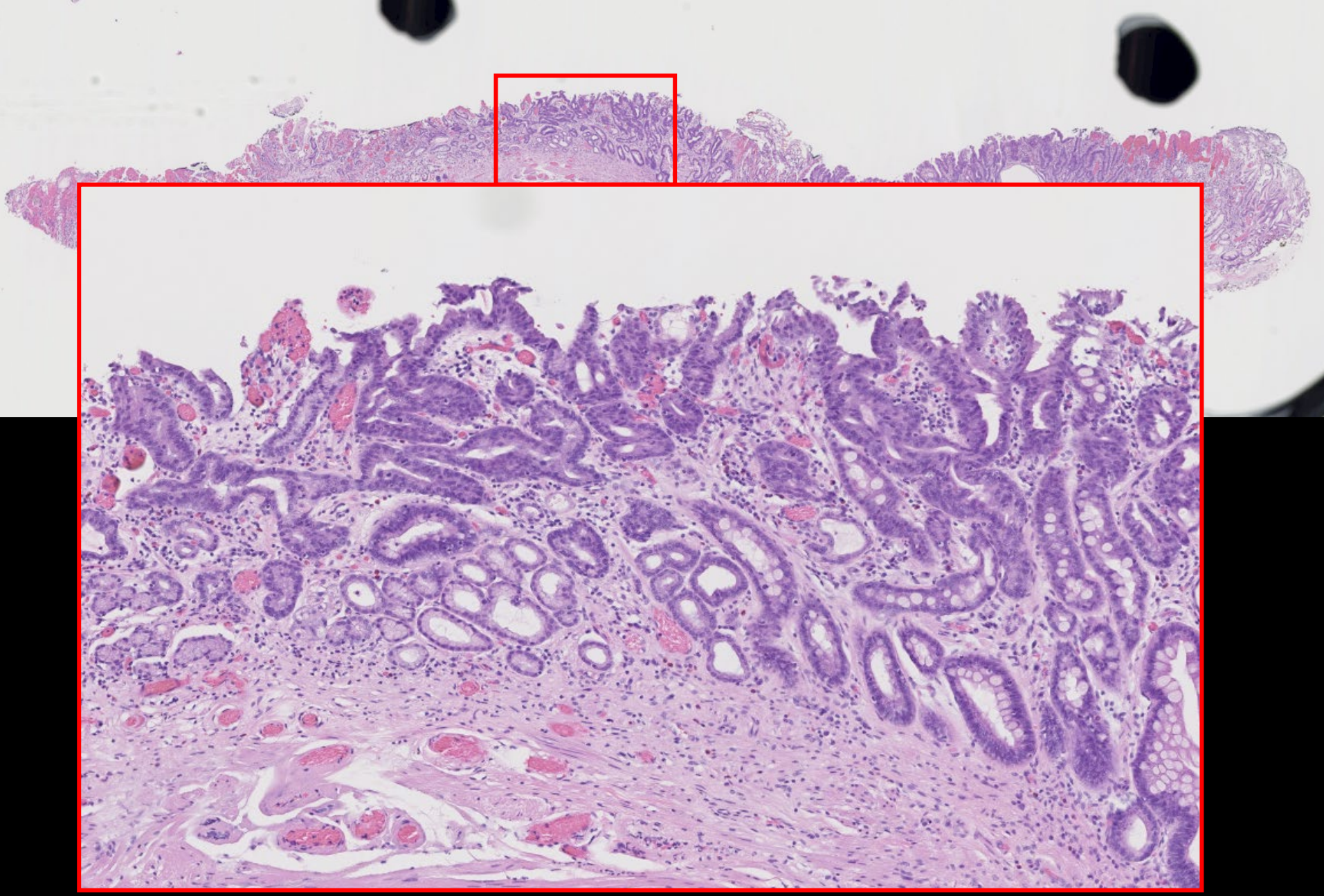
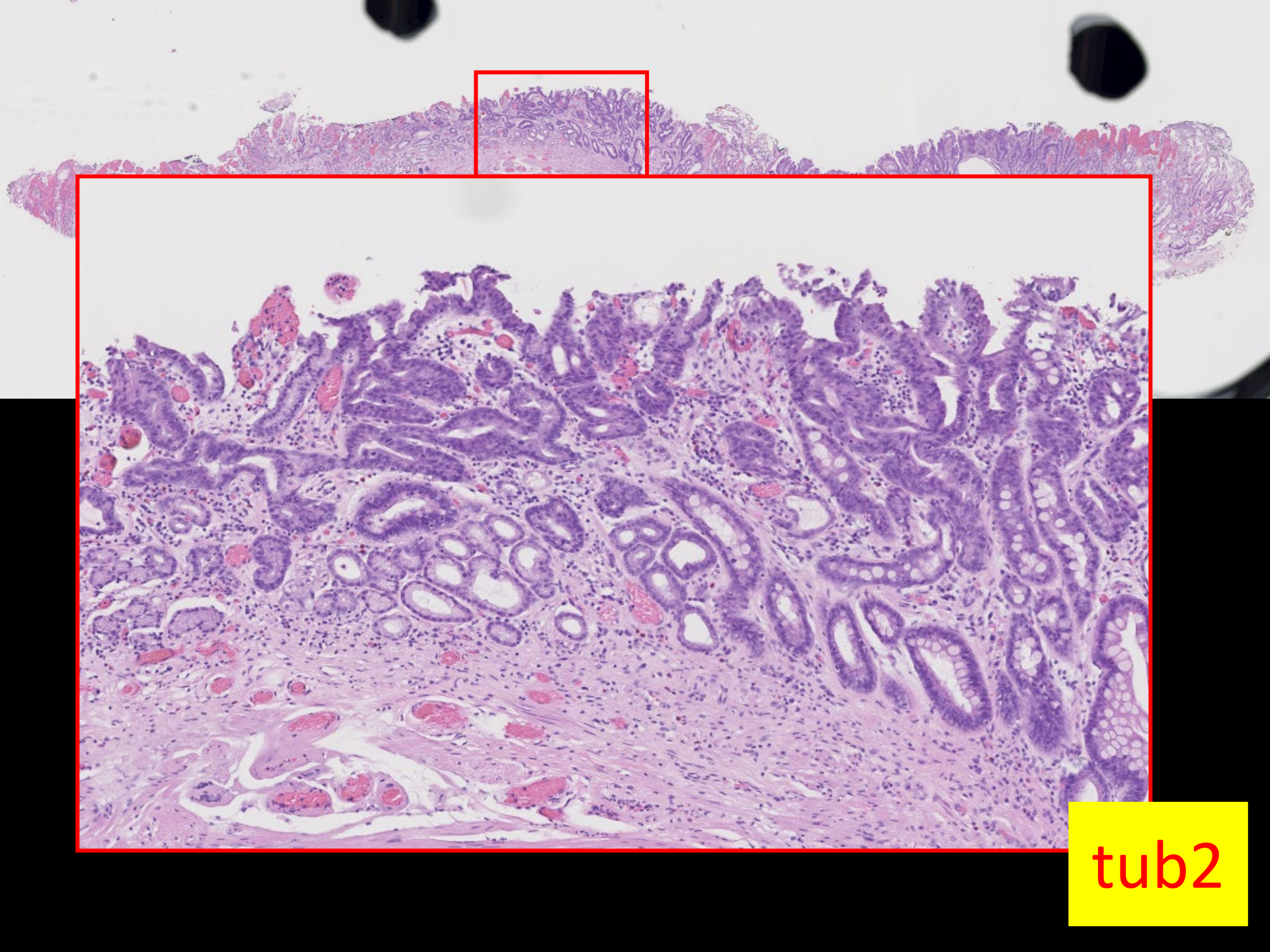





