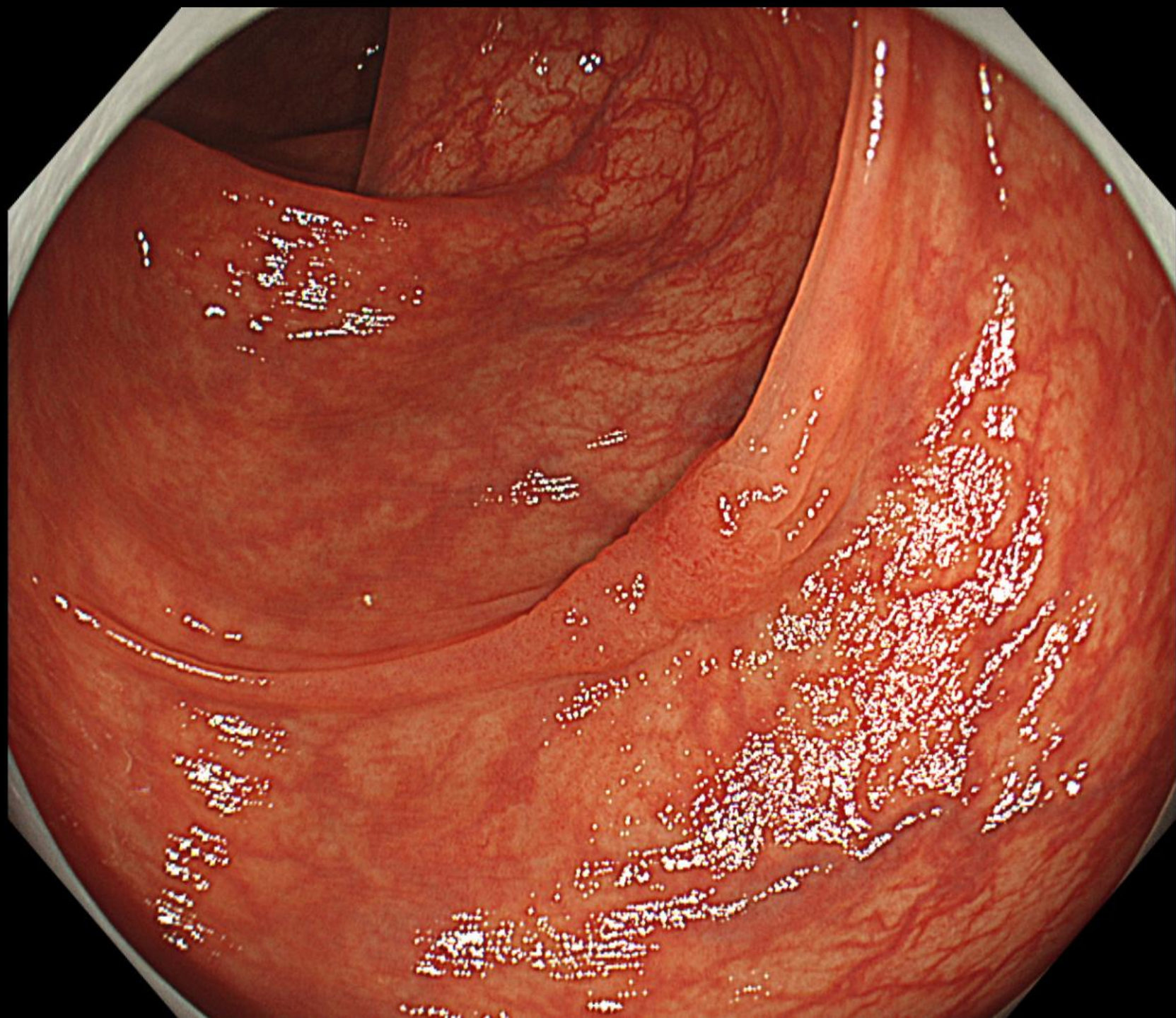


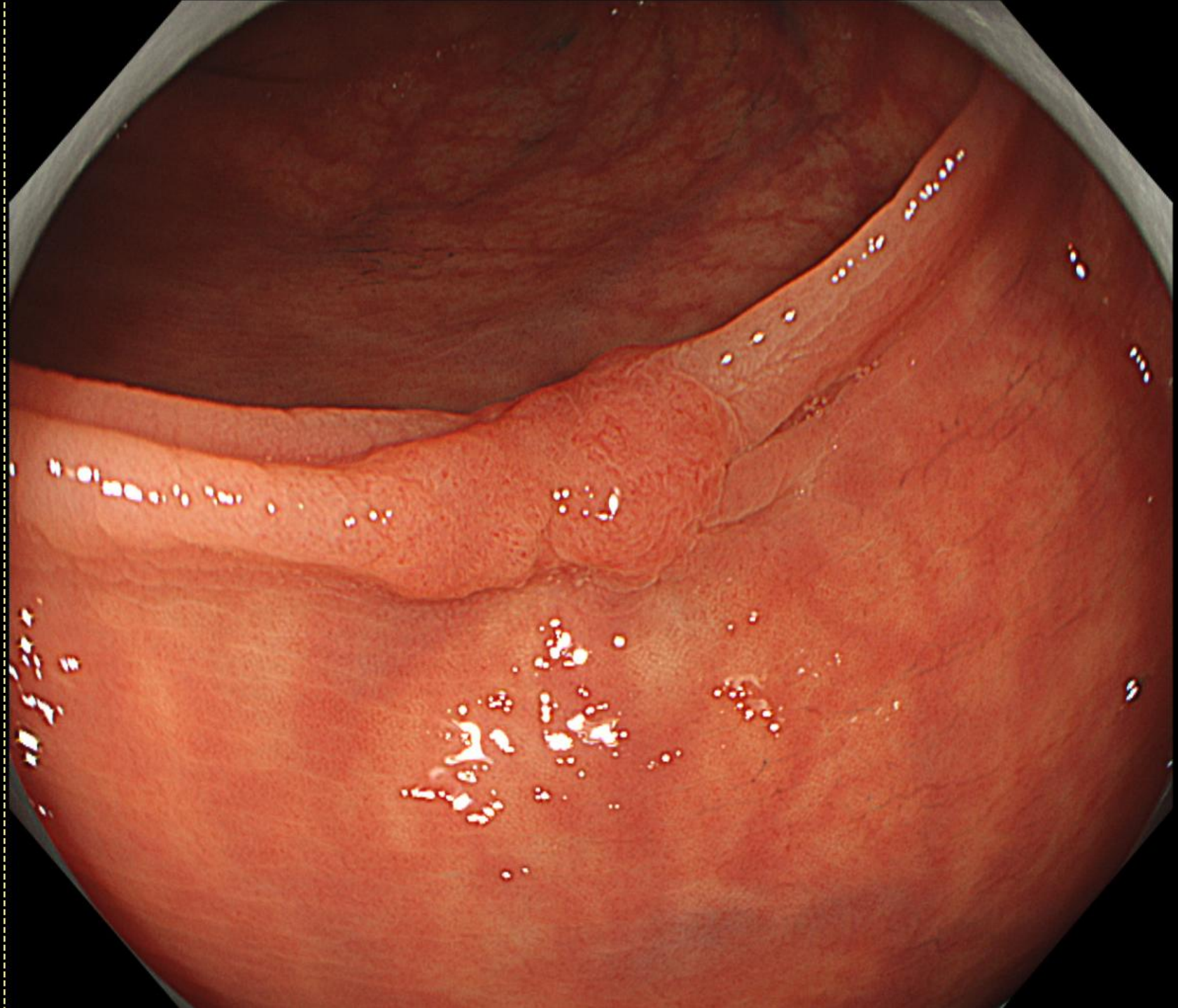
Mapping S状結腸

S

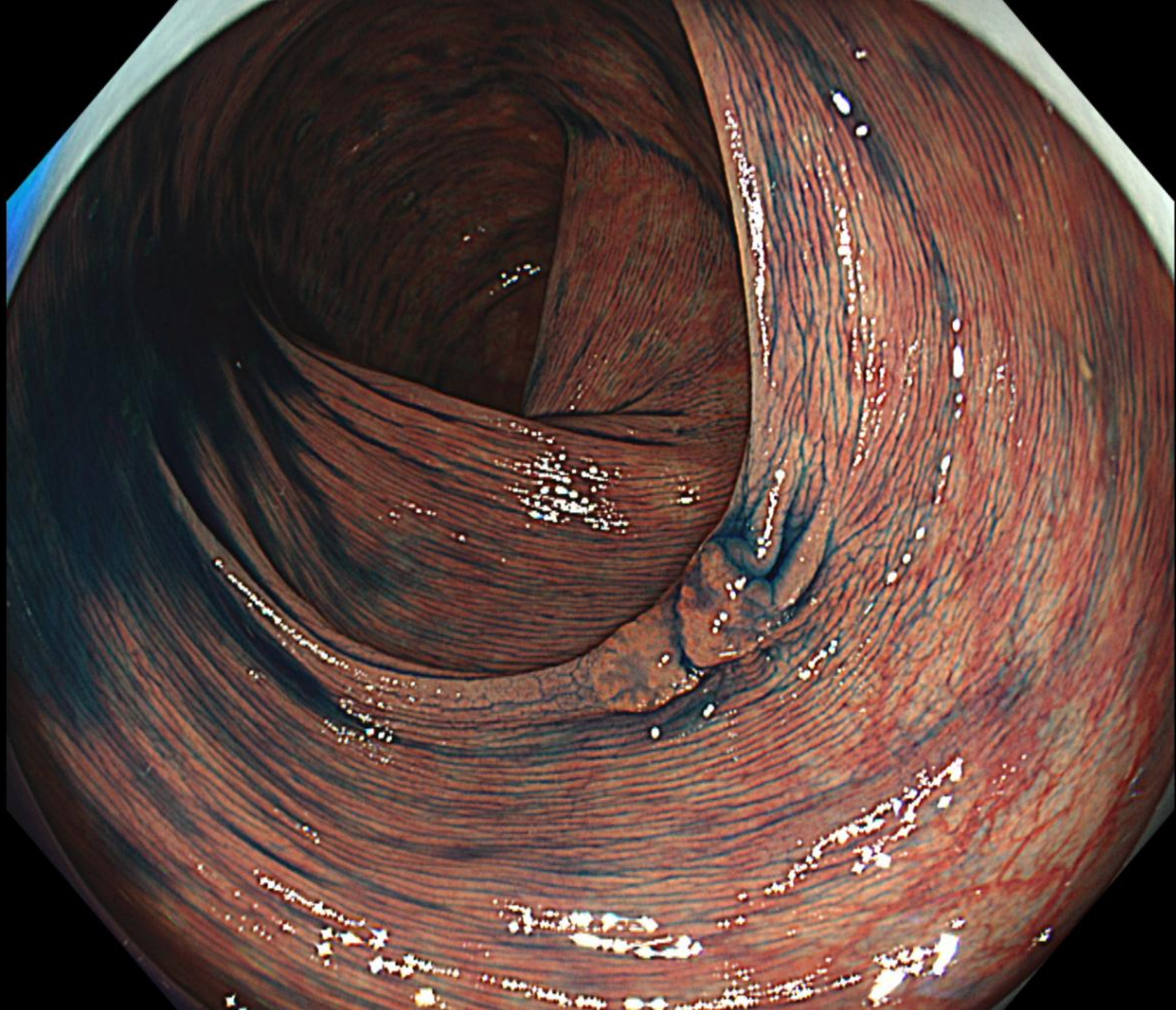
担当 伊丹 久実

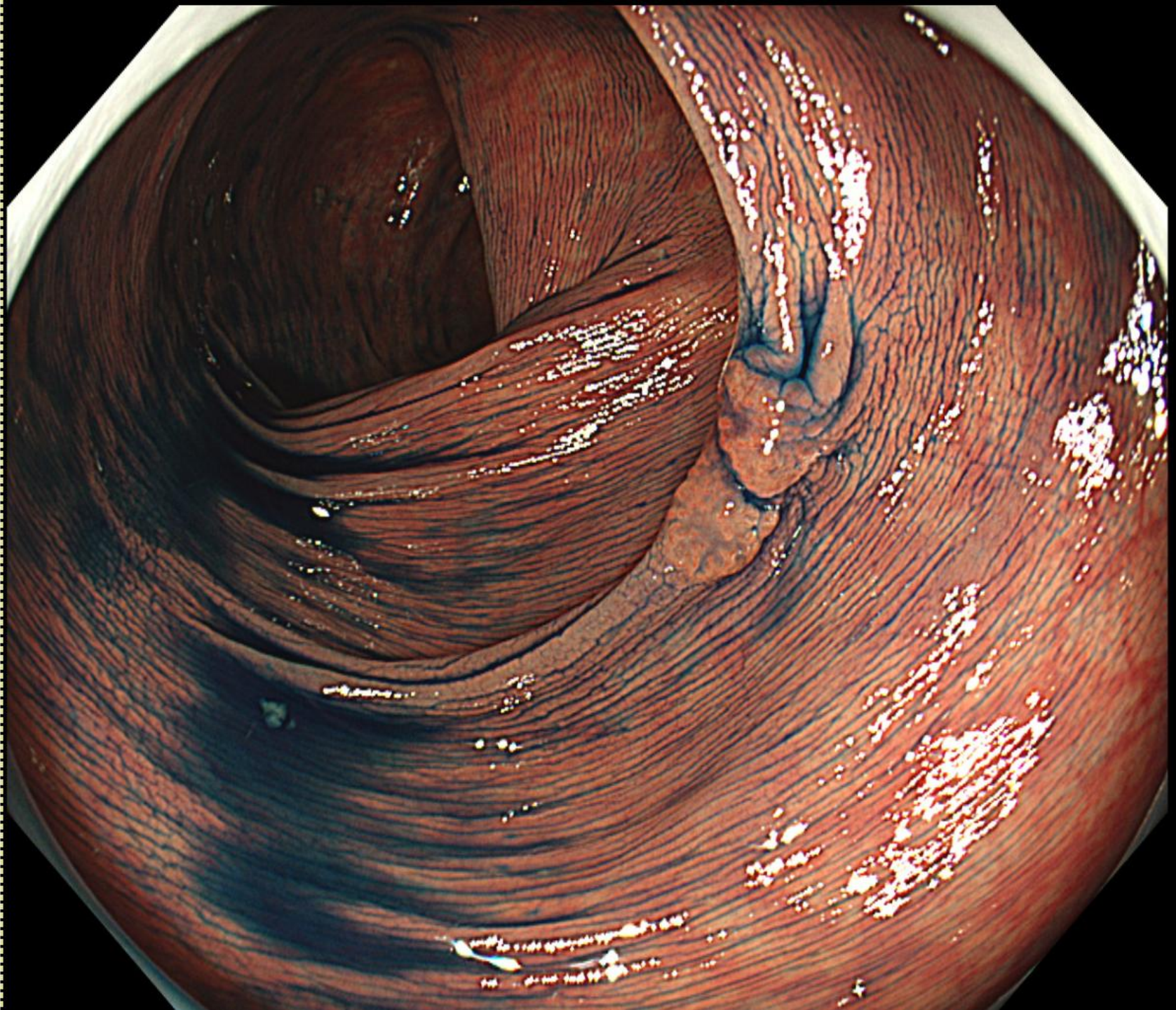
白色光
(2枚)

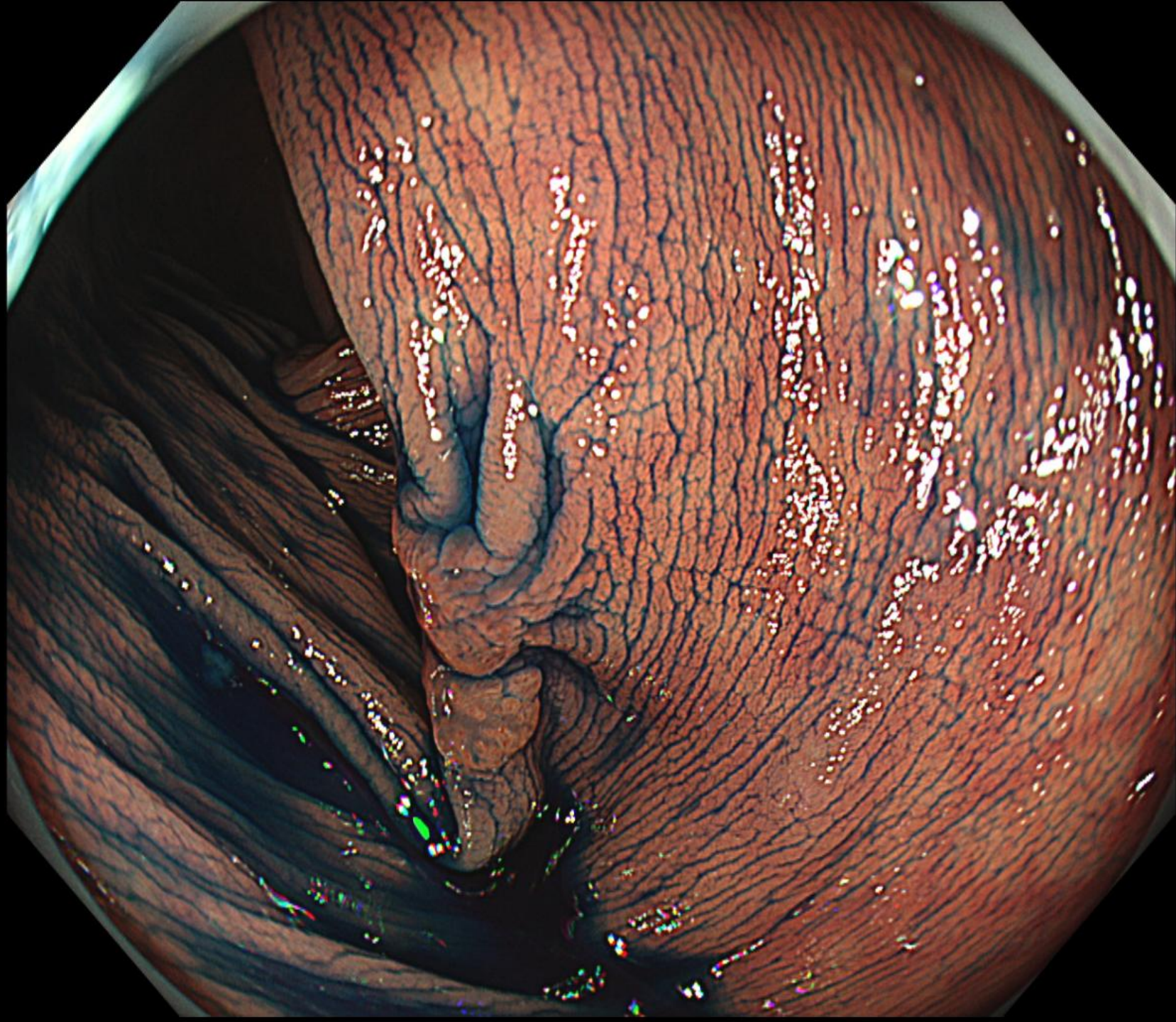


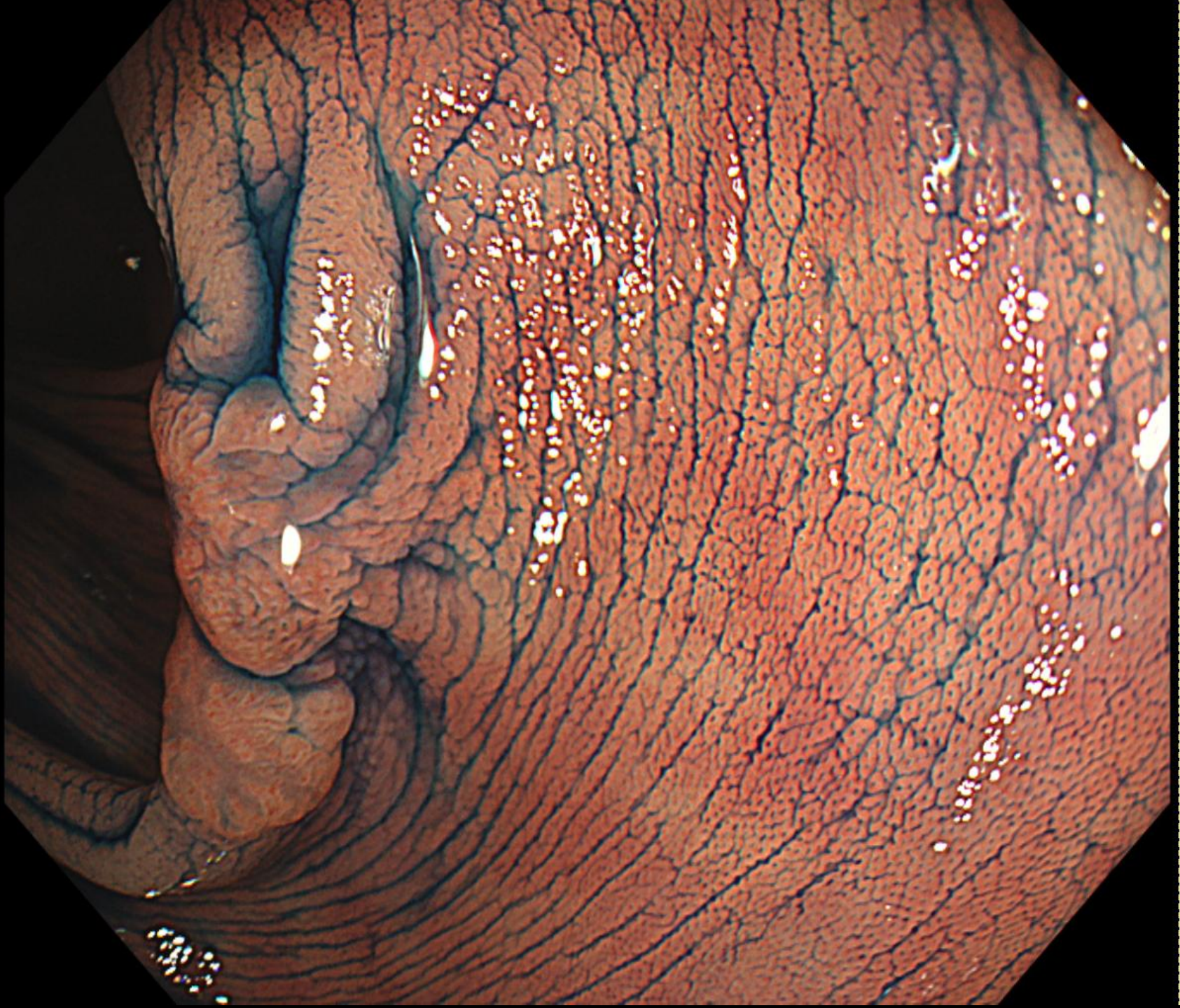


インジゴカルミン散布
(4枚)

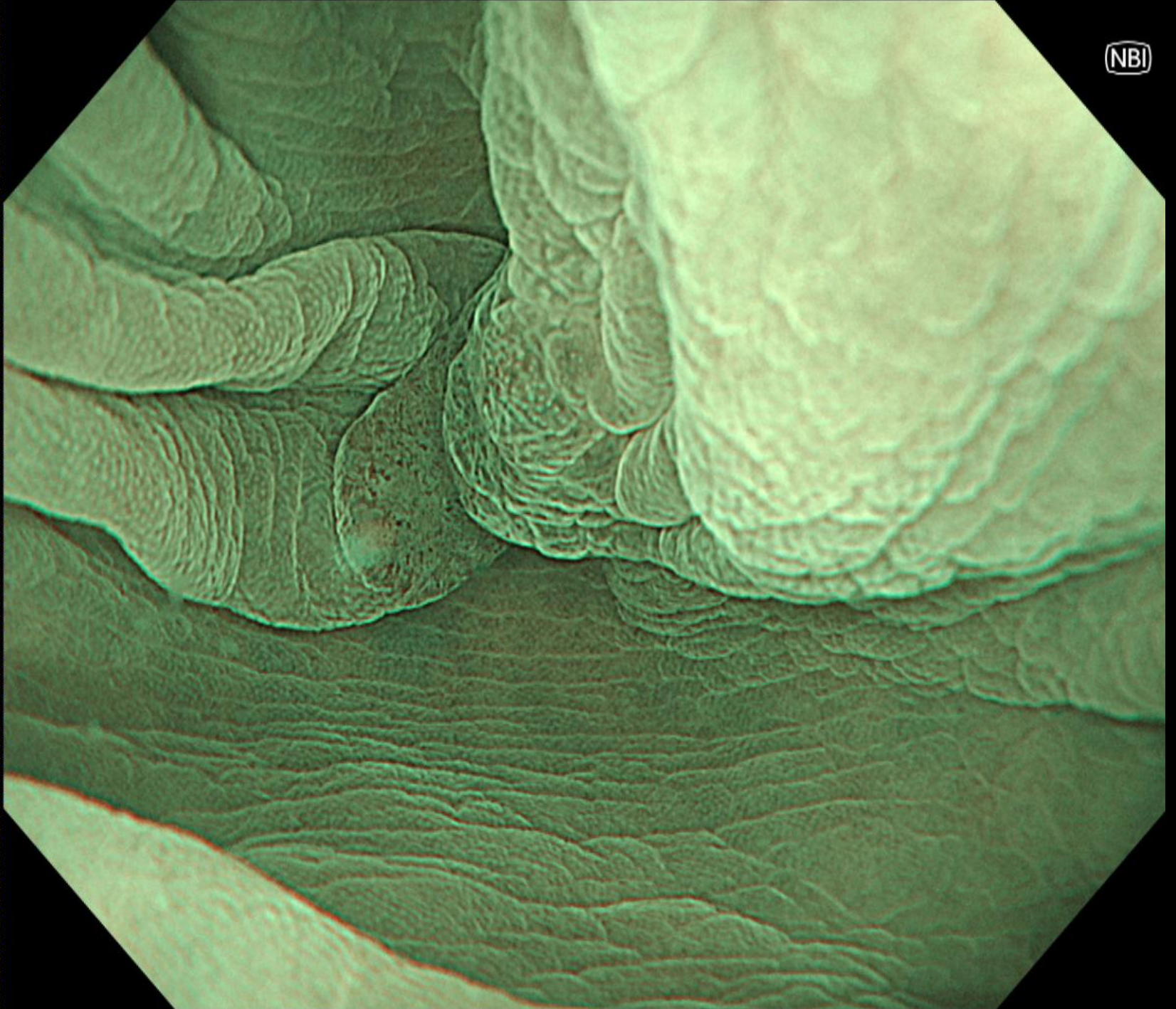


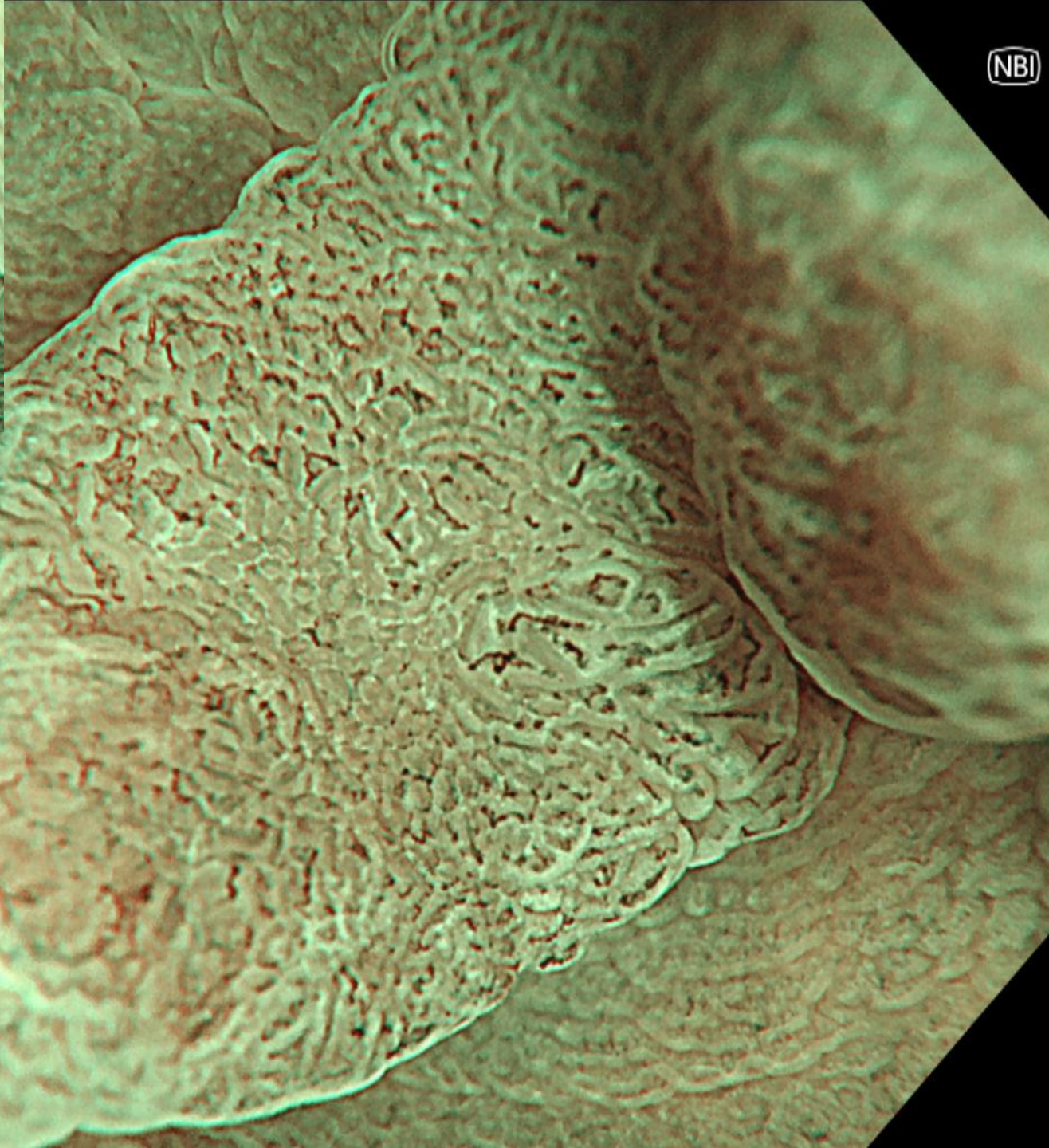


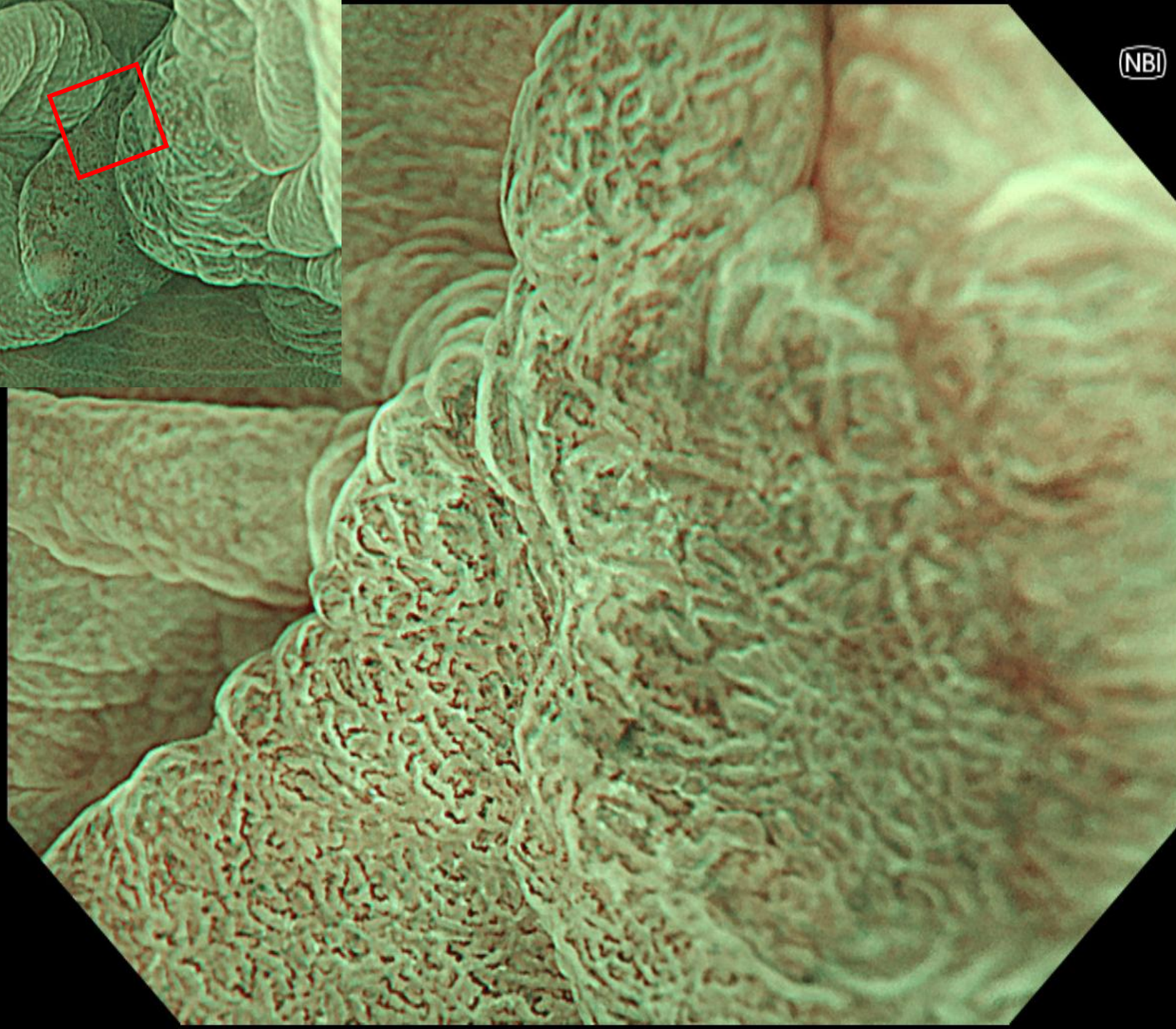




NBI
(3枚)