tub2

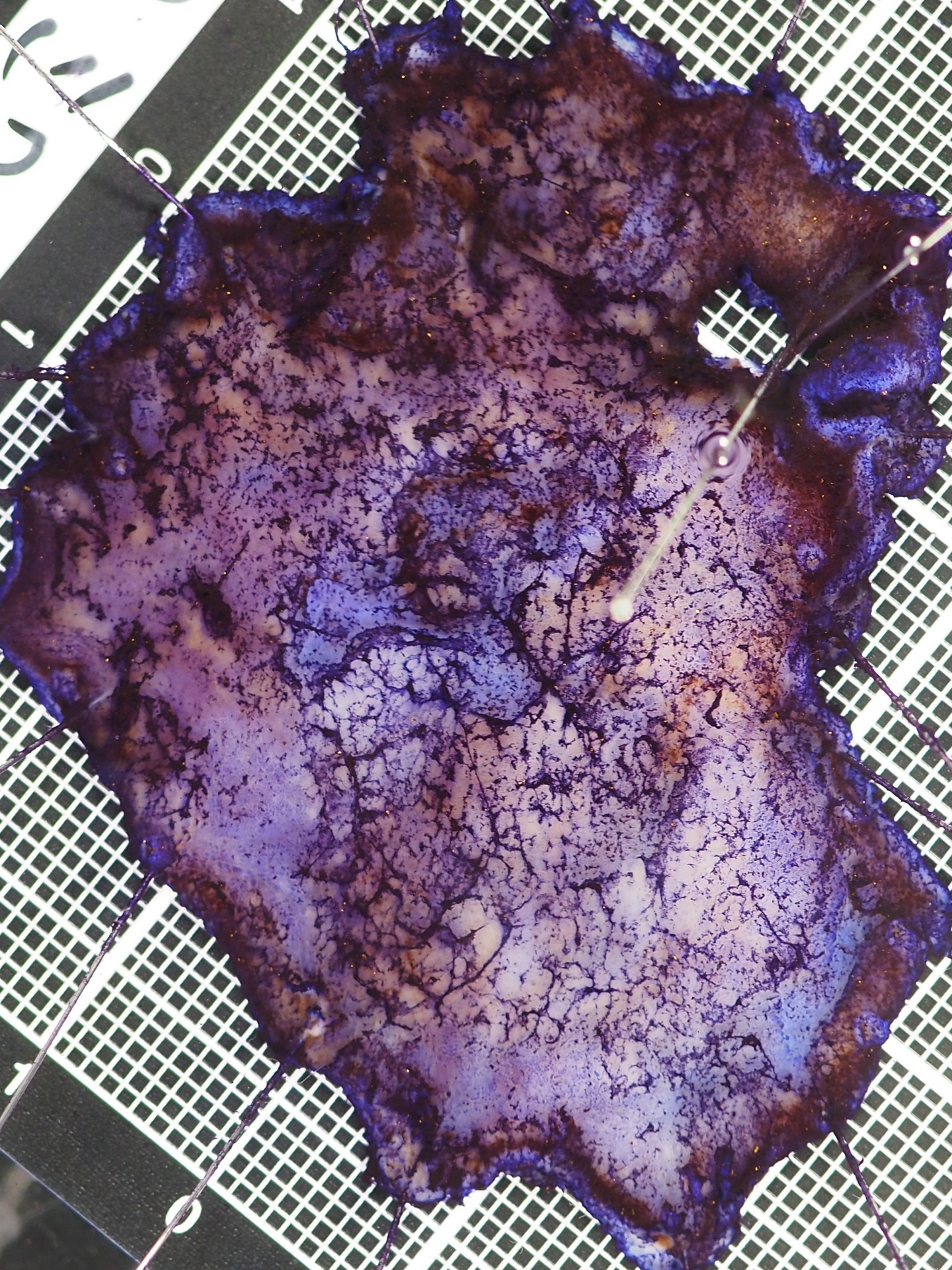
病理診断

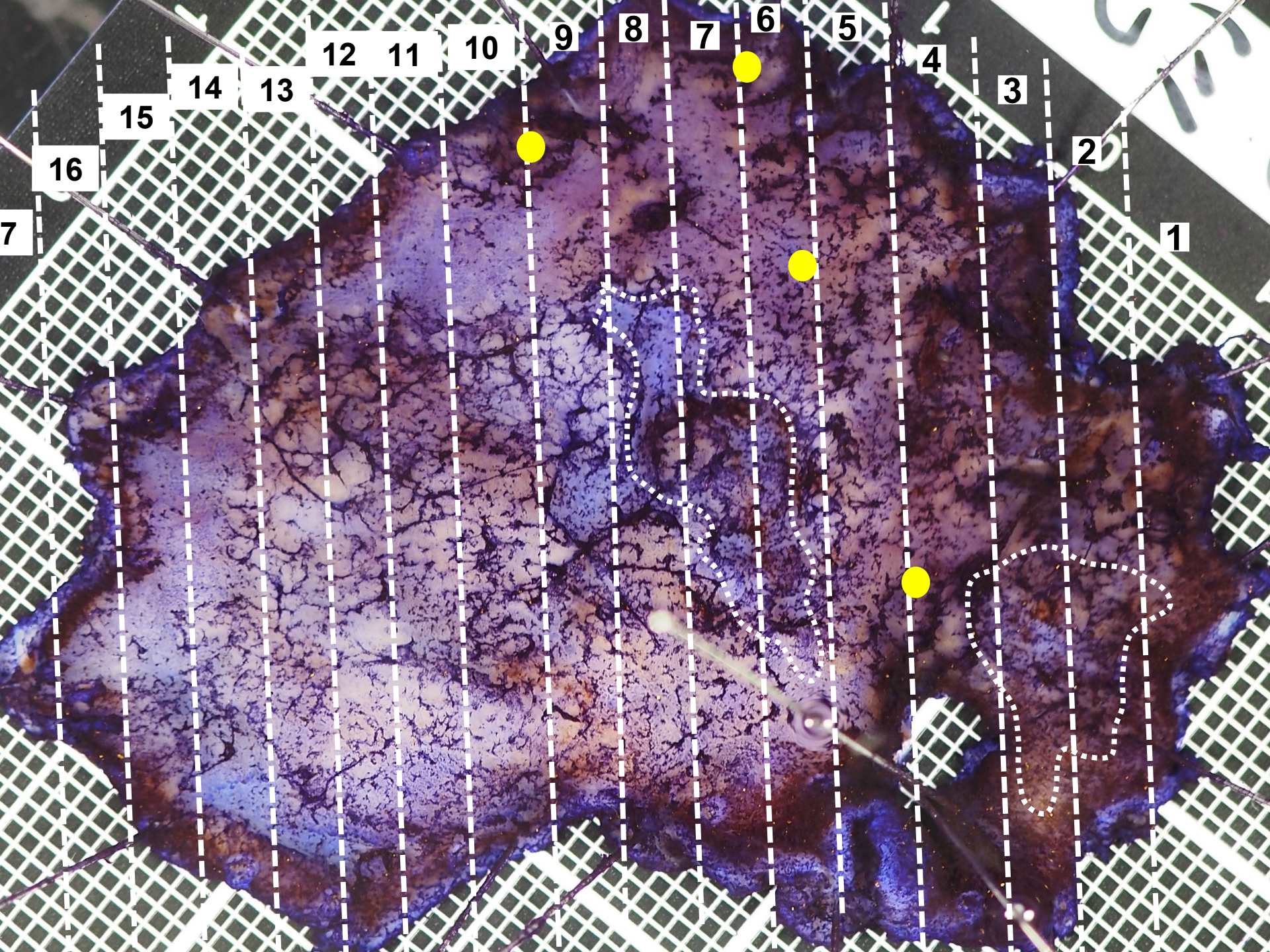
(1) tubular adenocarcinoma, moderately differentiated (tub2), pT1a(M), Ly0, V0, pUL1, pHMX, pVM0(#1-4)

(2) tubular adenocarcinoma, moderately differentiated (tub2>por2), pT1a(M), Ly0, V0, pUL1, pHMX,pVM0(#6-17)

→e-Cura C1

Mapping

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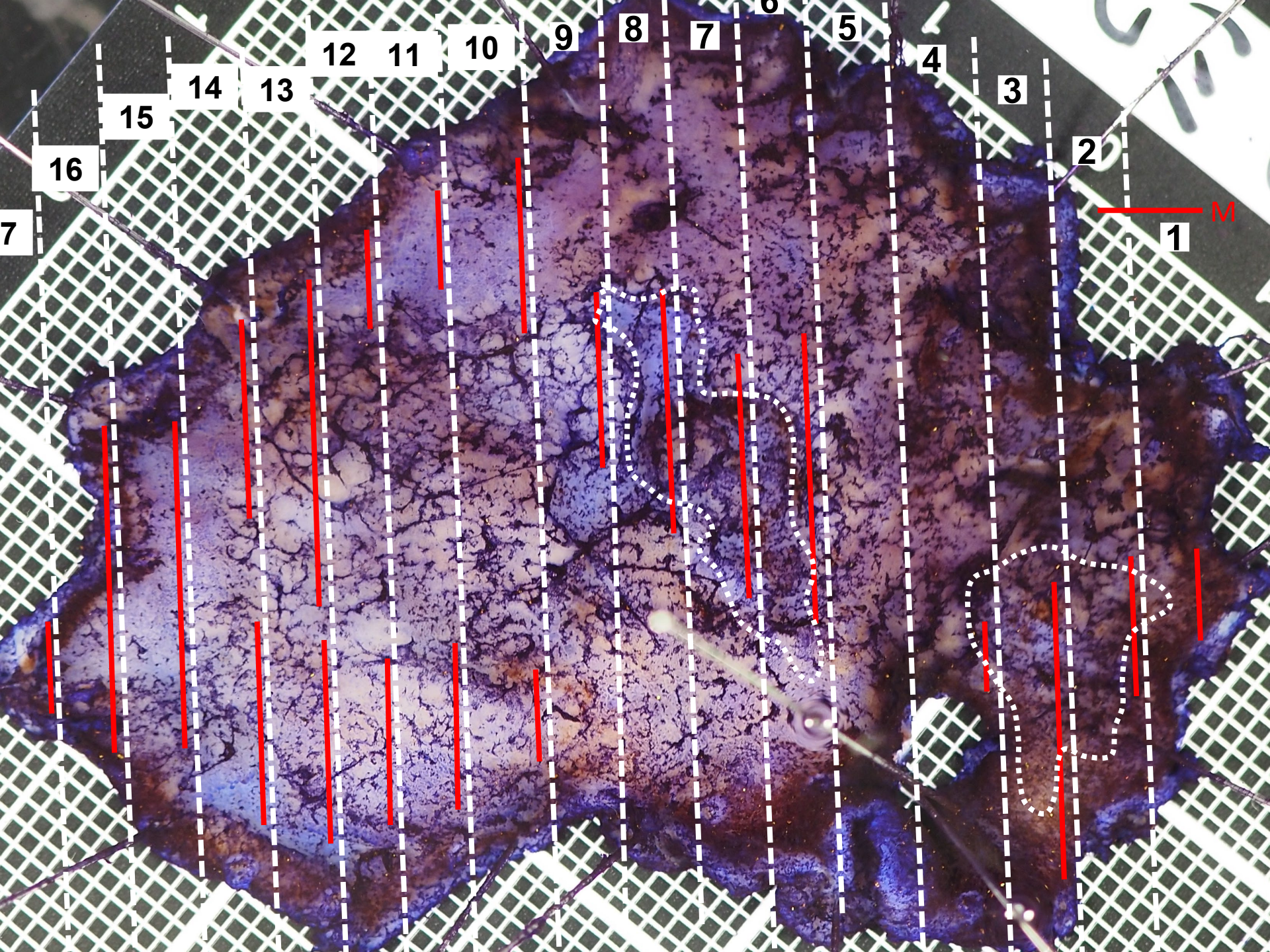
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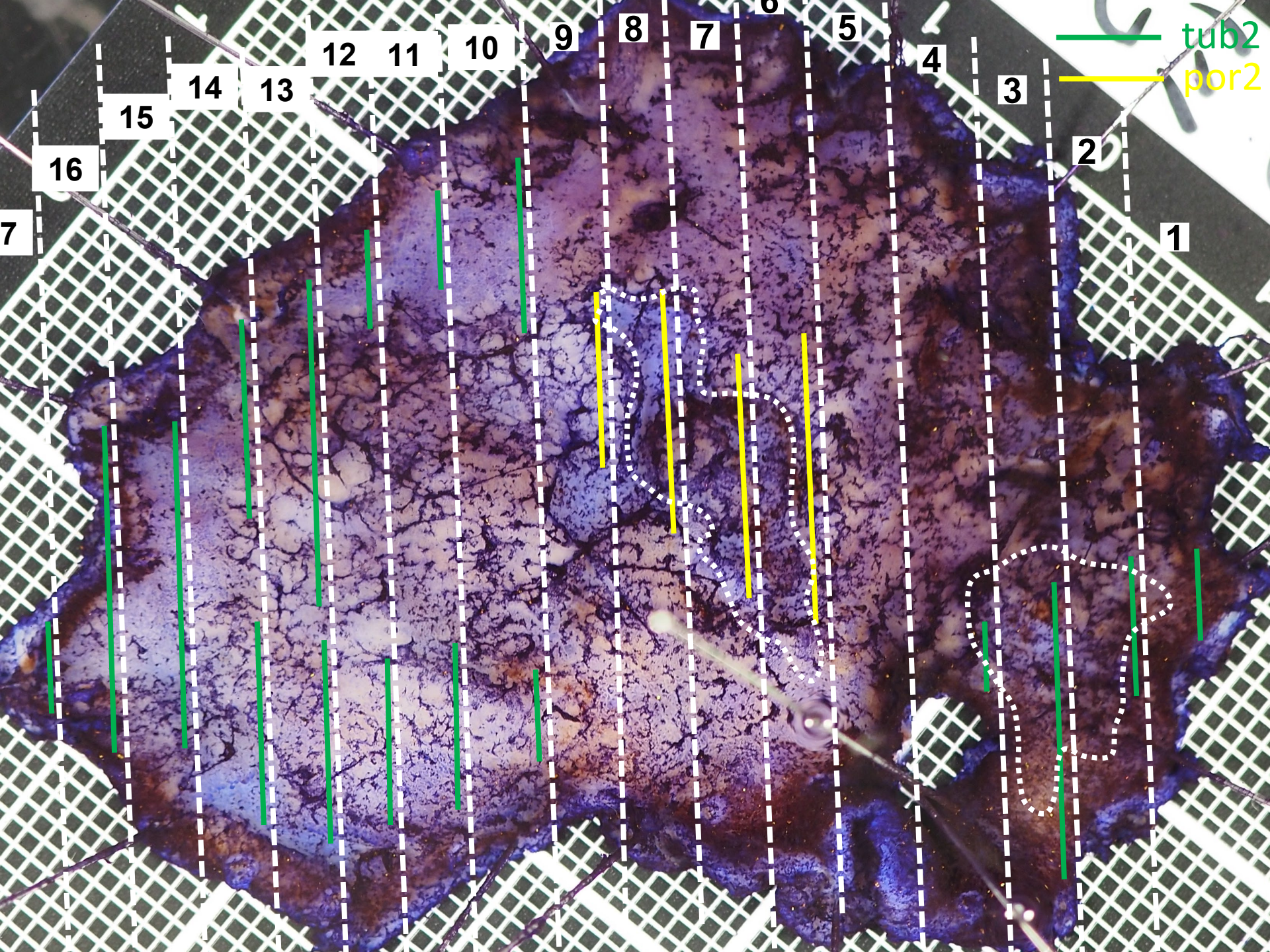
M