内視鏡診断

大腸腺腫

部位：S状結腸

大きさ：12mm 肉眼型：0-IIa

NBI観察：JNET

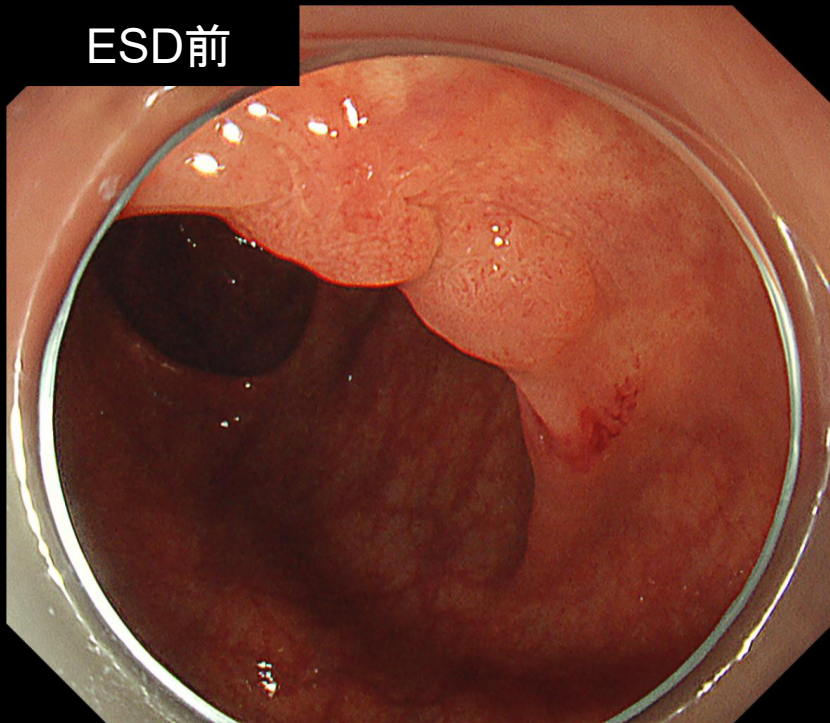
表面構造Type2A,

微小血管構造 Type2A

病変の中央陥凹部にひきつれがあるように見える

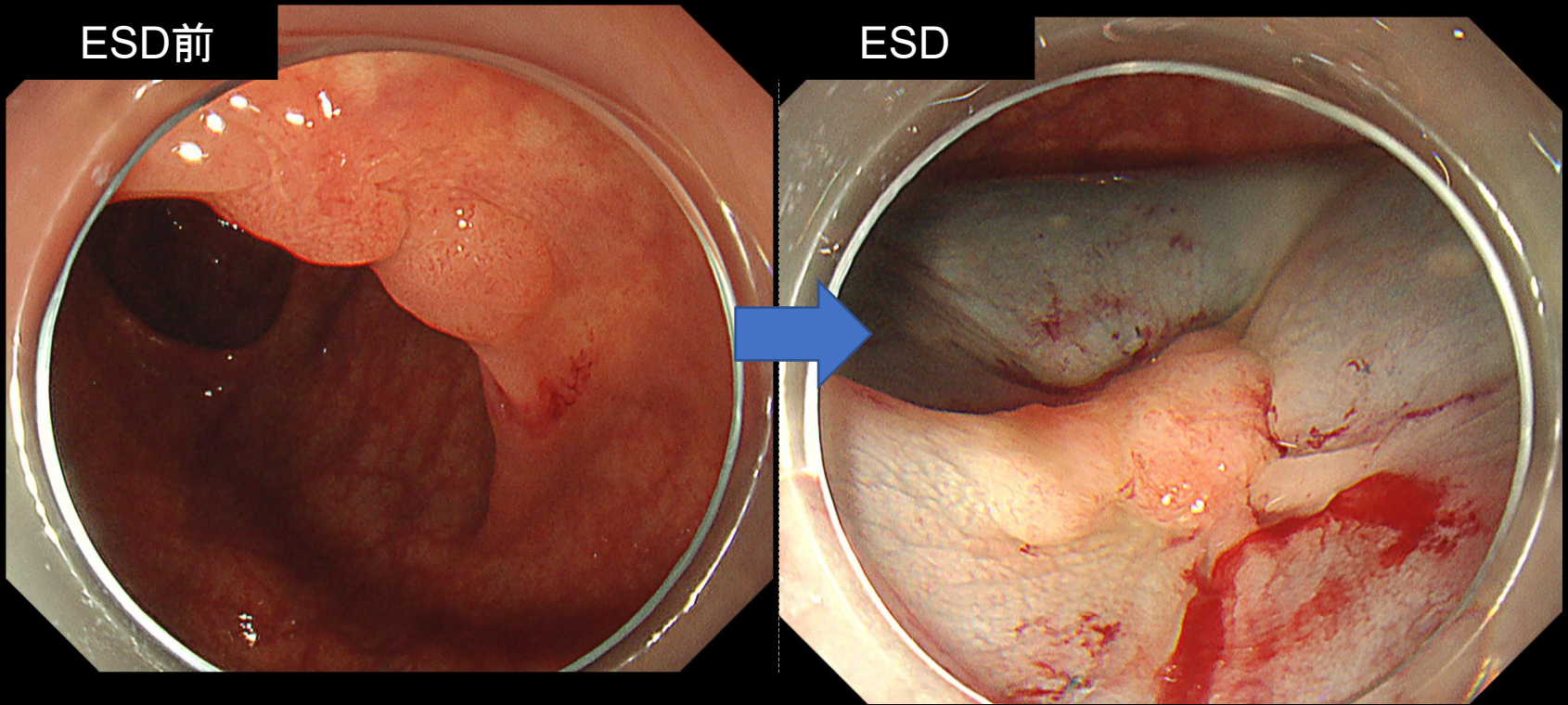
ESD

ESD前

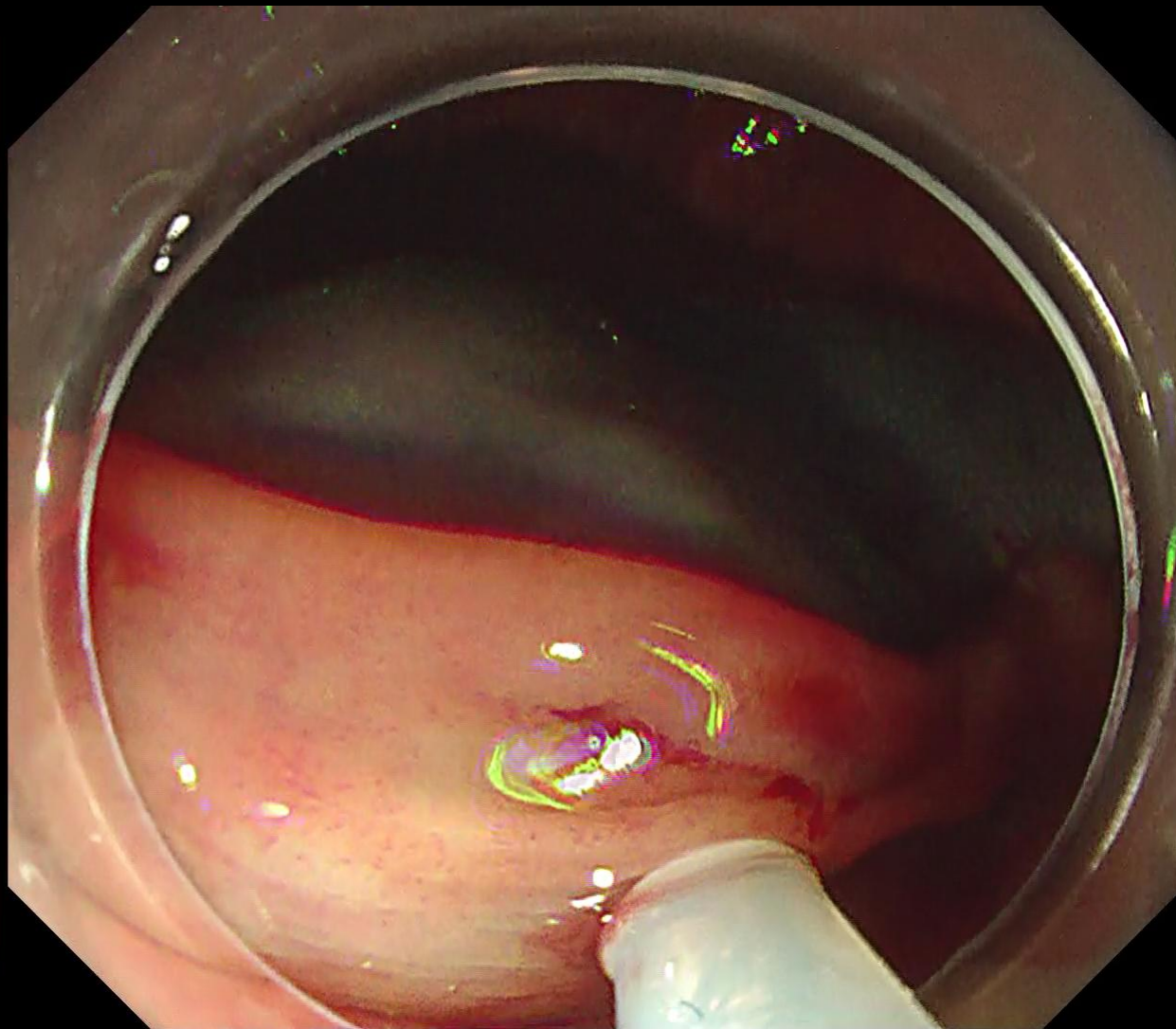


ESD前

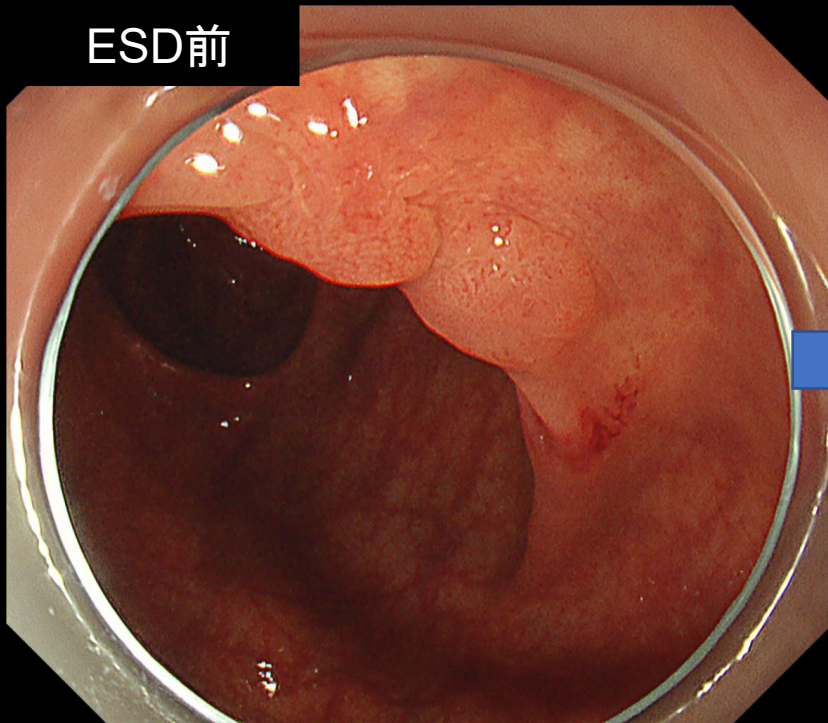
ESD



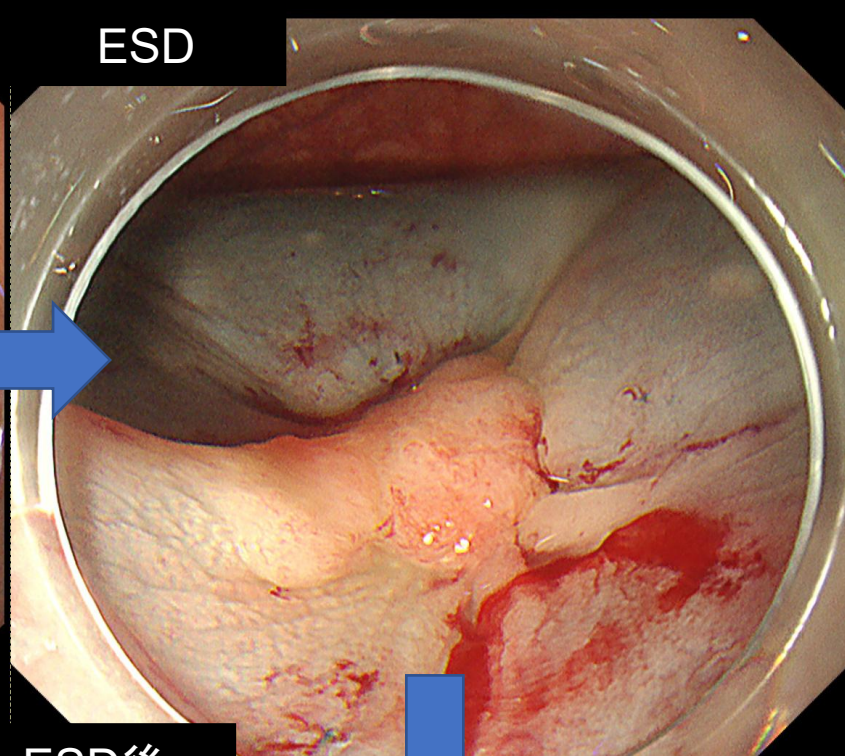
局注1



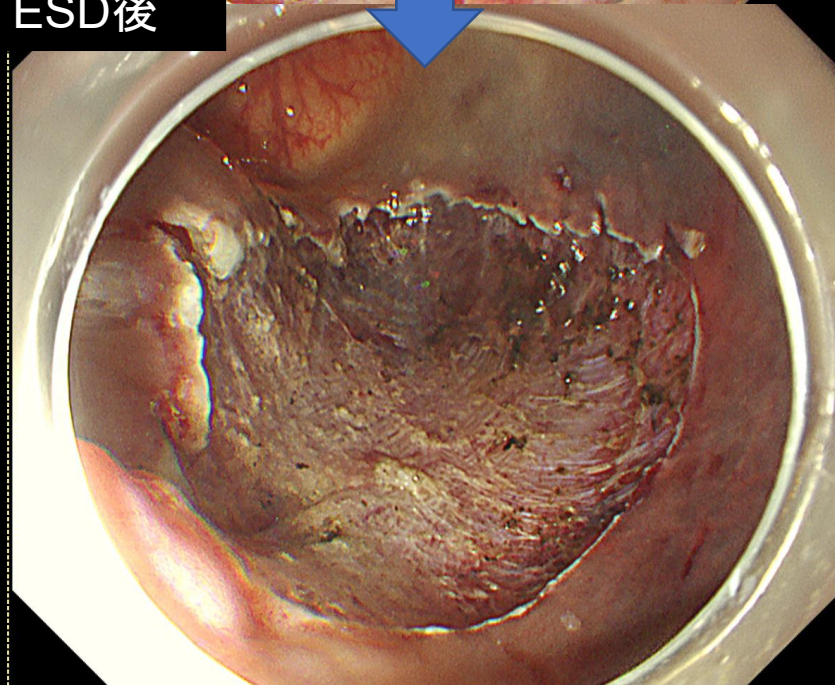
ESD前

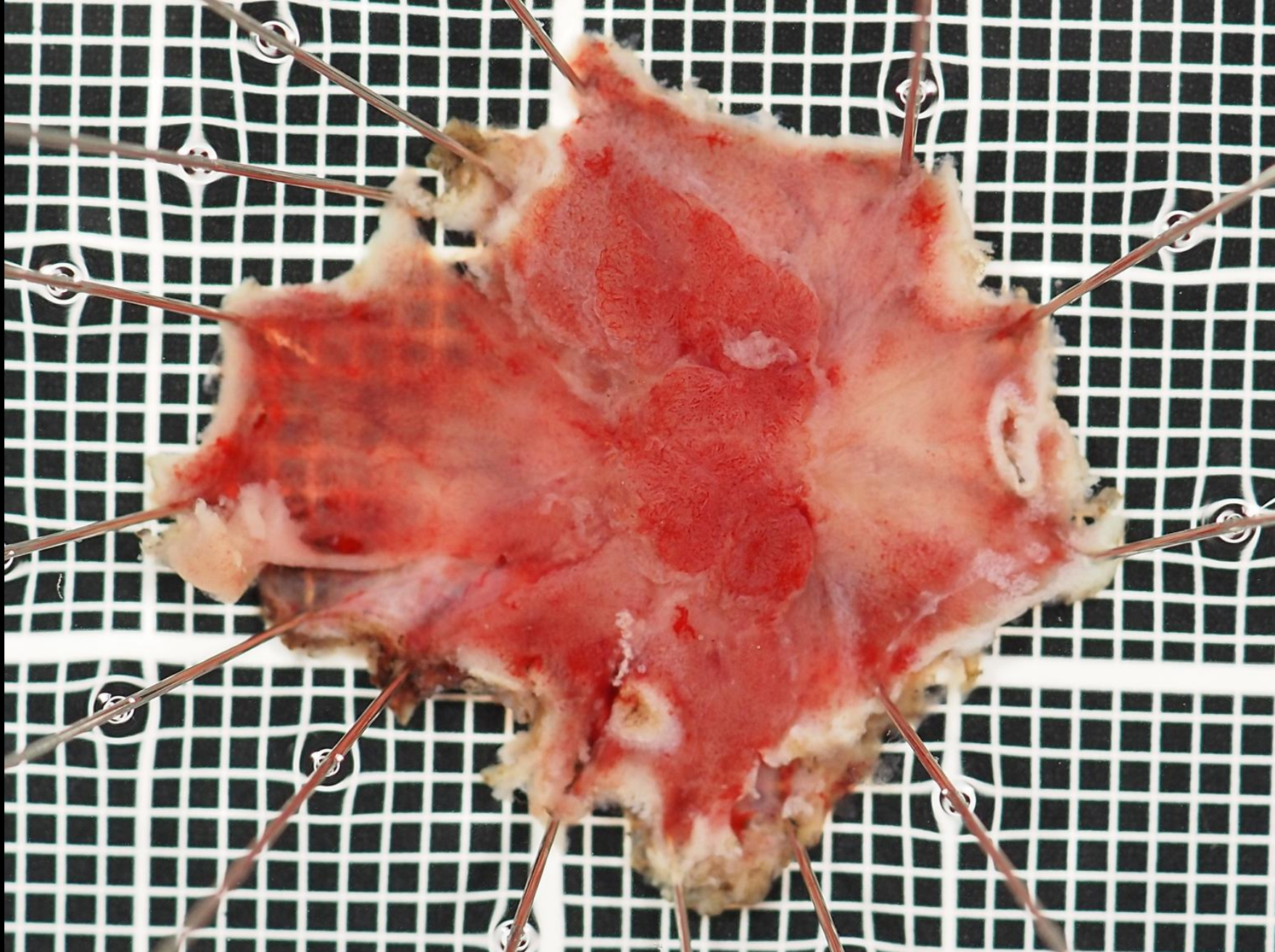


ESD



ESD後





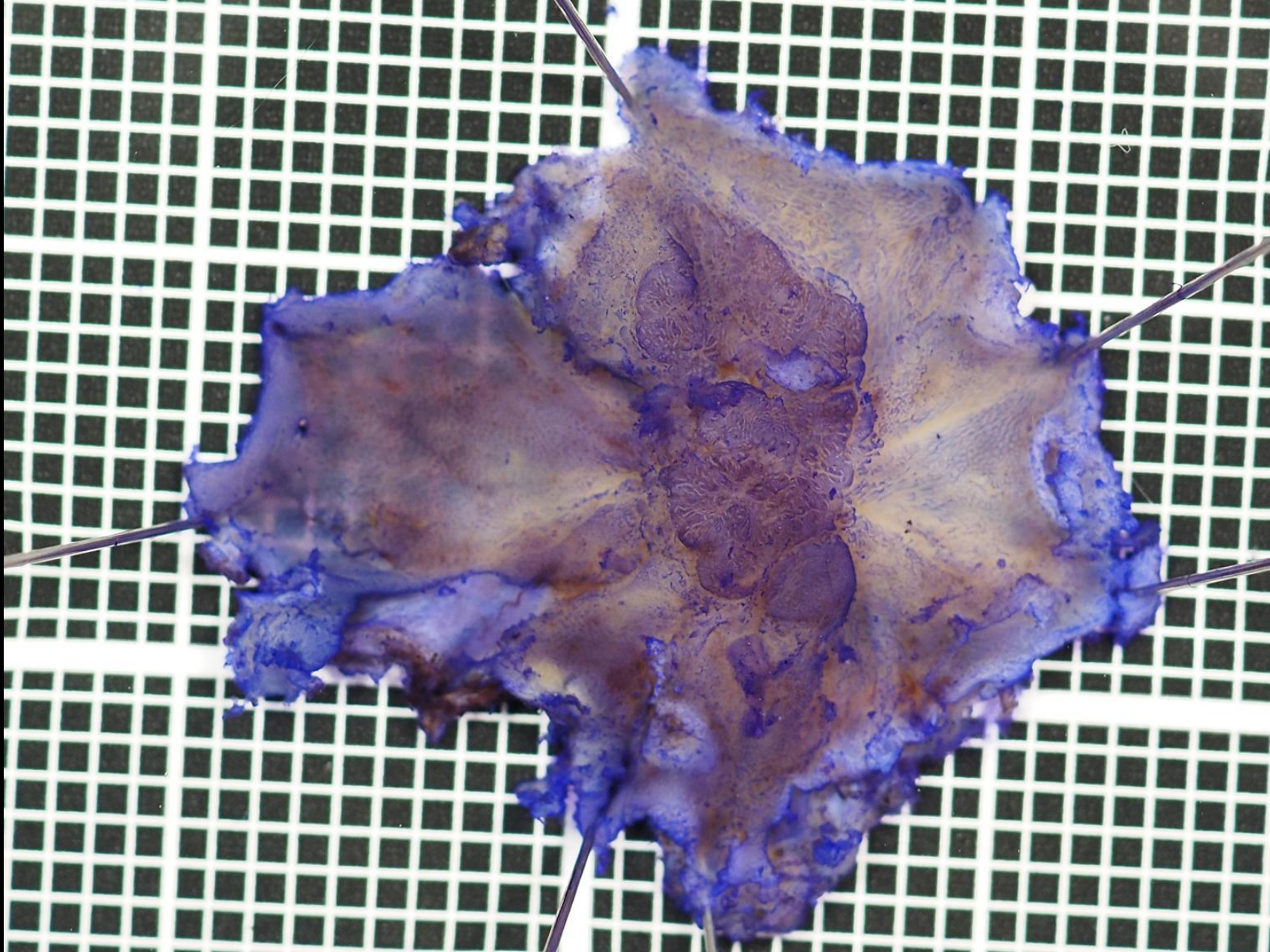
肛門側

口側



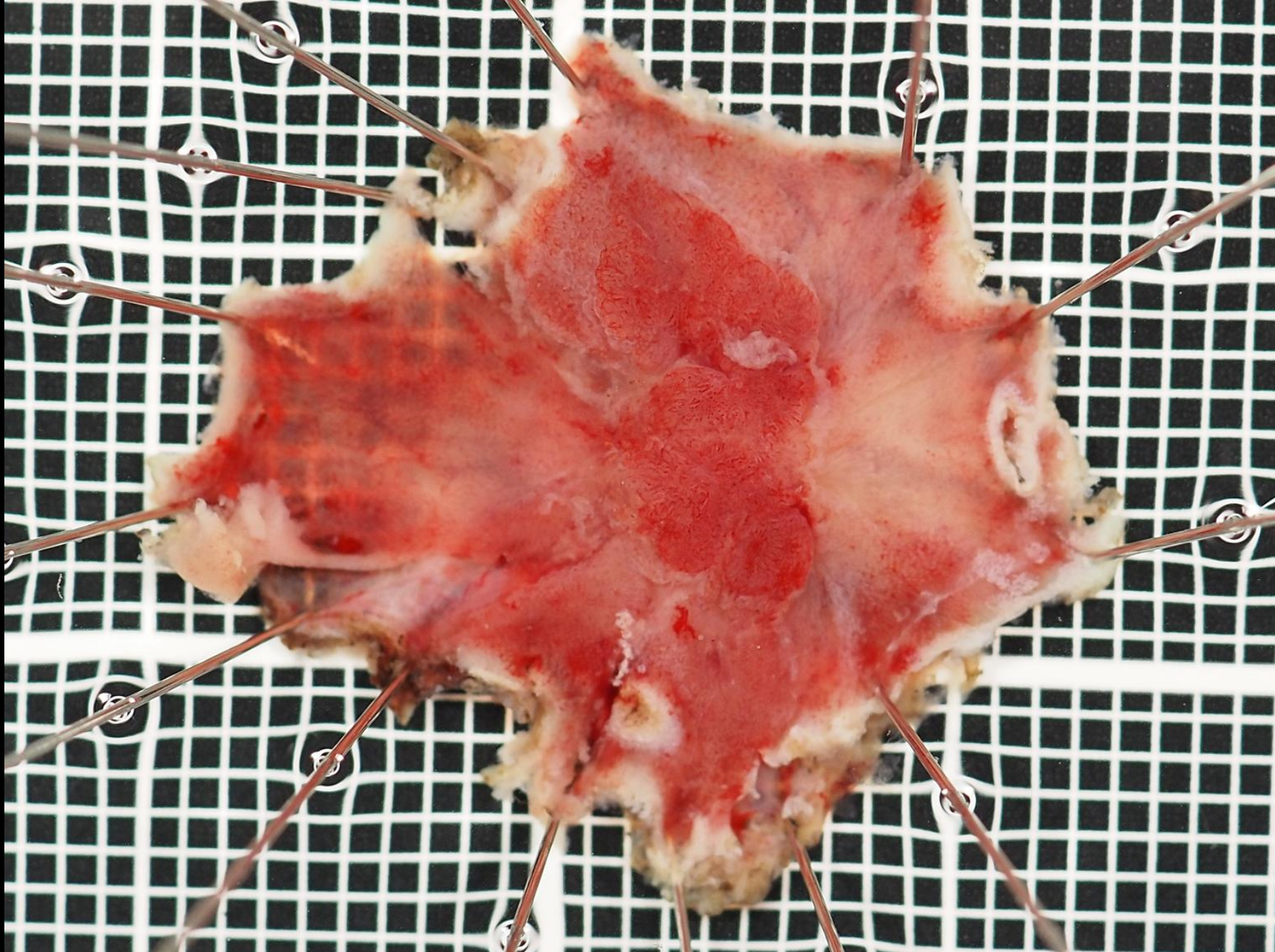