tub2
por2
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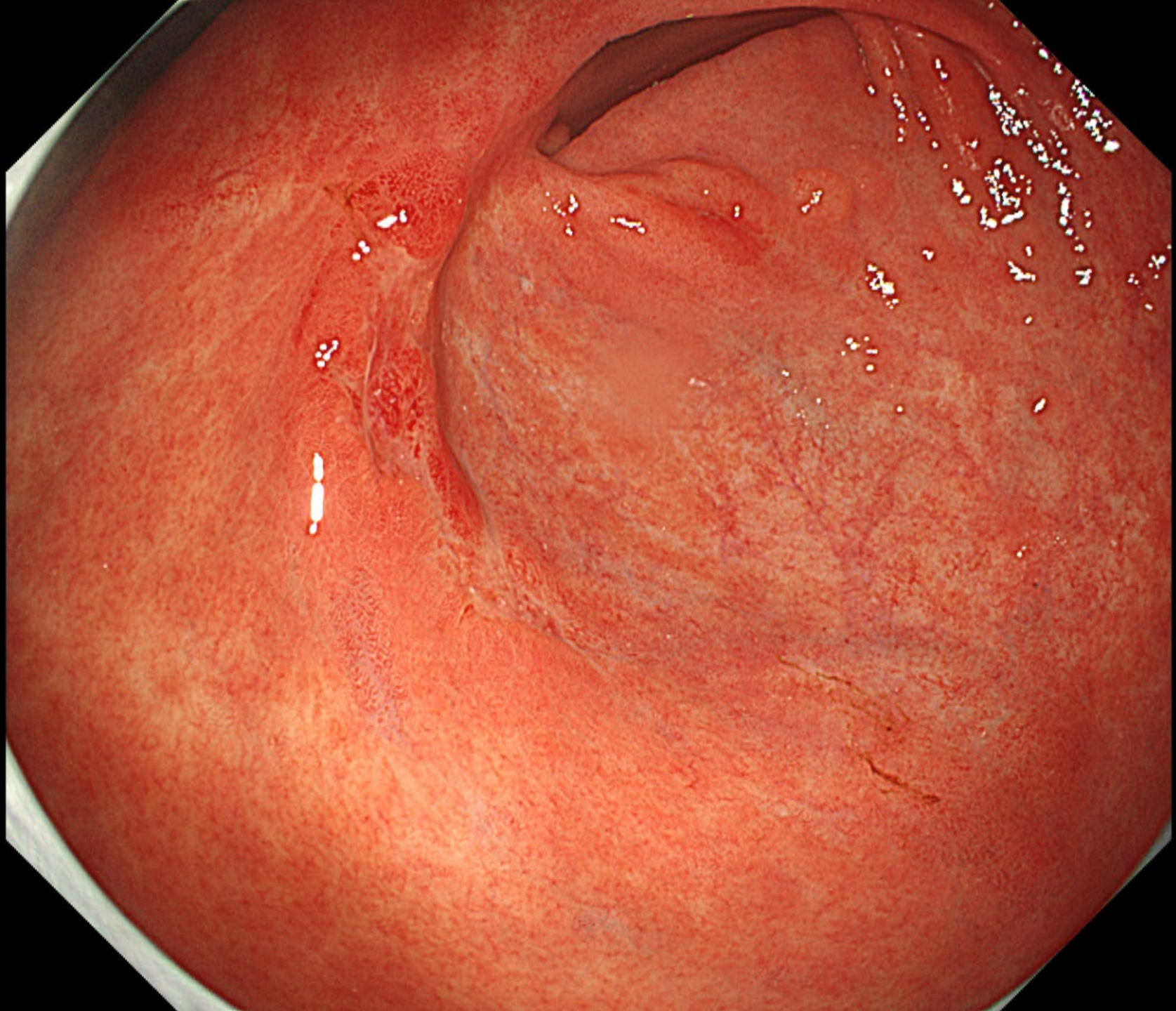
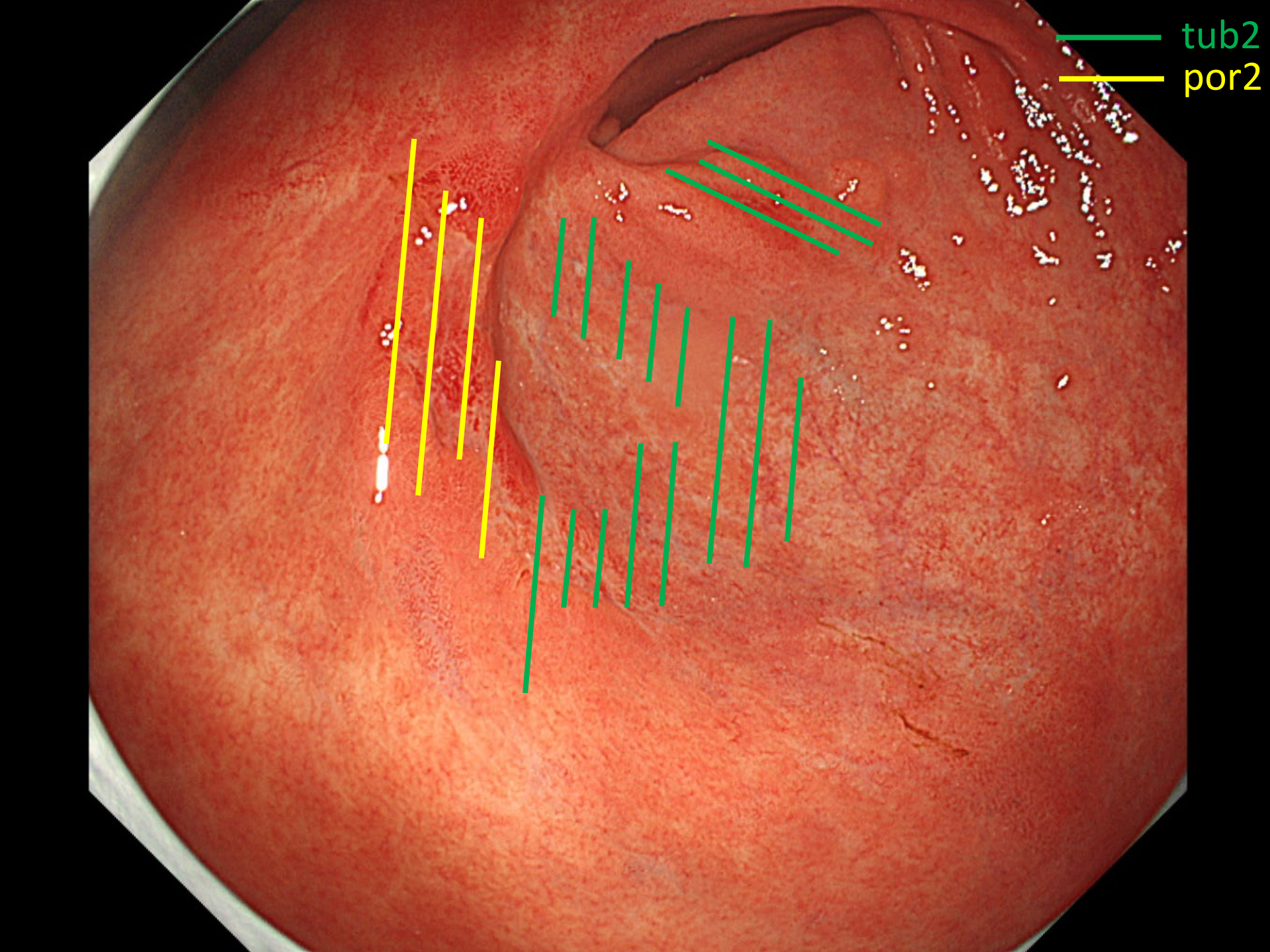
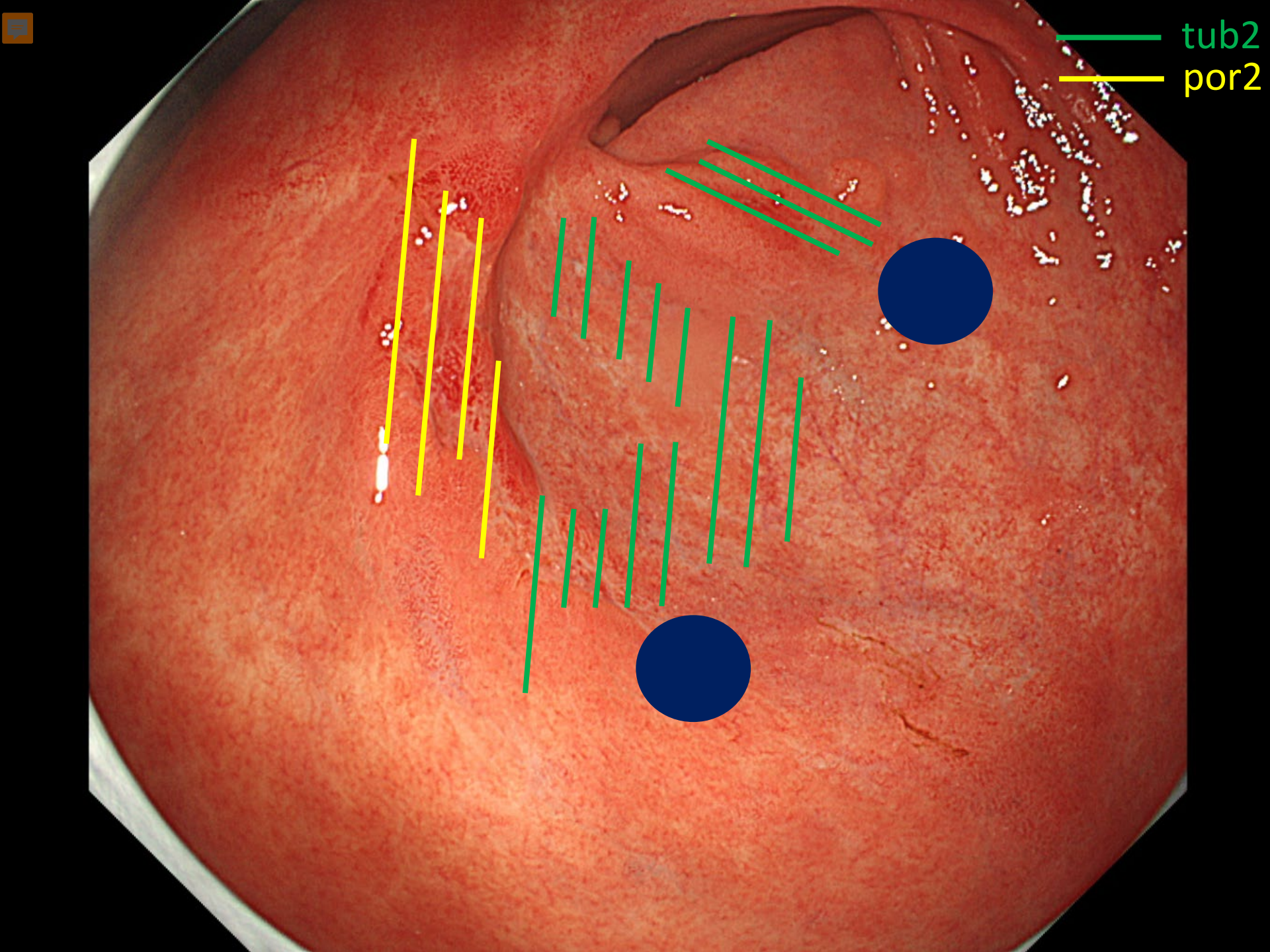
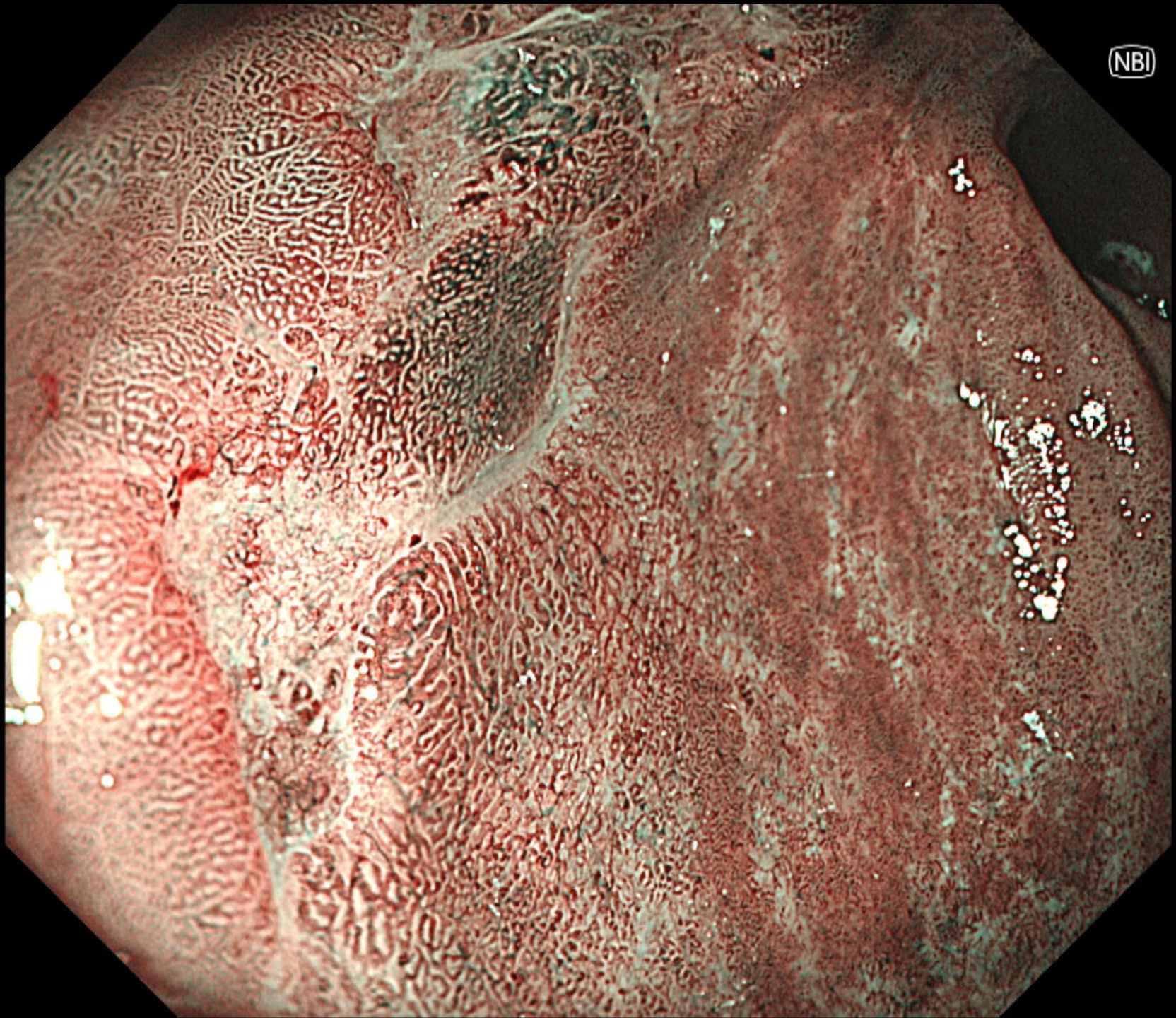
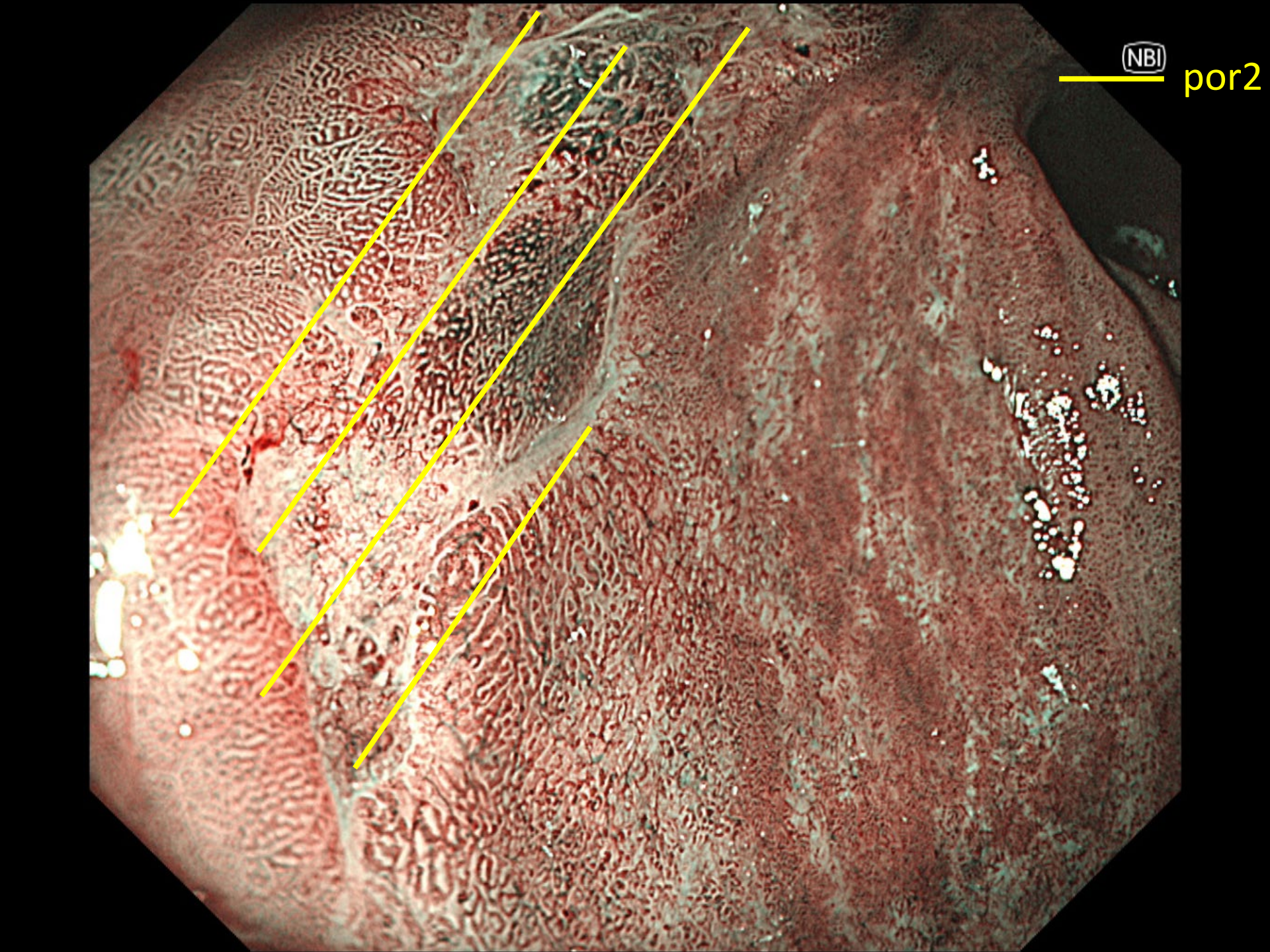
7