肛門側

口側



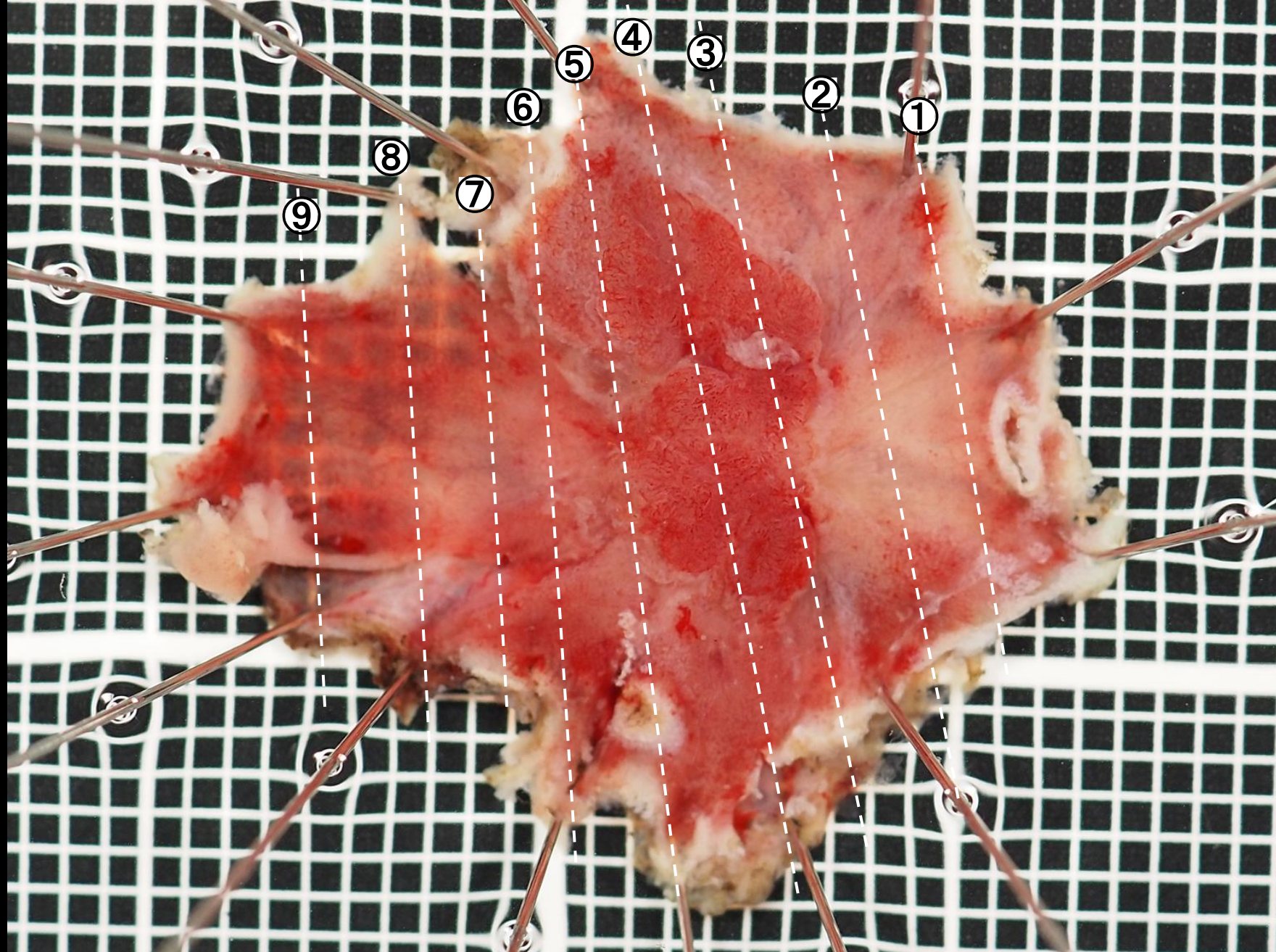
肛門側

口側



肛門側

口側



肛門側

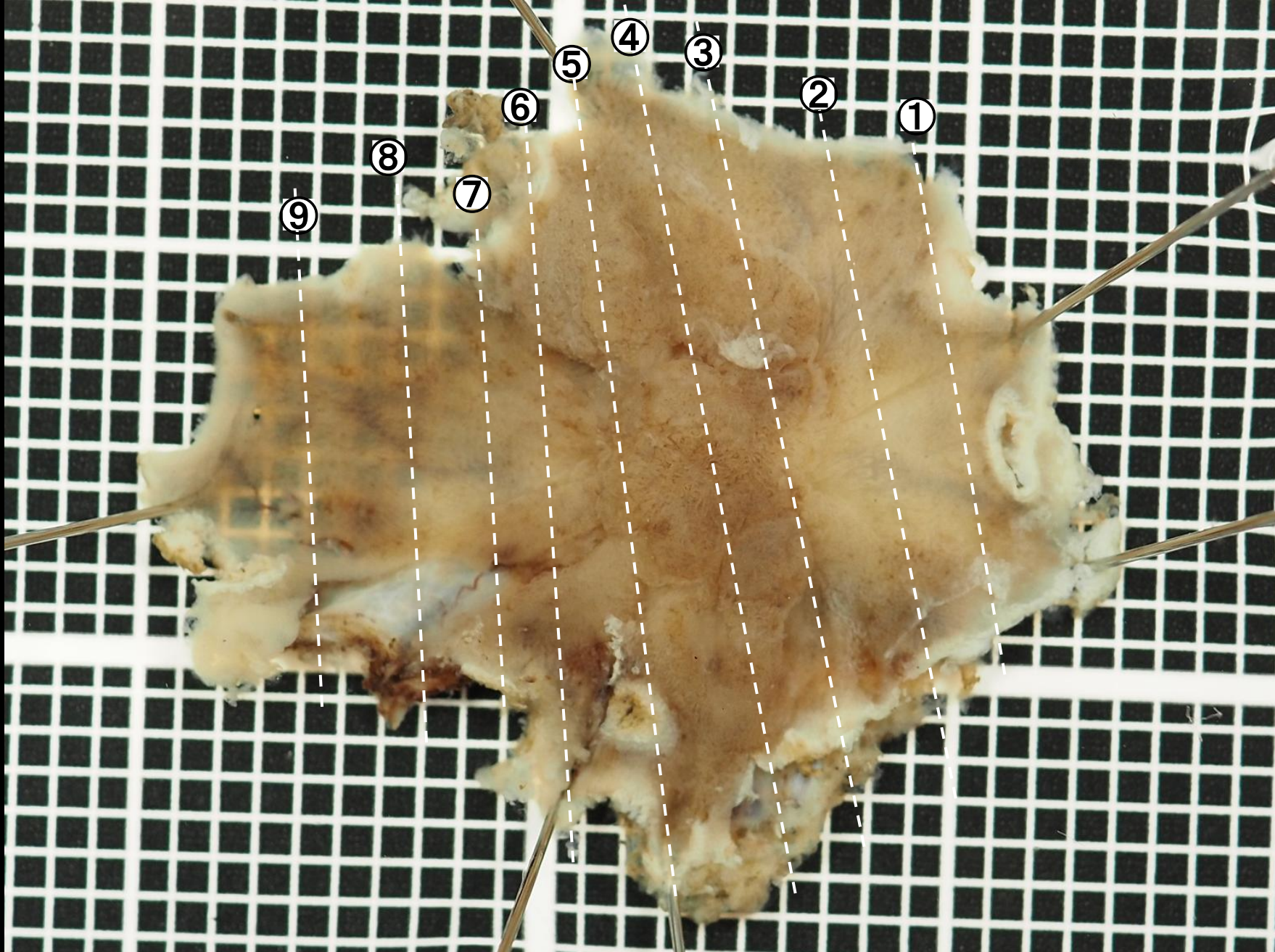


口側



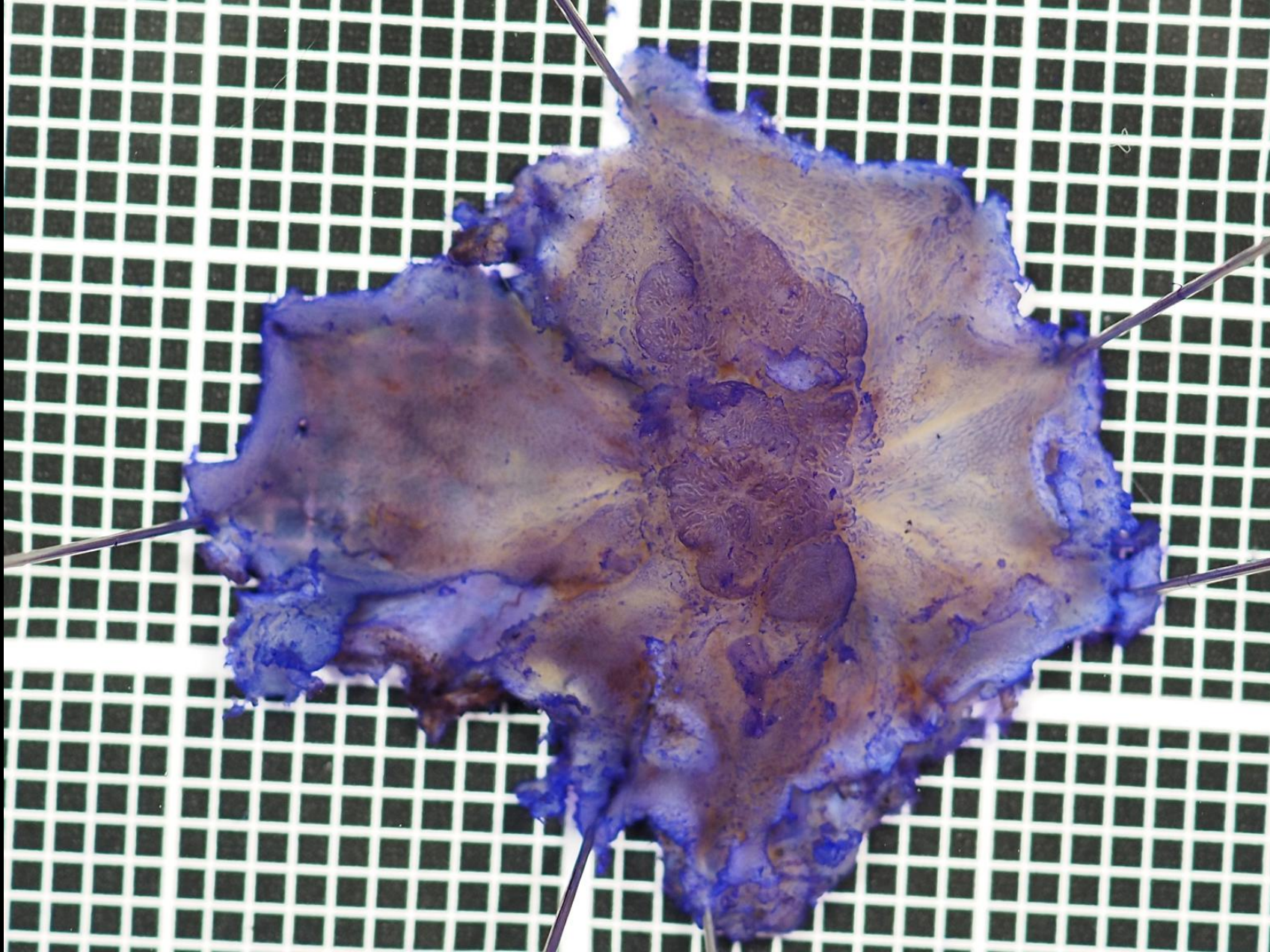
肛門側

口側



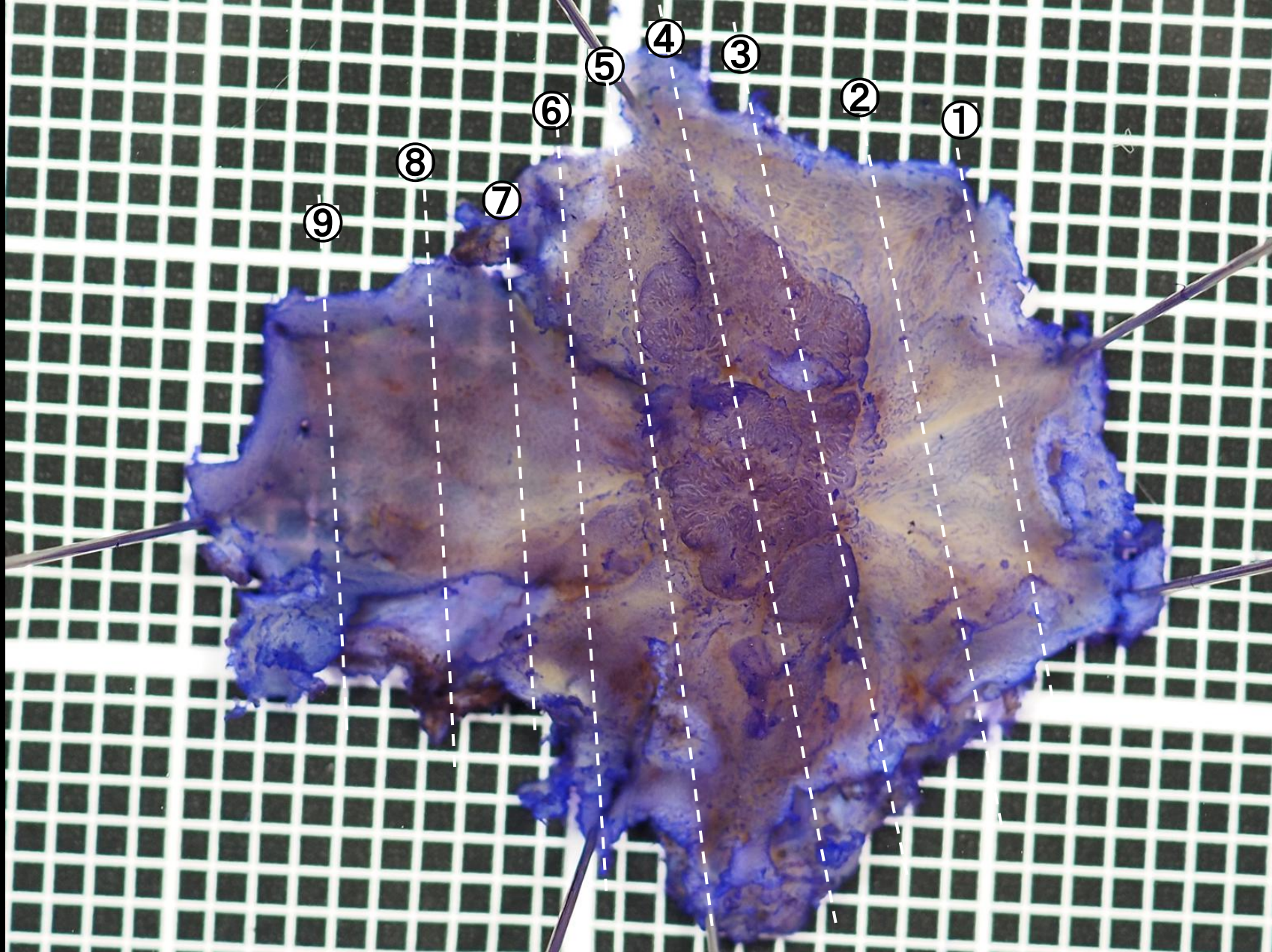
肛門側

口側



肛門側

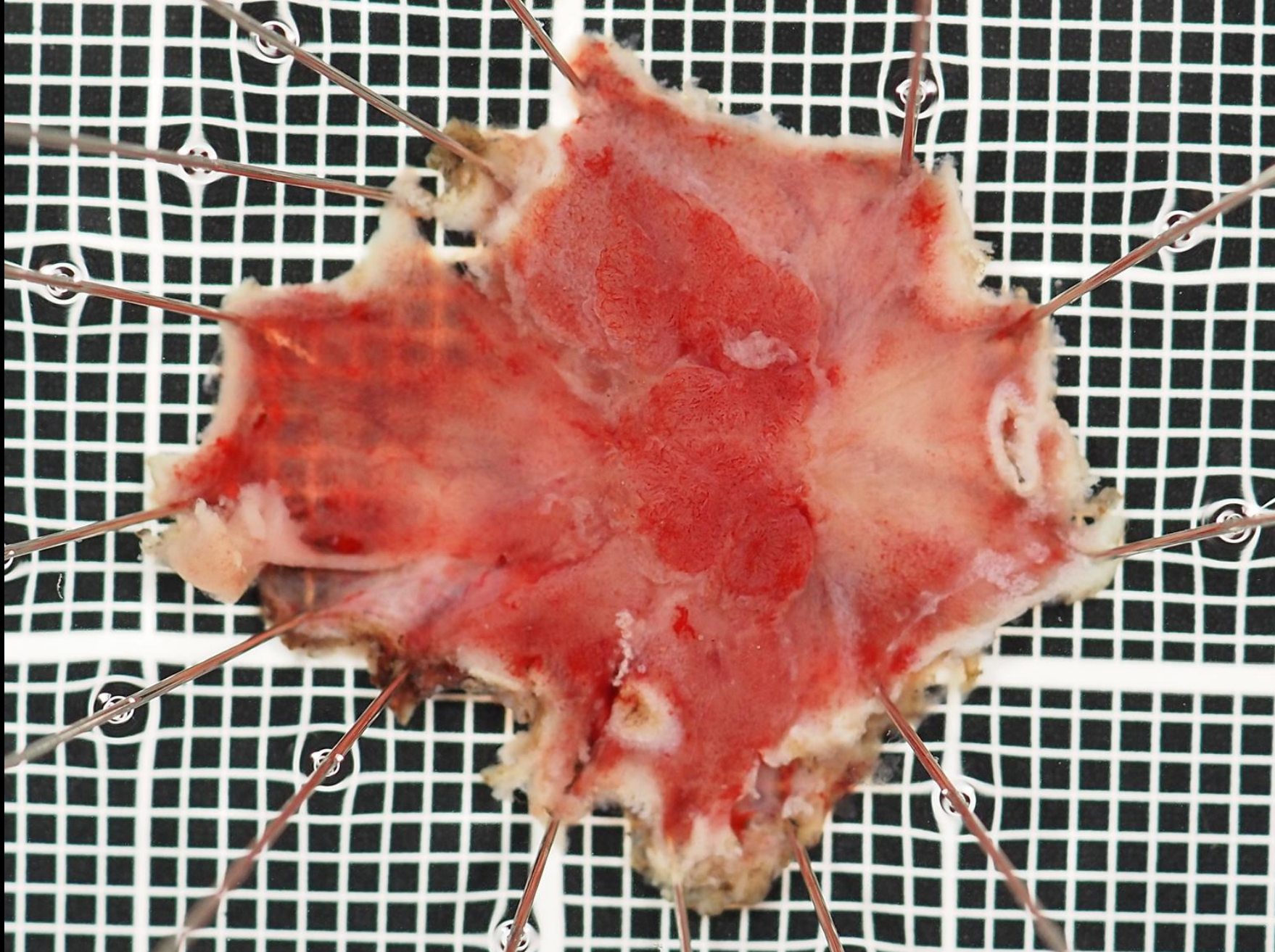
口側



肛門側

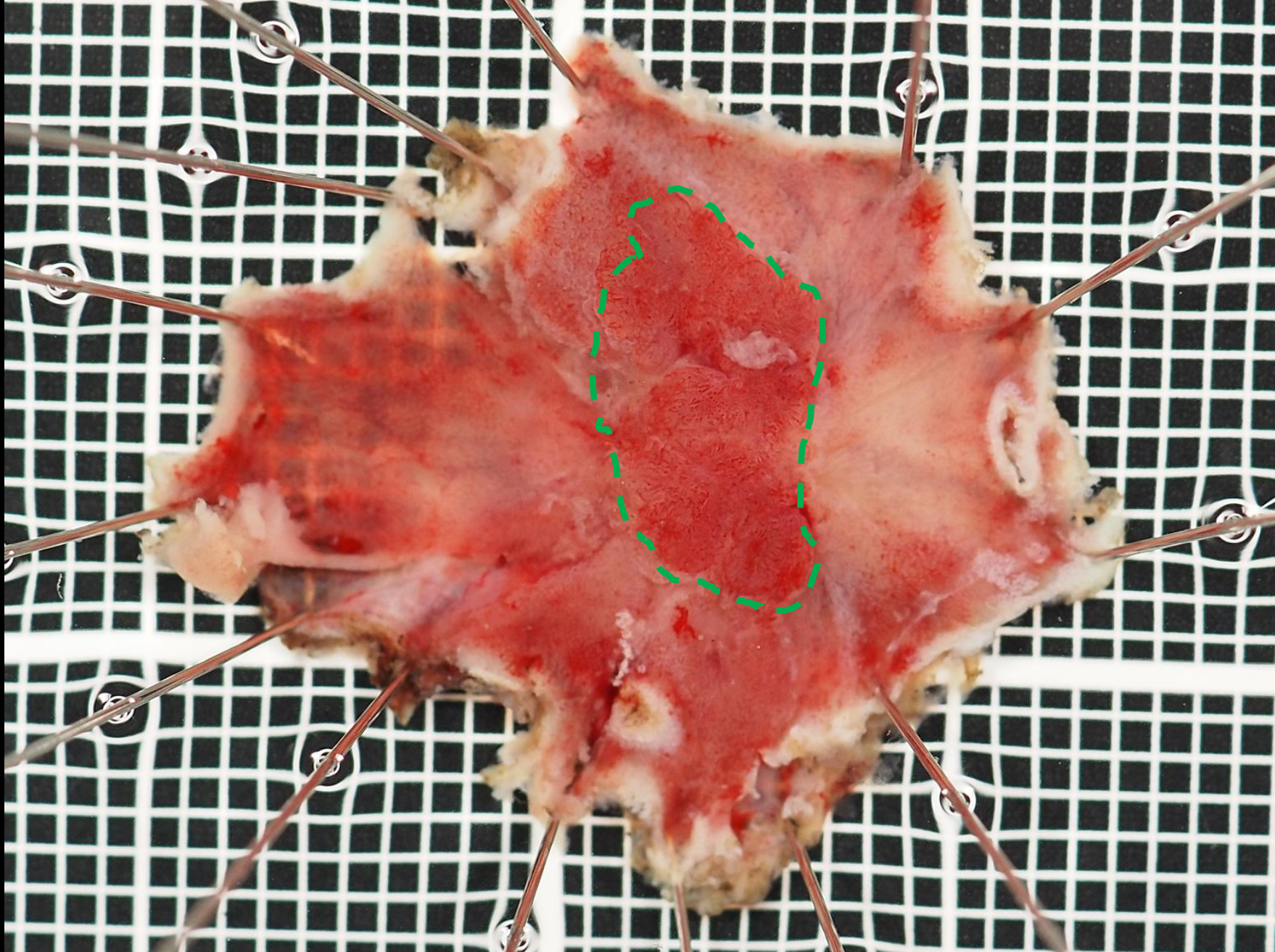


口側



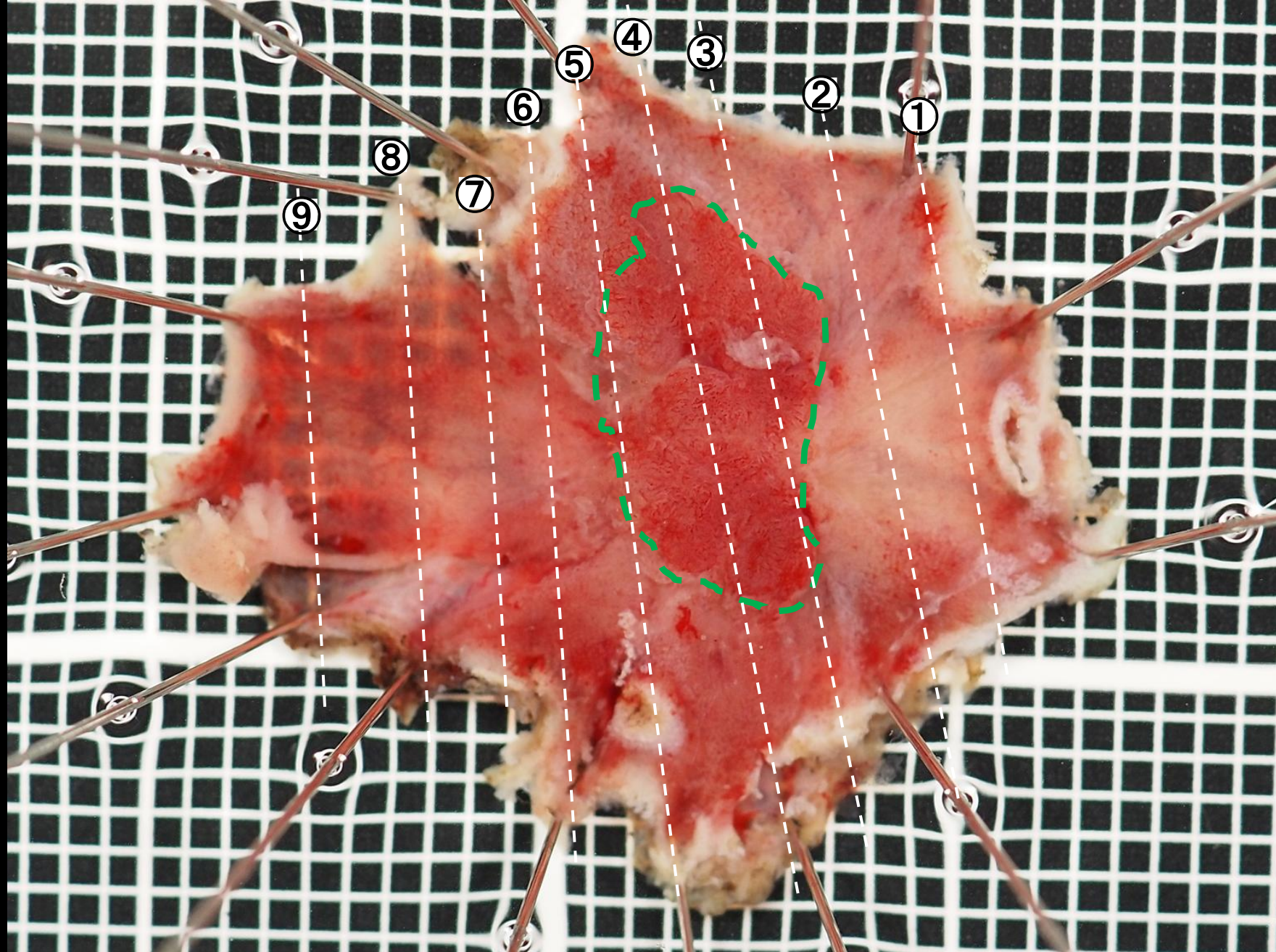
肛門側

口側



肛門側

口側



肛門側

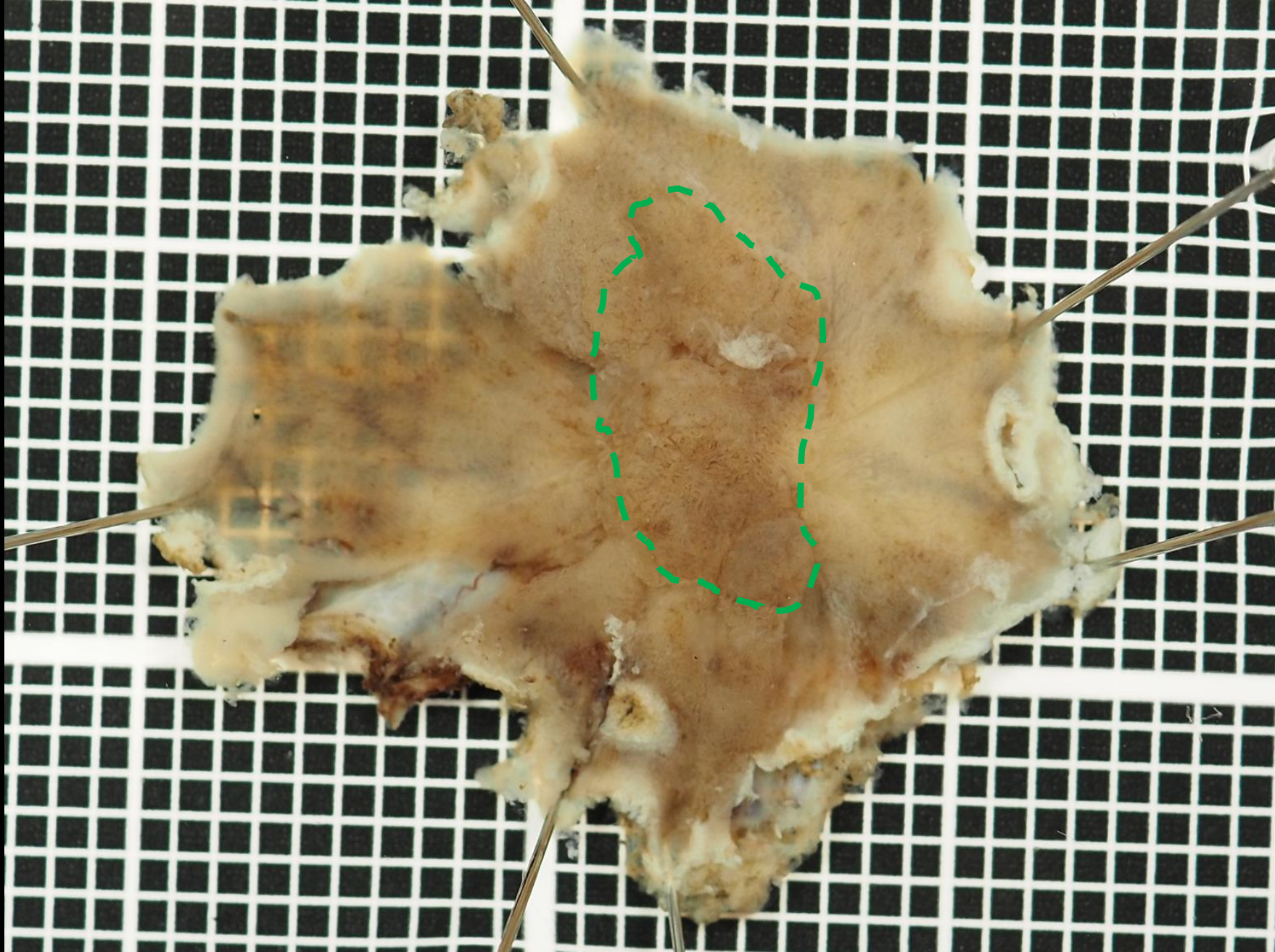


口側



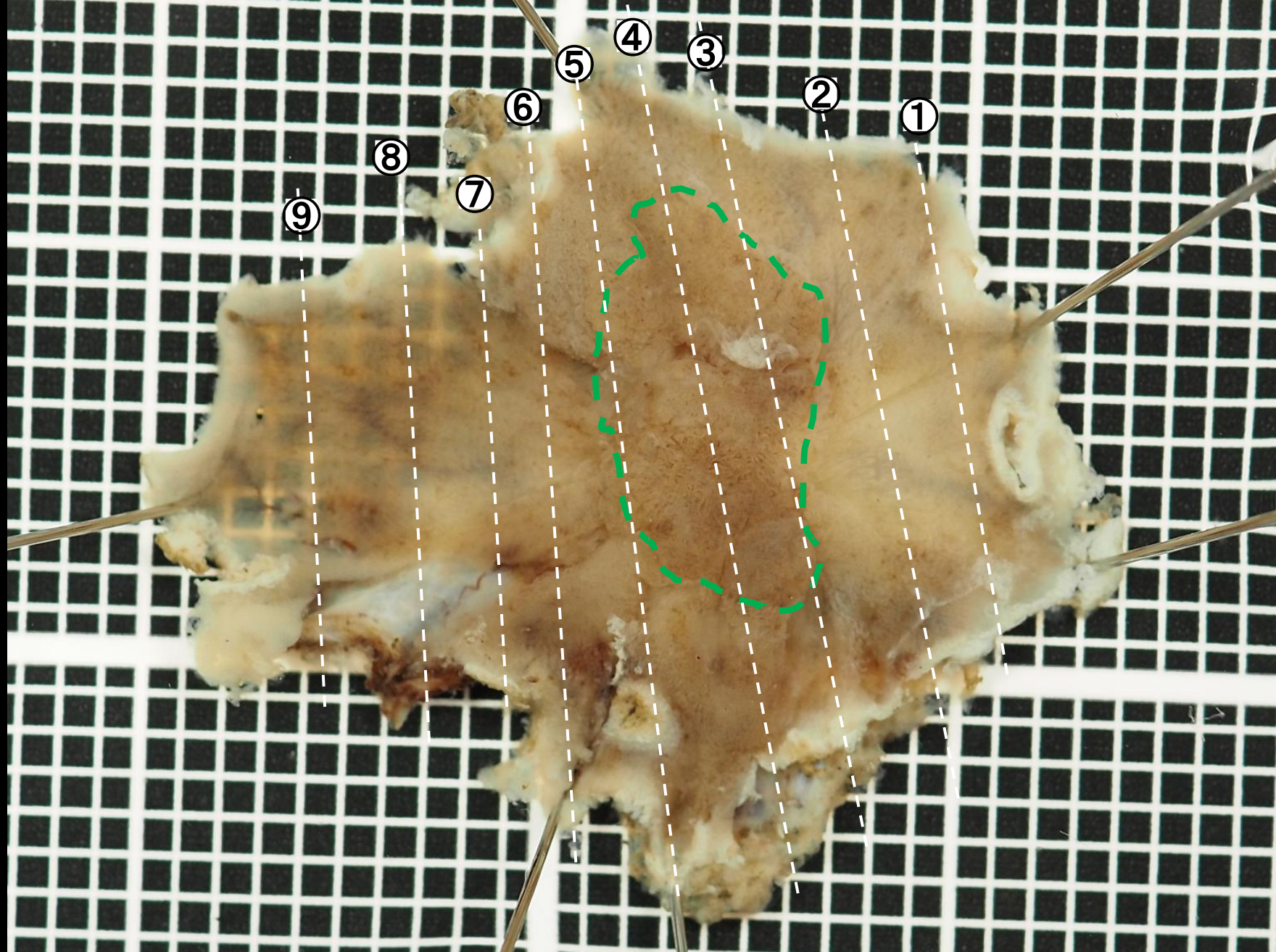
肛門側