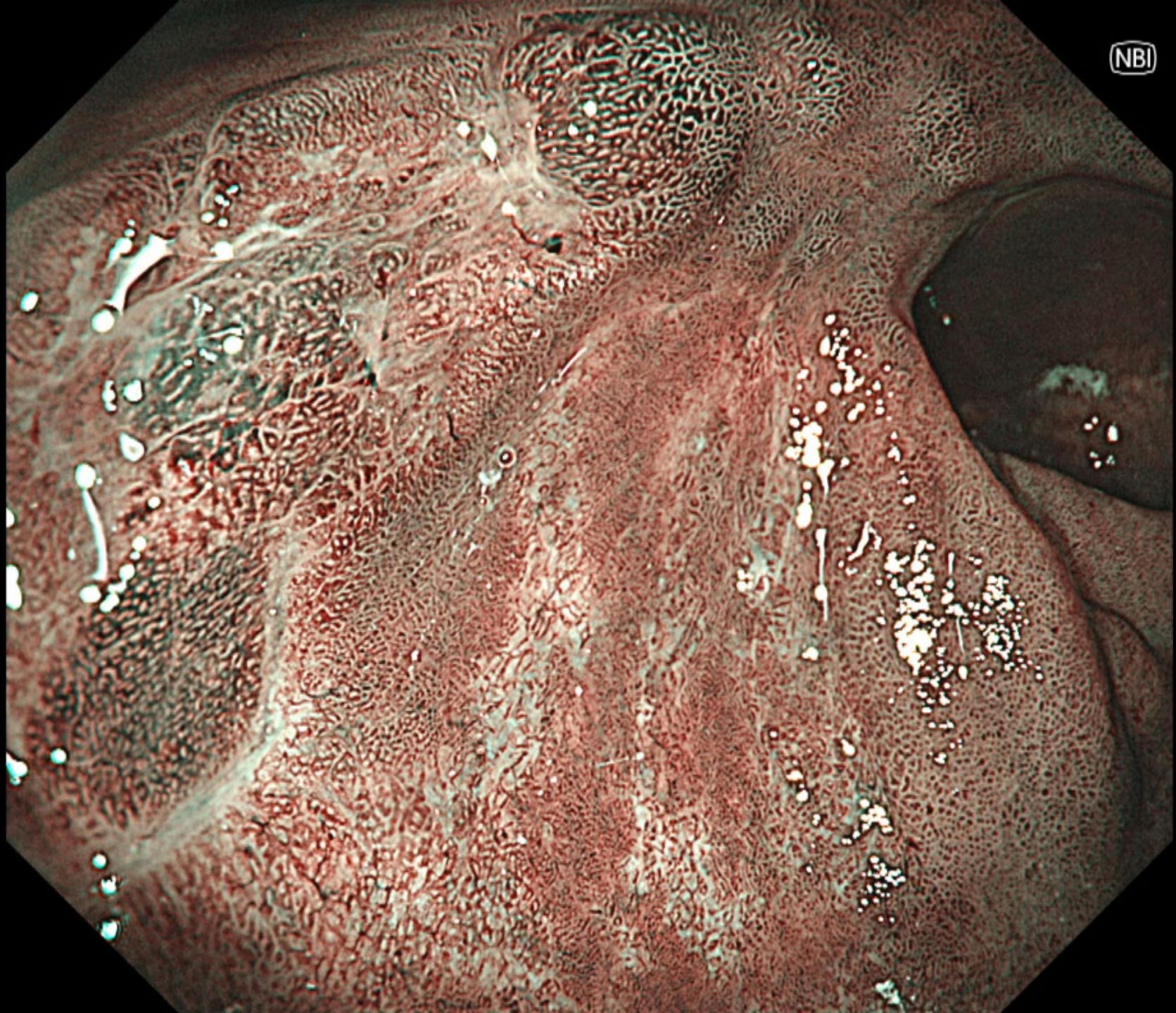


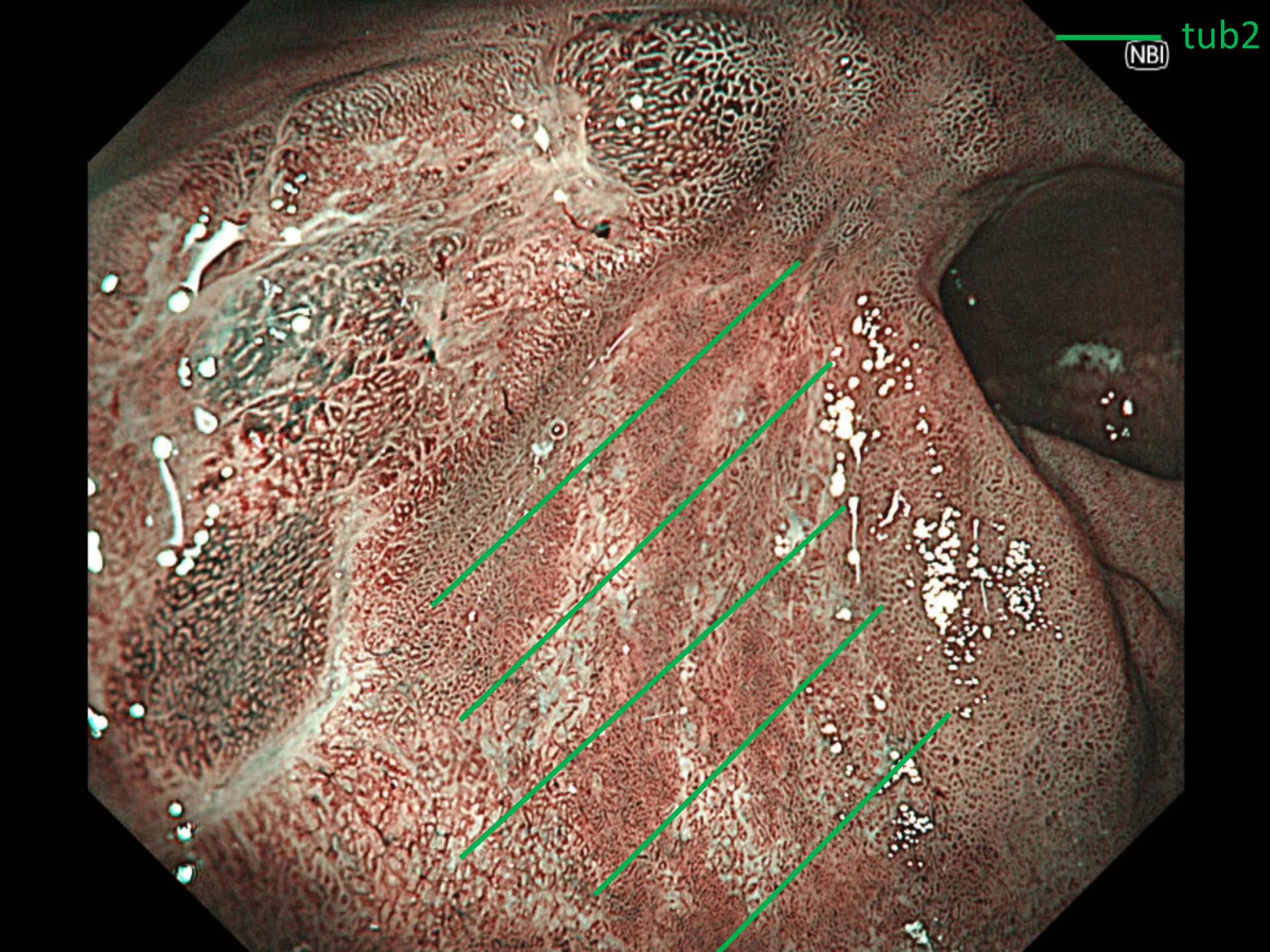

tub2
por2


tub2
por2

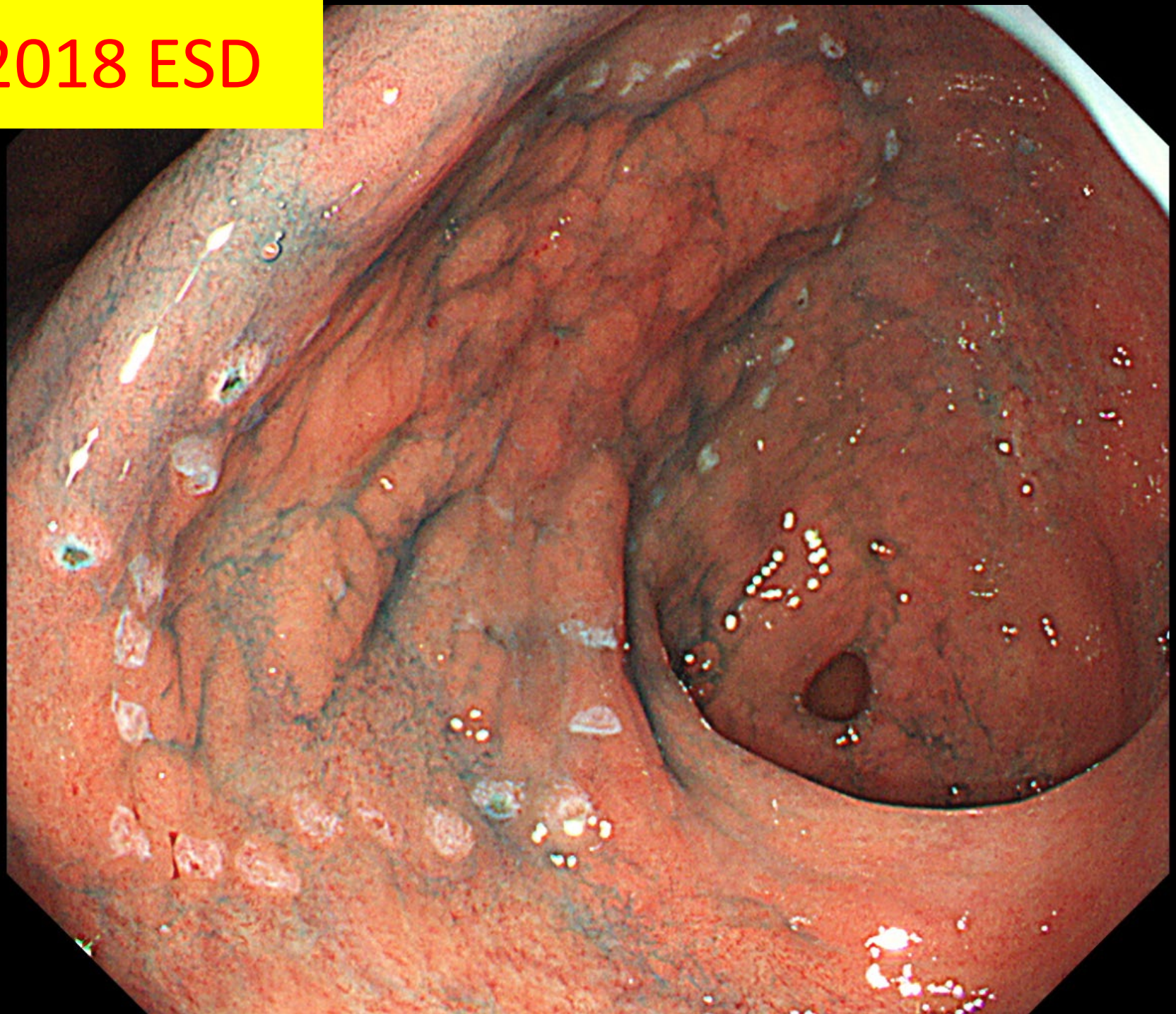

NBI


NBI
por2


NBI


NBI
tub2

2018 ESD



横這型胃癌・手つなぎ胃癌

- 萎縮した粘膜を背景にして、細胞増殖帯に相当する粘膜の中間層を中心に、固有層内を広く進展する傾向が顕著な癌

- 内視鏡的に病変の認識、範囲の同定が困難なことがあり、本病変の認識は重要である

滝澤登一郎.胃の形態病理学

Gastric Cancer (2013) 16:220–232
DOI 10.1007/s10120-012-0173-2

ORIGINAL ARTICL

横這型胃癌・手つなぎ胃癌

"Crawling-type" adenocarcinoma of the stomach: a distinct entity preceding poorly differentiated adenocarcinoma

Naoko Okamoto · Hiroshi Kawachi · Tatsuya Yoshida · Keisuke Kitagaki · Masaki Sekine · Kazuyuki Kojima · Tatsuyuki Kawano · Yoshinobu Eishi

横這型胃癌25病変のケースシリーズ

対象

○外科的切除検体
2002年1月から2011年7月までの間に
東京医科歯科大学病院で切除された
pT1a(M)およびpT1b(SM1)胃腺癌606病変

○内視鏡的切除病変
2003年10月から2011年7月までの間に
九段坂病院で切除された
pT1a(M)およびpT1b(SM1)胃腺癌270病変

→876病変

Table 1 Clinicopathological features of crawling-type adenocarcinoma examined in this study

Case no.	Age (years)	Sex	Therapeutic method	Tumor location	Tumor size[a] (mm)	Macroscopic type including UL[b]	Maximum diameter of PDC (mm)	Depth of invasion[b]	Vessel permeation	Stromal volume[b]	Tumor infiltration pattern[b]	Lymph node metastasis
1	62	M	DG	M/Less	45	0–IIc+UL	–	T1a, M	–	NA	NA	–
2	70	M	ESD	M/Post	31	0–IIb	–	T1a, M	–	NA	NA	NA
3	54	M	ESD	M/Gre	17	0–IIc	–	T1a, M	–	NA	NA	NA
4	75	M	ESD	M/Post	23	0–IIc	–	T1a, M	–	NA	NA	NA
5	69	M	TG	M/Less	17	0–IIb+UL	–	T1a, M	–	NA	NA	NA
6	79	M	DG	M/Post	22	0–IIc+III	–	T1a, M	–	NA	NA	–
7	84	F	ESD	L/Ant	33	0–IIb	0.003	T1a, M	–	NA	NA	NA
8	65	M	DG	M/Less	23	0–IIb+UL	0.012	T1a, M	–	NA	NA	–
9	63	M	DG	M/Less	30	0–IIc+UL	3	T1a, M	–	NA	NA	–
10	42	F	DG	M/Post	30	0–IIc+IIb	30	T1a, M	–	NA	NA	–
11	78	M	DG	L/Gre	47	0–IIc+IIb+UL	47	T1a, M	–	NA	NA	+
12	52	M	ESD	L/Ant	50	0–IIc	50	T1a, M	–	NA	NA	NA
13	56	M	DG	M/Gre	55	0–IIc+UL	55	T1a, M	–	NA	NA	–
14	43	M	DG	M/Less	60	0–IIc+IIb	60	T1a, M	–	NA	NA	–
15	40	M	DG	M/Less	65	0–IIc	65	T1a, M	–	NA	NA	–
16	74	M	DG	M/Less	70	0–IIc+IIb+UL	70	T1a, M	–	NA	NA	–
17	60	M	TG	U/Post	32	0–IIc+UL	10	T1b, SM2	–	sci	INFc	–
18	55	F	DG	M/Post	16	0–IIc	16	T1b, SM2	–	sci	INFc	–
19	65	M	DG	M/Less	65	0–IIc+IIb+UL	17	T1b, SM1	–	sci	INFc	–
20	40	M	DG	L/Less	18	0–IIc+IIb+UL	18	T1b, SM2	–	int	INFb	–
21	43	M	DG	M/Gre	25	0–IIc	22	T1b, SM2	ly	int	INFb	+
22	63	M	DG	M/Ant	35	0–IIc+UL	35	T1b, SM2	v	sci	INFb	–
23	59	M	DG	M/Post	40	0–IIc+IIb+UL	40	T1b, SM2	–	sci	INFc	–
24	61	F	DG	M/Post	74	0–IIc	74	T1b, SM2	ly	sci	INFc	+
25	61	M	TG	U/Less	185	0–IIc+IIa	185	T1b, SM1	–	sci	INFb	+

Table 1 Clinicopathological features of crawling-type adenocarcinoma examined in this study

Case no.	Age (years)	Sex	Therapeutic method	Tumor location	Tumor size[a] (mm)	Macroscopic type including UL[b]	Maximum diameter of PDC (mm)	Depth of invasion[b]	Vessel permeation	Stromal volume[b]	Tumor infiltration pattern[b]	Lymph node metastasis
1	62	M	DG	M/Less	45	0–IIc+UL	–	T1a, M	–	NA	NA	–
2	70	M	ESD	M/Post	31	0–IIb	–	T1a, M	–	NA	NA	NA
3	54	M	ESD	M/Gre	17	0–IIc	–	T1a, M	–	NA	NA	NA
4	75	M	ESD	M/Post	23	0–IIc	–	T1a, M	–	NA	NA	NA
5	69	M	TG	M/Less	17	0–IIb+UL	–	T1a, M	–	NA	NA	NA
6	79	M	DG	M/Post	22	0–IIc+III	–	T1a, M	–	NA	NA	–
7	84	F	ESD	L/Ant	33	0–IIb	0.003	T1a, M	–	NA	NA	NA
8	65	M										–
9	63	M										–
10	42	F										–
11	78	M										+
12	52	M										NA
13	56	M										–
14	43	M										–
15	40	M	DG	M/Less	65	0–IIc	65	T1a, M	–	NA	NA	–
16	74	M	DG	M/Less	70	0–IIc+IIb+UL	70	T1a, M	–	NA	NA	–
17	60	M	TG	U/Post	32	0–IIc+UL	10	T1b, SM2	–	sci	INFc	–
18	55	F	DG	M/Post	16	0–IIc	16	T1b, SM2	–	sci	INFc	–
19	65	M	DG	M/Less	65	0–IIc+IIb+UL	17	T1b, SM1	–	sci	INFc	–
20	40	M	DG	L/Less	18	0–IIc+IIb+UL	18	T1b, SM2	–	int	INFb	–
21	43	M	DG	M/Gre	25	0–IIc	22	T1b, SM2	ly	int	INFb	+
22	63	M	DG	M/Ant	35	0–IIc+UL	35	T1b, SM2	v	sci	INFb	–
23	59	M	DG	M/Post	40	0–IIc+IIb+UL	40	T1b, SM2	–	sci	INFc	–
24	61	F	DG	M/Post	74	0–IIc	74	T1b, SM2	ly	sci	INFc	+
25	61	M	TG	U/Less	185	0–IIc+IIa	185	T1b, SM1	–	sci	INFb	+

19病変(76%)はM～L領域
10病変(40%)は小彎側

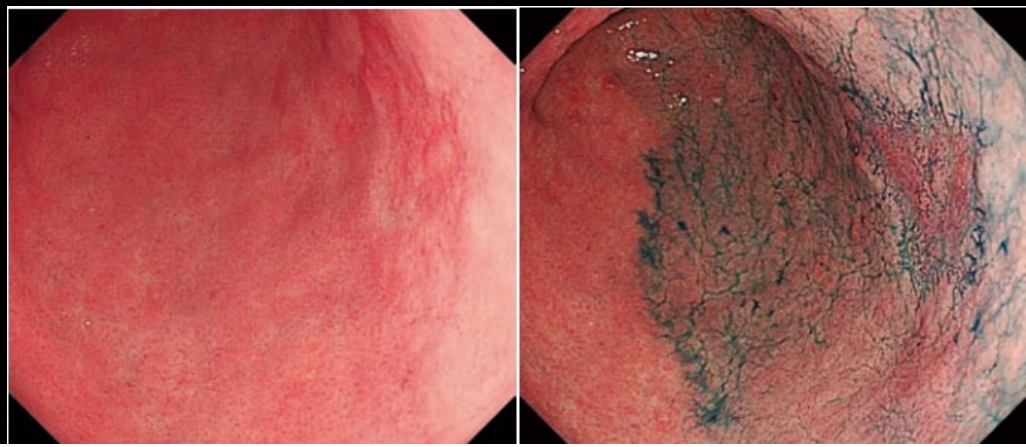
Table 1 Clinicopathological features of crawling-type adenocarcinoma examined in this study