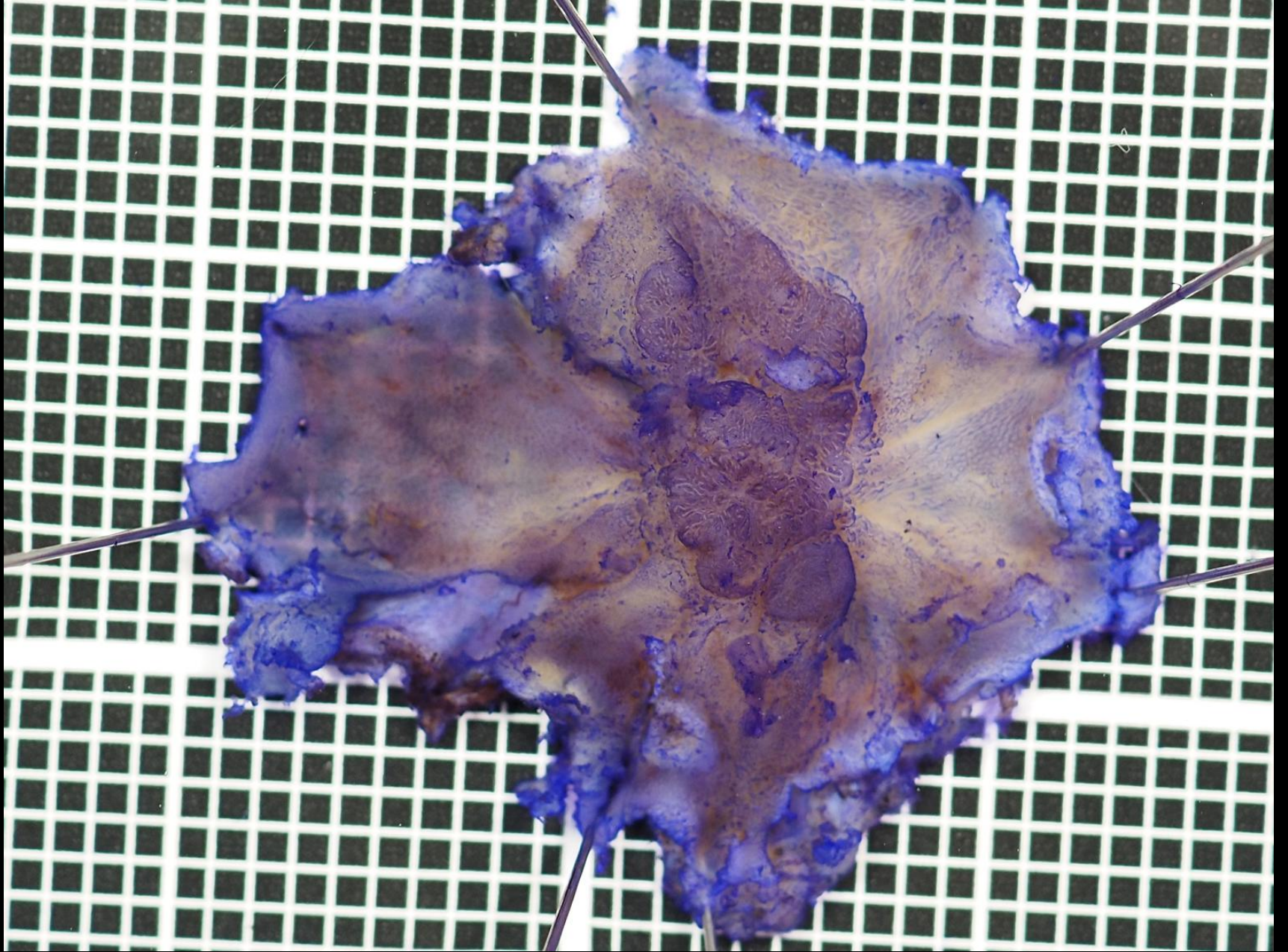
口側



肛門側

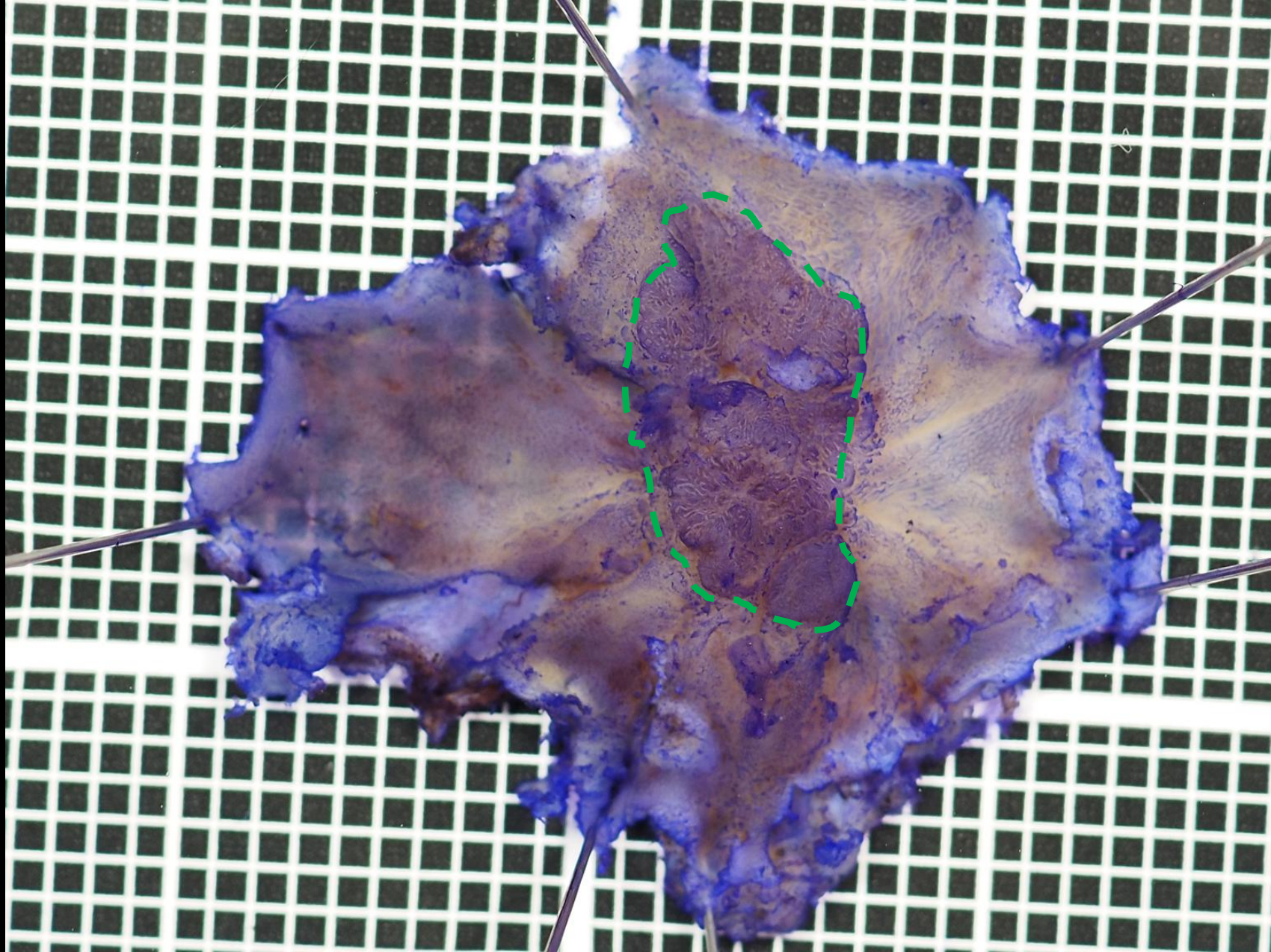
口側





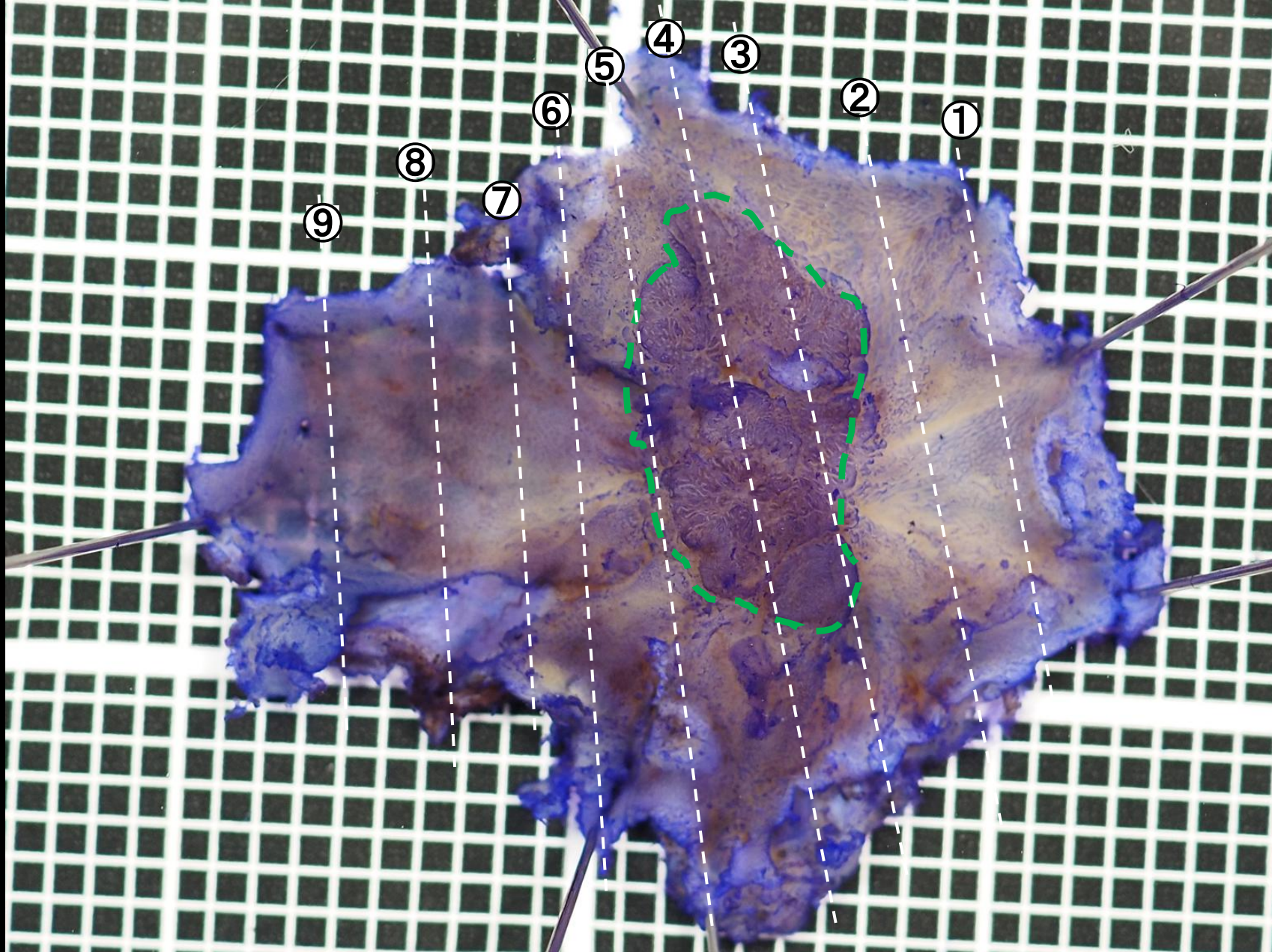
肛門側

口側



肛門側

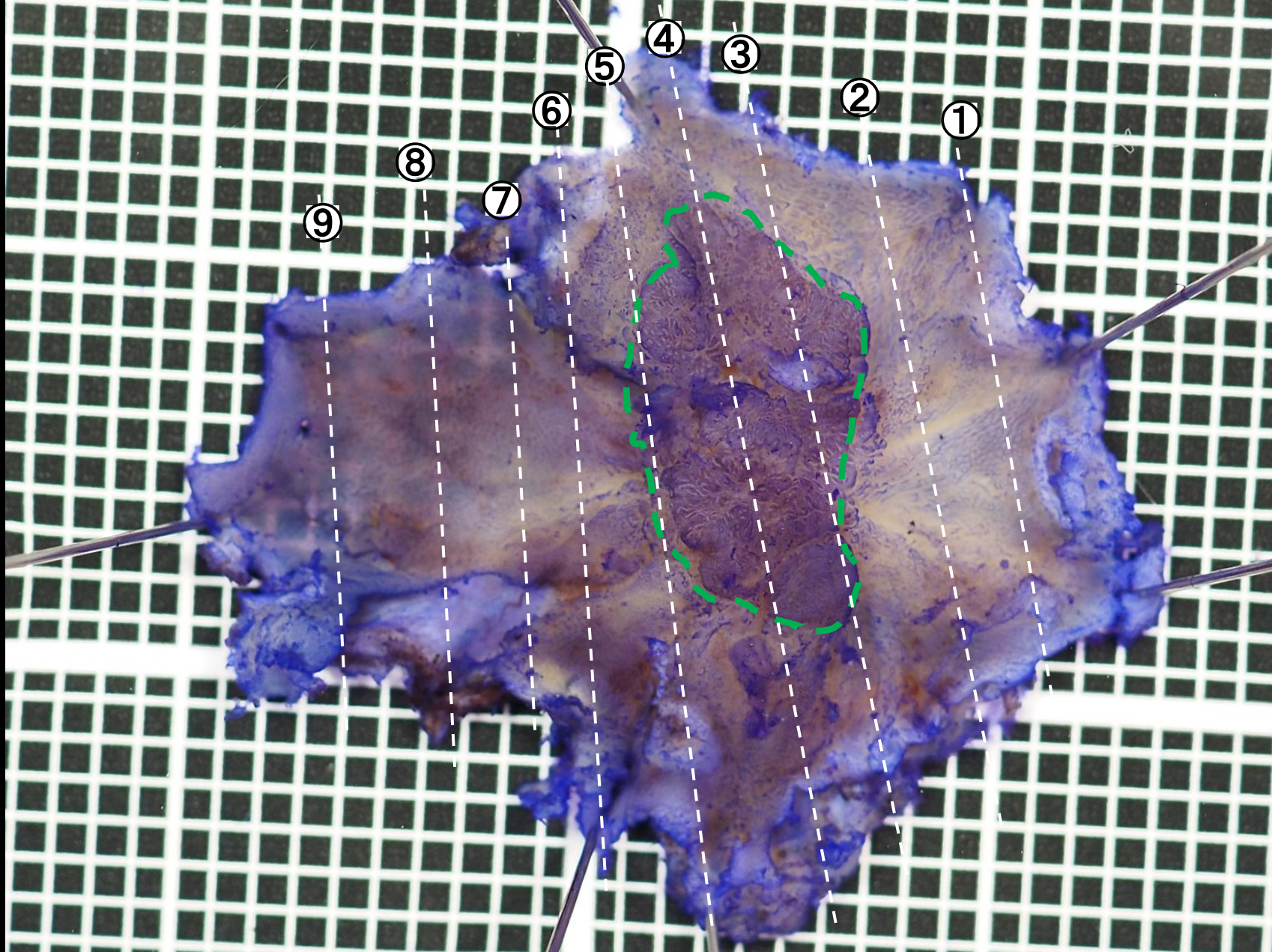
口側

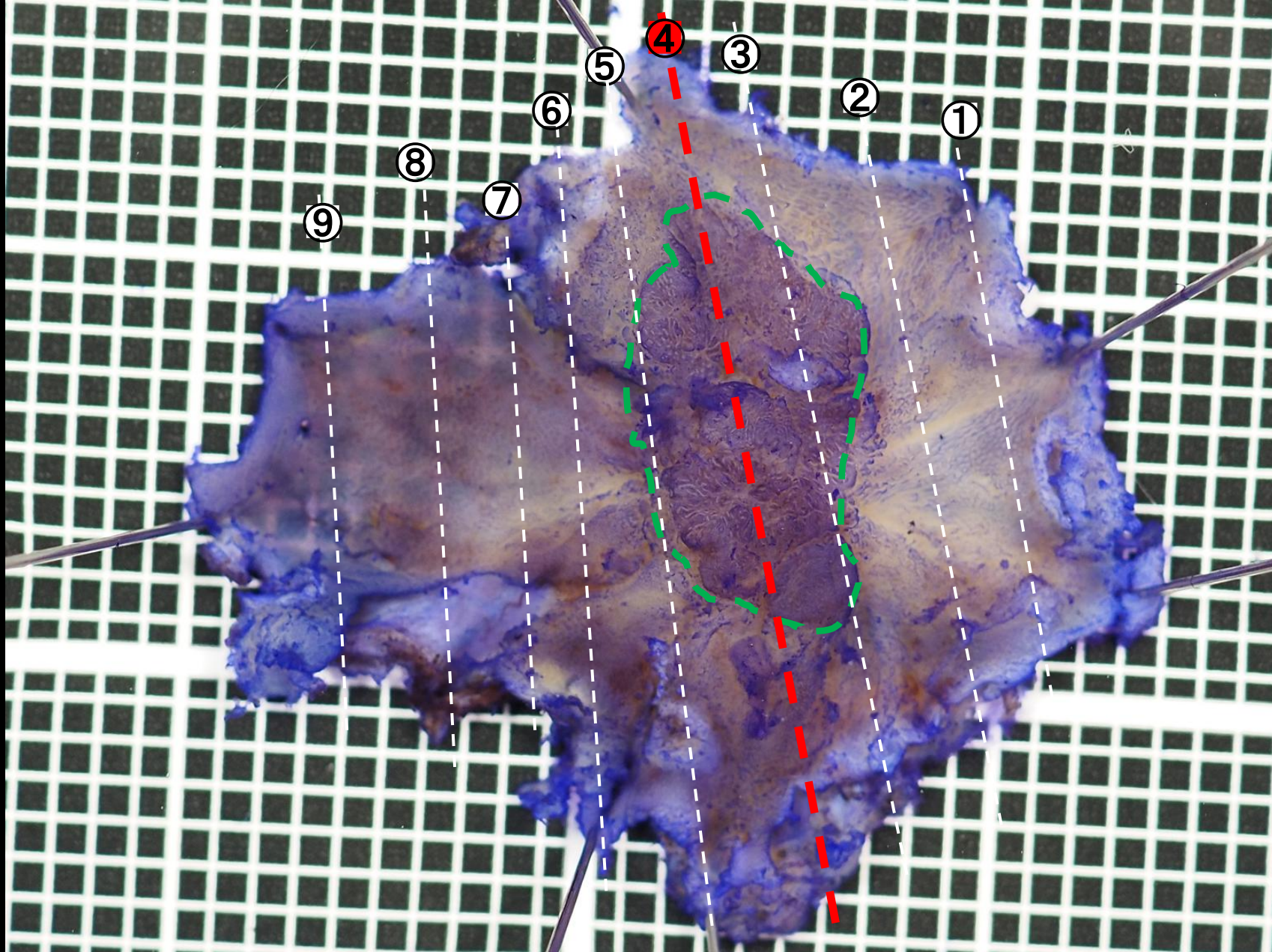


肛門側

口側

Key Slice