Case no.	Age (years)	Sex	Therapeutic method	Tumor location	Tumor size[a] (mm)	Macroscopic type including UL[b]	Maximum diameter of PDC (mm)	Depth of invasion[b]	Vessel permeation	Stromal volume[b]	Tumor infiltration pattern[b]	Lymph node metastasis
1	62	M	DG	M/Less	45	0–IIc+UL	–	T1a, M	–	NA	NA	–
2	70	M	ESD	M/Post	31	0–IIb	–	T1a, M	–	NA	NA	NA
3	54	M	ESD	M/Gre	17	0–IIc	–	T1a, M	–	NA	NA	NA
4	75	M	ESD	M/Post	23	0–IIc	–	T1a, M	–	NA	NA	NA
5	69	M	TG	M/Less	17	0–IIb+UL	–	T1a, M	–	NA	NA	NA
6	79	M	DG	M/Post	22	0–IIc+III	–	T1a, M	–	NA	NA	–
7	84	F	ESD	L/Ant	33	0–IIb	0.003	T1a, M	–	NA	NA	NA
8	65	M	DG	M/Less	23	0–IIb+UL	0.012	T1a, M	–	NA	NA	–
9	63	M	DG								NA	–
10	42	F	DG								NA	–
11	78	M	DG								NA	+
12	52	M	ESD								NA	NA
13	56	M	DG								NA	–
14	43	M	DG	M/Less	60	0–IIc+IIb	60	T1a, M	–	NA	NA	–
15	40	M	DG	M/Less	65	0–IIc	65	T1a, M	–	NA	NA	–
16	74	M	DG	M/Less	70	0–IIc+IIb+UL	70	T1a, M	–	NA	NA	–
17	60	M	TG	U/Post	32	0–IIc+UL	10	T1b, SM2	–	sci	INFc	–
18	55	F	DG	M/Post	16	0–IIc	16	T1b, SM2	–	sci	INFc	–
19	65	M	DG	M/Less	65	0–IIc+IIb+UL	17	T1b, SM1	–	sci	INFc	–
20	40	M	DG	L/Less	18	0–IIc+IIb+UL	18	T1b, SM2	–	int	INFb	–
21	43	M	DG	M/Gre	25	0–IIc	22	T1b, SM2	ly	int	INFb	+
22	63	M	DG	M/Ant	35	0–IIc+UL	35	T1b, SM2	v	sci	INFb	–
23	59	M	DG	M/Post	40	0–IIc+IIb+UL	40	T1b, SM2	–	sci	INFc	–
24	61	F	DG	M/Post	74	0–IIc	74	T1b, SM2	ly	sci	INFc	+
25	61	M	TG	U/Less	185	0–IIc+IIa	185	T1b, SM1	–	sci	INFb	+

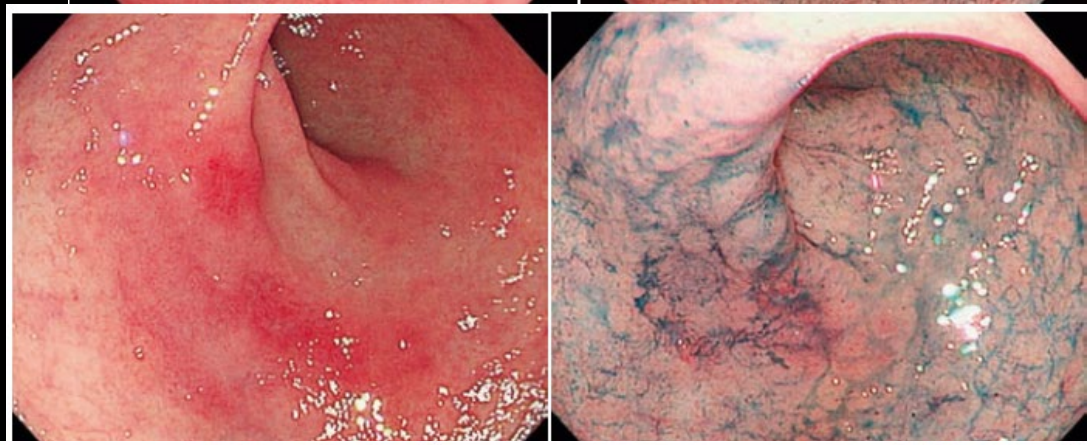
21病変(84%)が0-ⅡC

内視鏡像

発赤調、0-Ⅱc



発赤＋褪色調、0-Ⅱb



発赤調、0-Ⅱc＋Ⅱb

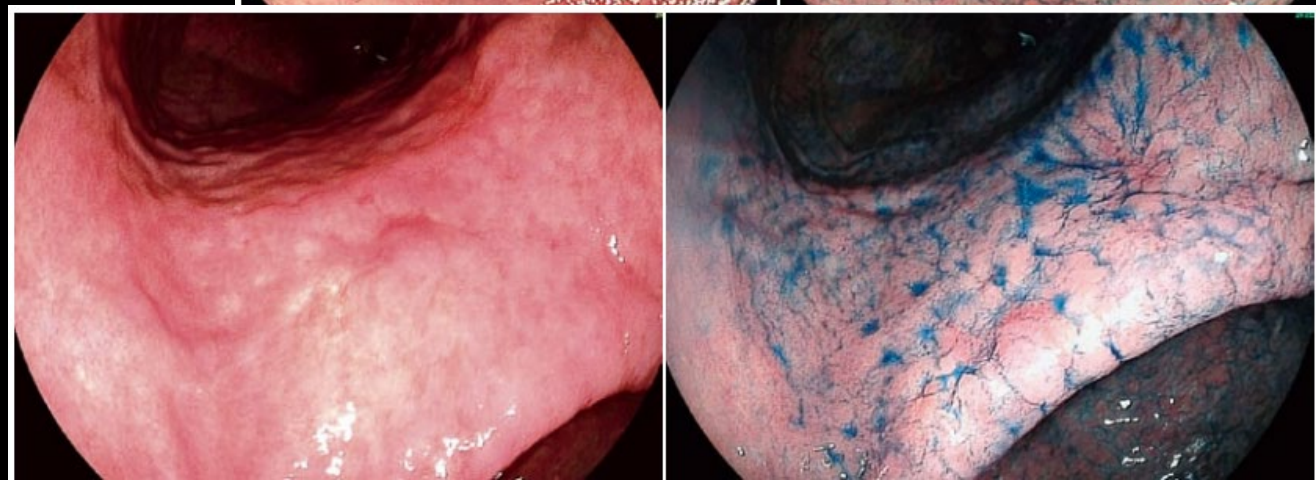


Table 1 Clinicopathological features of crawling-type adenocarcinoma examined in this study

Case no.	Age (years)	Sex	Therapeutic method	Tumor location	Tumor size[a] (mm)	Macroscopic type including UL[b]	Maximum diameter of PDC (mm)	Depth of invasion[b]	Vessel permeation	Stromal volume[b]	Tumor infiltration pattern[b]	Lymph node metastasis
1	62	M	DG	M/Less	45	0–IIc+UL	–	T1a, M	–	NA	NA	–
2	70	M	ESD	M/Post	31	0–IIb	–	T1a, M	–	NA	NA	NA
3	54	M	ESD	M/Gre	17	0–IIc	–	T1a, M	–	NA	NA	NA
4	75	M	ESD	M/Post	23	0–IIc	–	T1a, M	–	NA	NA	NA
5	69	M	TG	M/Less	17	0–IIb+UL	–	T1a, M	–	NA	NA	NA
6	79	M	DG	M/Post	22	0–IIc+III	–	T1a, M	–	NA	NA	–
7	84	F	ESD	L/Ant	33	0–IIb	0.003	T1a, M	–	NA	NA	NA
8	65	M	DG	M/Less	23	0–IIb+UL	0.012	T1a, M	–	NA	NA	–
9	63	M	DG	M/Less	30	0–IIc+UL	3	T1a, M	–	NA	NA	–
10												
11												
12												
13	56	M	DG	M/Gre	55	0–IIc+UL	55	T1a, M	–	NA	NA	–
14	43	M	DG	M/Less	60	0–IIc+IIb	60	T1a, M	–	NA	NA	–
15	40	M	DG	M/Less	65	0–IIc	65	T1a, M	–	NA	NA	–
16	74	M	DG	M/Less	70	0–IIc+IIb+UL	70	T1a, M	–	NA	NA	–
17	60	M	TG	U/Post	32	0–IIc+UL	10	T1b, SM2	–	sci	INFc	–
18	55	F	DG	M/Post	16	0–IIc	16	T1b, SM2	–	sci	INFc	–
19	65	M	DG	M/Less	65	0–IIc+IIb+UL	17	T1b, SM1	–	sci	INFc	–
20	40	M	DG	L/Less	18	0–IIc+IIb+UL	18	T1b, SM2	–	int	INFb	–
21	43	M	DG	M/Gre	25	0–IIc	22	T1b, SM2	ly	int	INFb	+
22	63	M	DG	M/Ant	35	0–IIc+UL	35	T1b, SM2	v	sci	INFb	–
23	59	M	DG	M/Post	40	0–IIc+IIb+UL	40	T1b, SM2	–	sci	INFc	–
24	61	F	DG	M/Post	74	0–IIc	74	T1b, SM2	ly	sci	INFc	+
25	61	M	TG	U/Less	185	0–IIc+IIa	185	T1b, SM1	–	sci	INFb	+

16病変がM癌、9病変がSM癌

Table 1 Clinicopathological features of crawling-type adenocarcinoma examined in this study

Case no.	Age (years)	Sex	Therapeutic method	Tumor location	Tumor size[a] (mm)	Macroscopic type including UL[b]	Maximum diameter of PDC (mm)	Depth of invasion[b]	Vessel permeation	Stromal volume[b]	Tumor infiltration pattern[b]	Lymph node metastasis
1	62	M	DG	M/Less	45	0–IIc+UL	–	T1a, M	–	NA	NA	–
2	70	M	ESD	M/Post	31	0–IIb	–	T1a, M	–	NA	NA	NA
3	54	M	ESD	M/Gre	17	0–IIc	–	T1a, M	–	NA	NA	NA
4	75	M	ESD	M/Post	23	0–IIc	–	T1a, M	–	NA	NA	NA
5	69	M	TG	M/Less	17	0–IIb+UL	–	T1a, M	–	NA	NA	NA
6	79	M	DG	M/Post	22	0–IIc+III	–	T1a, M	–	NA	NA	–
7	84	F	ESD	L/Ant	33	0–IIb	0.003	T1a, M	–	NA	NA	NA
8	65	M										–
9	63	M										–
10	42	F										–
11	78	M										+
12	52	M										NA
13	56	M										–
14	43	M										–
15	40	M	DG	M/Less	65	0–IIc	65	T1a, M	–	NA	NA	–
16	74	M	DG	M/Less	70	0–IIc+IIb+UL	70	T1a, M	–	NA	NA	–
17	60	M	TG	U/Post	32	0–IIc+UL	10	T1b, SM2	–	sci	INFc	–
18	55	F	DG	M/Post	16	0–IIc	16	T1b, SM2	–	sci	INFc	–
19	65	M	DG	M/Less	65	0–IIc+IIb+UL	17	T1b, SM1	–	sci	INFc	–
20	40	M	DG	L/Less	18	0–IIc+IIb+UL	18	T1b, SM2	–	int	INFb	–
21	43	M	DG	M/Gre	25	0–IIc	22	T1b, SM2	ly	int	INFb	+
22	63	M	DG	M/Ant	35	0–IIc+UL	35	T1b, SM2	v	sci	INFb	–
23	59	M	DG	M/Post	40	0–IIc+IIb+UL	40	T1b, SM2	–	sci	INFc	–
24	61	F	DG	M/Post	74	0–IIc	74	T1b, SM2	ly	sci	INFc	+
25	61	M	TG	U/Less	185	0–IIc+IIa	185	T1b, SM1	–	sci	INFb	+

2病変がリンパ管侵襲(＋)
1病変が静脈侵襲(＋)

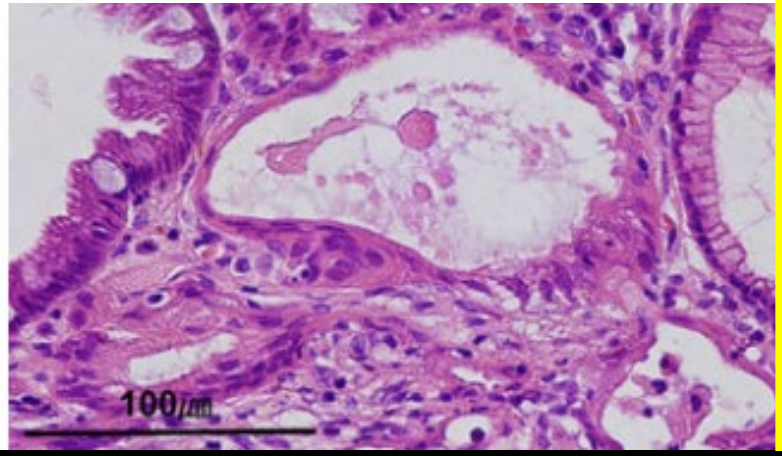
Table 1 Clinicopathological features of crawling-type adenocarcinoma examined in this study

Case no.	Age (years)	Sex	Therapeutic method	Tumor location	Tumor size[a] (mm)	Macroscopic type including UL[b]	Maximum diameter of PDC (mm)	Depth of invasion[b]	Vessel permeation	Stromal volume[b]	Tumor infiltration pattern[b]	Lymph node metastasis
1	62	M	DG	M/Less	45	0–IIc+UL	–	T1a, M	–	NA	NA	–
2	70	M	ESD	M/Post	31	0–IIb	–	T1a, M	–	NA	NA	NA
3	54	M	ESD	M/Gre	17	0–IIc	–	T1a, M	–	NA	NA	NA
4	75	M	ESD	M/Post	23	0–IIc	–	T1a, M	–	NA	NA	NA
5	69	M	TG	M/Less	17	0–IIb+UL	–	T1a, M	–	NA	NA	NA
6	79	M	DG	M/Post	22	0–IIc+III	–	T1a, M	–	NA	NA	–
7	84	F	ESD	L/Ant	33	0–IIb	0.003	T1a, M	–	NA	NA	NA
8	65											–
9	63											–
10	42											–
11	78											+
12	52											NA
13	56											–
14	43											–
15	40	M	DG	M/Less	65	0–IIc	65	T1a, M	–	NA	NA	–
16	74	M	DG	M/Less	70	0–IIc+IIb+UL	70	T1a, M	–	NA	NA	–
17	60	M	TG	U/Post	32	0–IIc+UL	10	T1b, SM2	–	sci	INFc	–
18	55	F	DG	M/Post	16	0–IIc	16	T1b, SM2	–	sci	INFc	–
19	65	M	DG	M/Less	65	0–IIc+IIb+UL	17	T1b, SM1	–	sci	INFc	–
20	40	M	DG	L/Less	18	0–IIc+IIb+UL	18	T1b, SM2	–	int	INFb	–
21	43	M	DG	M/Gre	25	0–IIc	22	T1b, SM2	ly	int	INFb	+
22	63	M	DG	M/Ant	35	0–IIc+UL	35	T1b, SM2	v	sci	INFb	–
23	59	M	DG	M/Post	40	0–IIc+IIb+UL	40	T1b, SM2	–	sci	INFc	–
24	61	F	DG	M/Post	74	0–IIc	74	T1b, SM2	ly	sci	INFc	+
25	61	M	TG	U/Less	185	0–IIc+IIa	185	T1b, SM1	–	sci	INFb	+

4病変(M病変1、SM病変3)でリンパ節転移(＋)

病理学的特徴

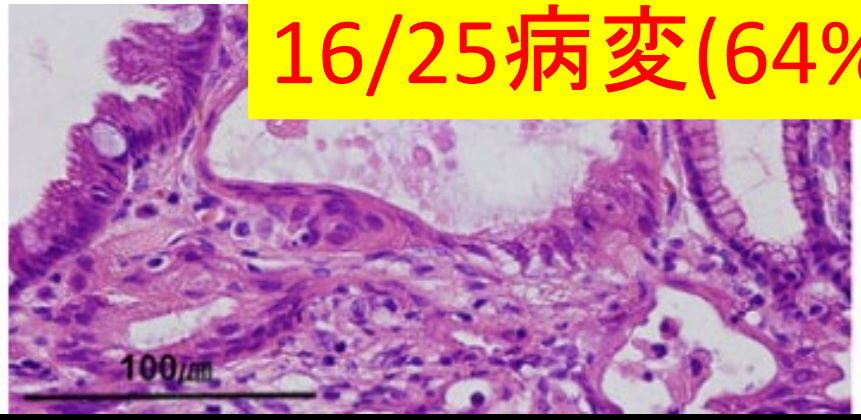
Histologically, irregularly fused tumor glands with low-grade cellular atypia were located mainly in the epithelial proliferative zone (Figs. 1e–f, 2d–e). Almost all of the tumor glands included goblet cells and occasionally seemed to mimic IM. In all lesions, cystic dilated glands comprising cells with slightly eosinophilic and cuboidal cytoplasm were found focally among the irregularly fused glands (Figs. 1g, 2f). Further, foci of signet-ring cells (Fig. 2g) were found in 16 of the 25 (64 %) lesions. In all SM-CTACs, tumor tissues in



- 細胞異型は軽微
- 融合腺管
- 腸上皮化生に類似
- 淡好酸性細胞からなる嚢胞拡張腺管(全例)

病理学的特徴

Histologically, irregularly fused tumor glands with low-grade cellular atypia were located mainly in the epithelial proliferative zone (Figs. 1e–f, 2d–e). Almost all of the tumor glands included goblet cells and occasionally seemed to mimic IM. In all lesions, cystic dilated glands comprising cells with slightly eosinophilic and cuboidal cytoplasm were found focally among the irregularly fused glands (Figs. 1g, 2f). Further, foci of signet-ring cells (Fig. 2g) were found in 16 of the 25 (64 %) lesions. In all SM-CTACs, tumor tissues in the submucosal invasive area



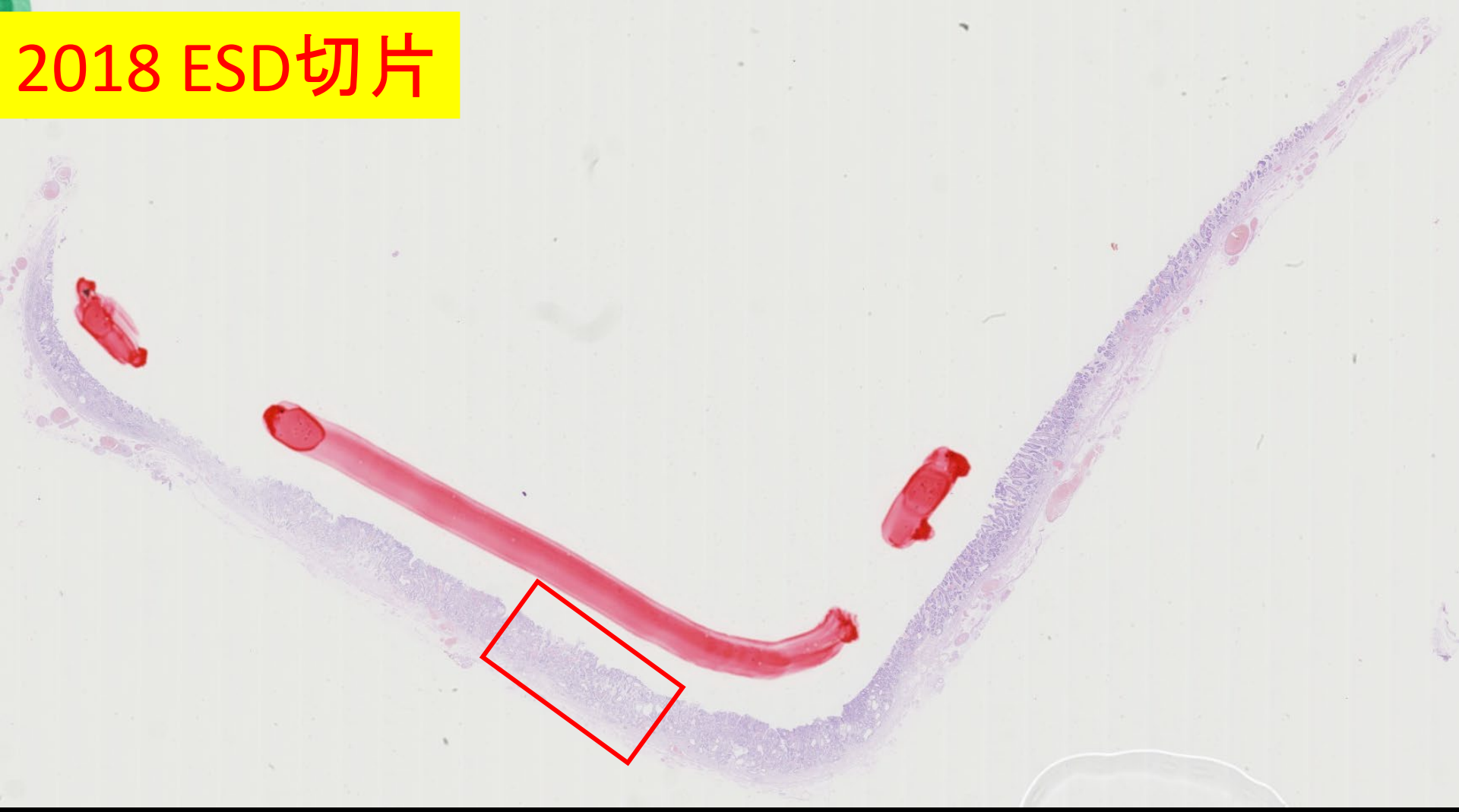
16/25病変(64%)で印環細胞を認めた

横這型胃癌・手つなぎ胃癌まとめ

・萎縮した粘膜を背景にして、細胞増殖帯に相当する粘膜の中間層を中心に、固有層内を広く進展する傾向が顕著な癌

・M～L領域、小弯側に発生する傾向がある

・病理学的には、
① 細胞異型は軽度で、融合傾向の腺管を認める(tub2)
② 腸上皮化生腺管に類似することがある
③ 嚢胞拡張腺管
④ しばしば印鑑細胞癌を認める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