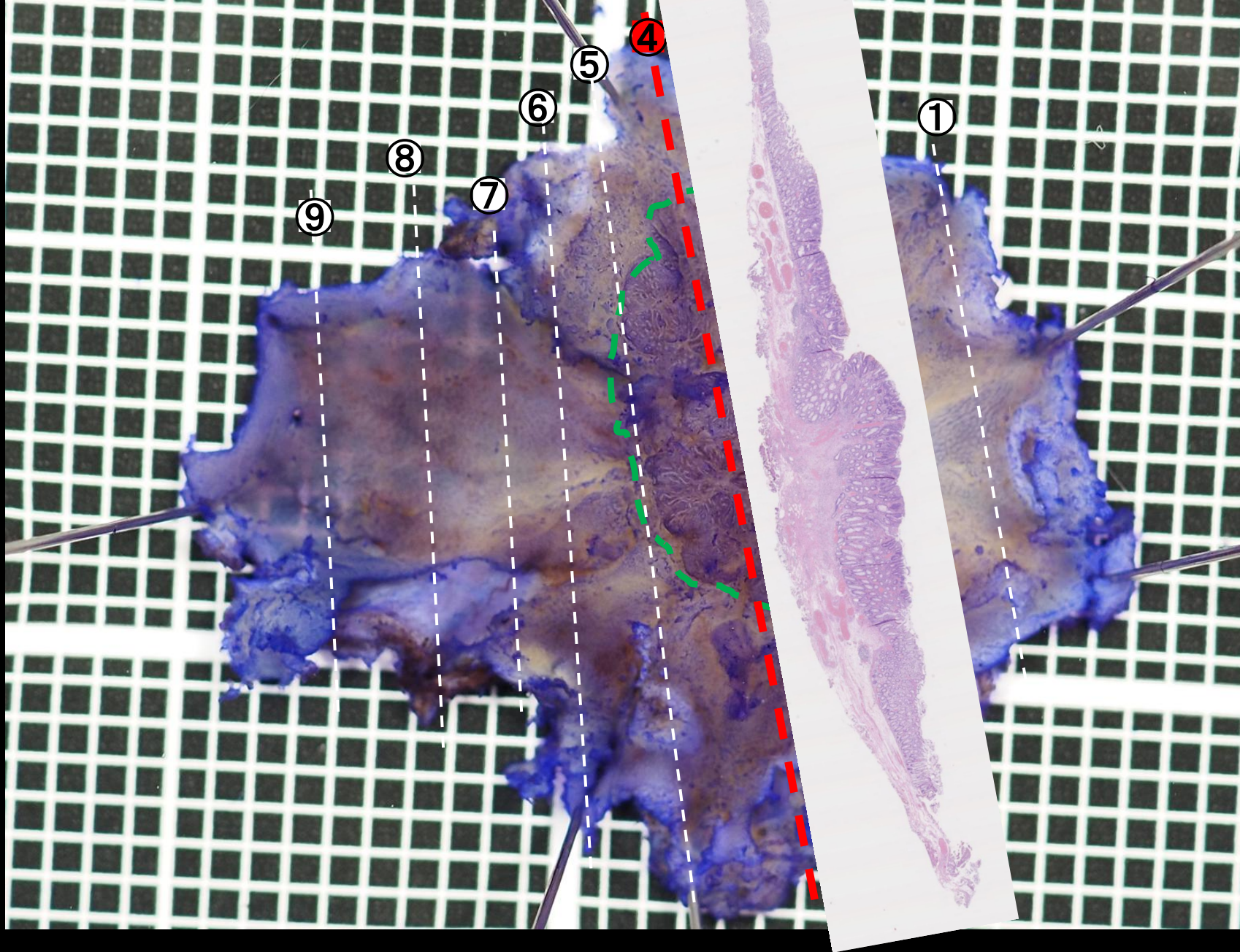




肛門側



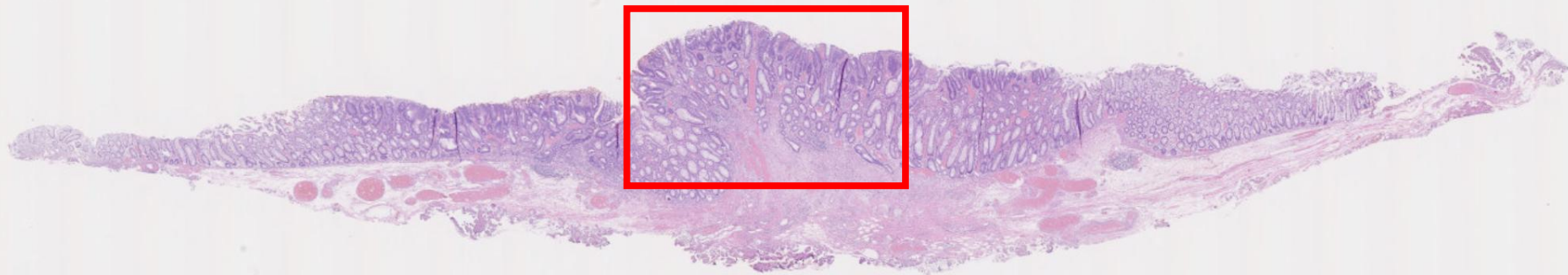
口側

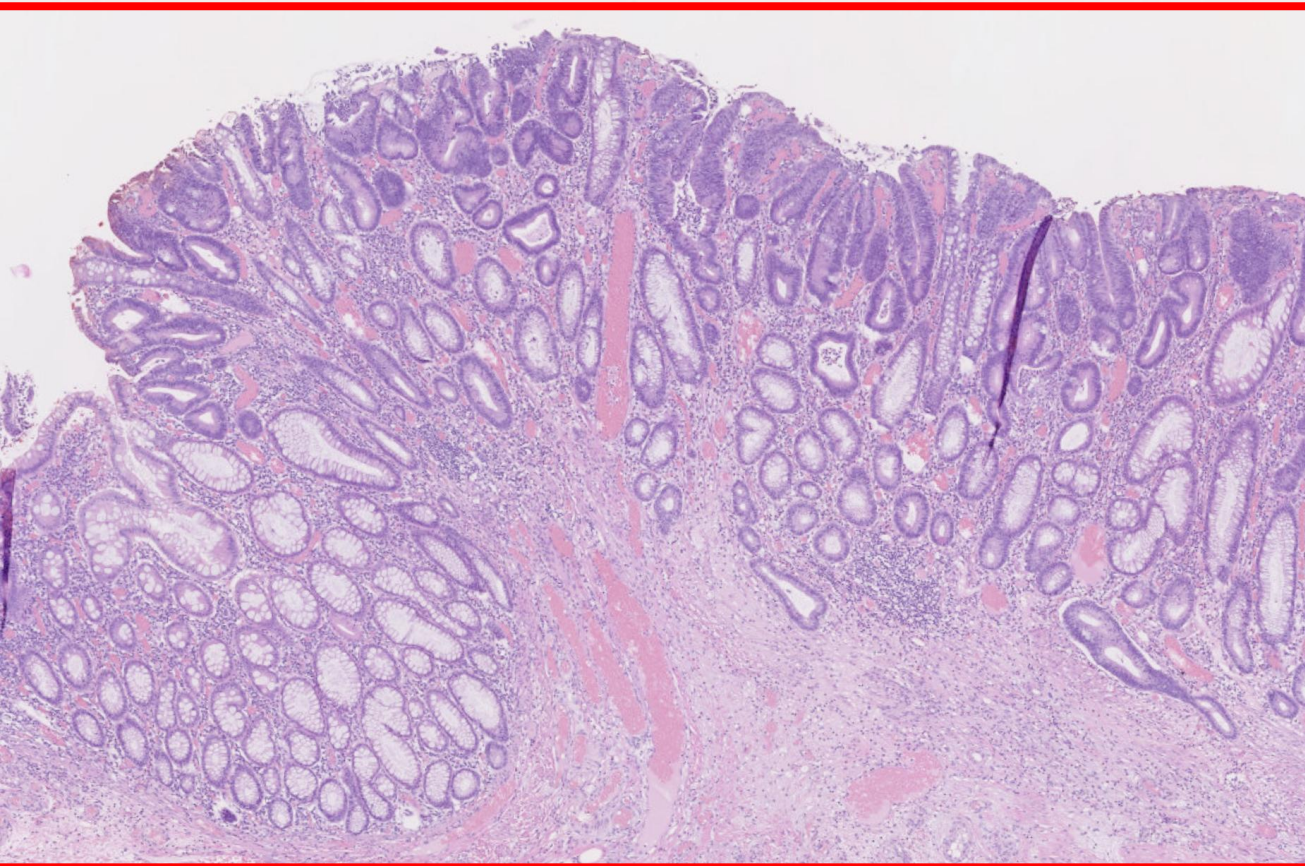
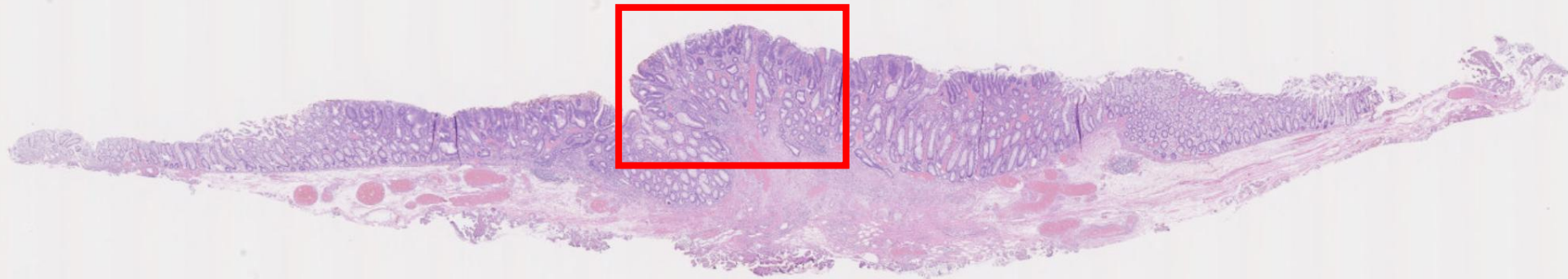


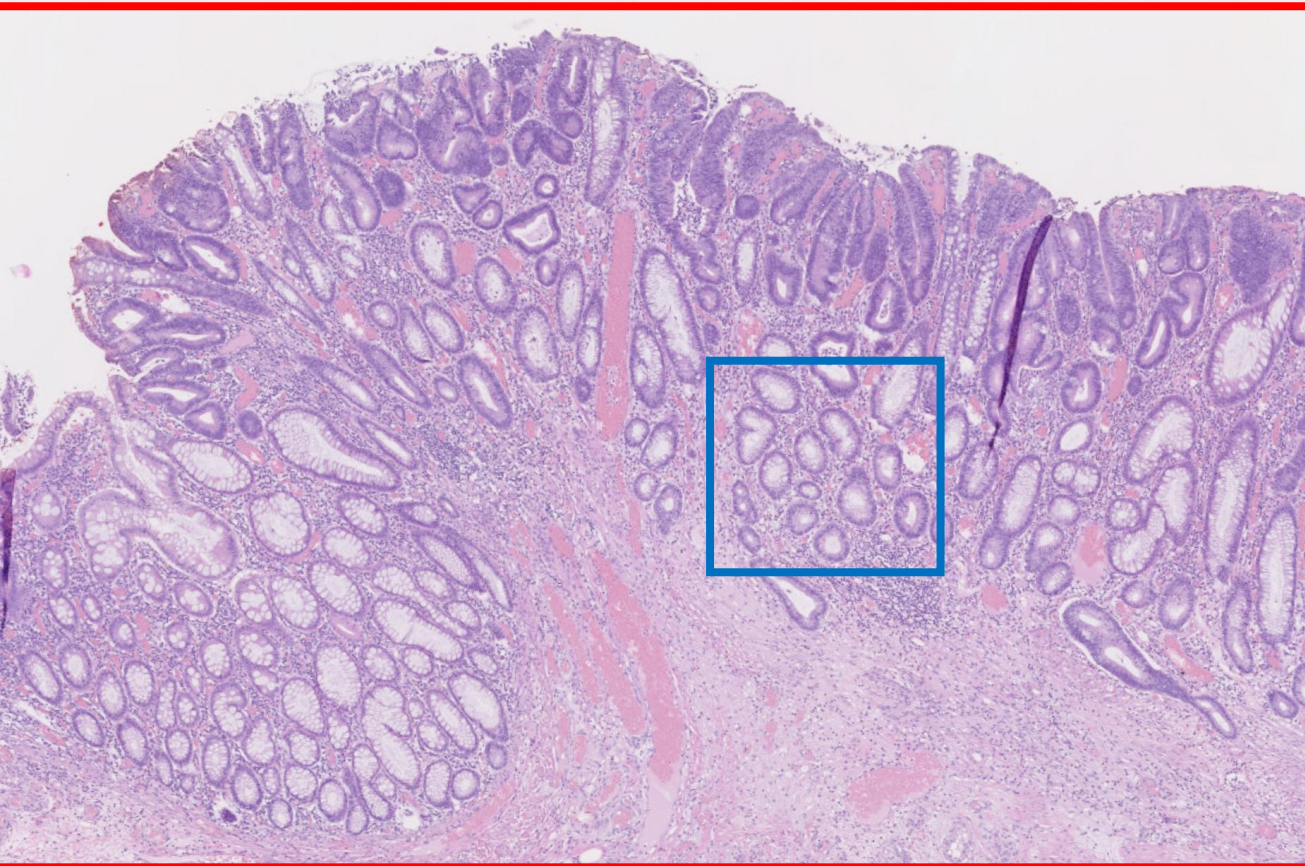
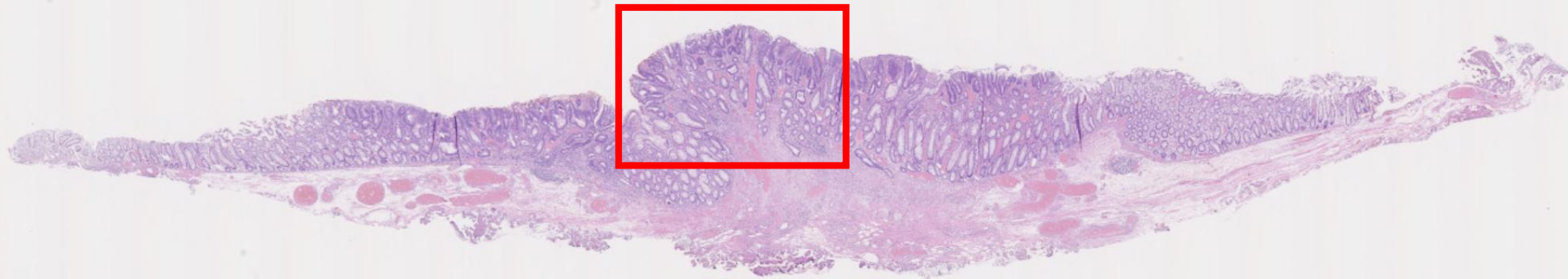
肛門側

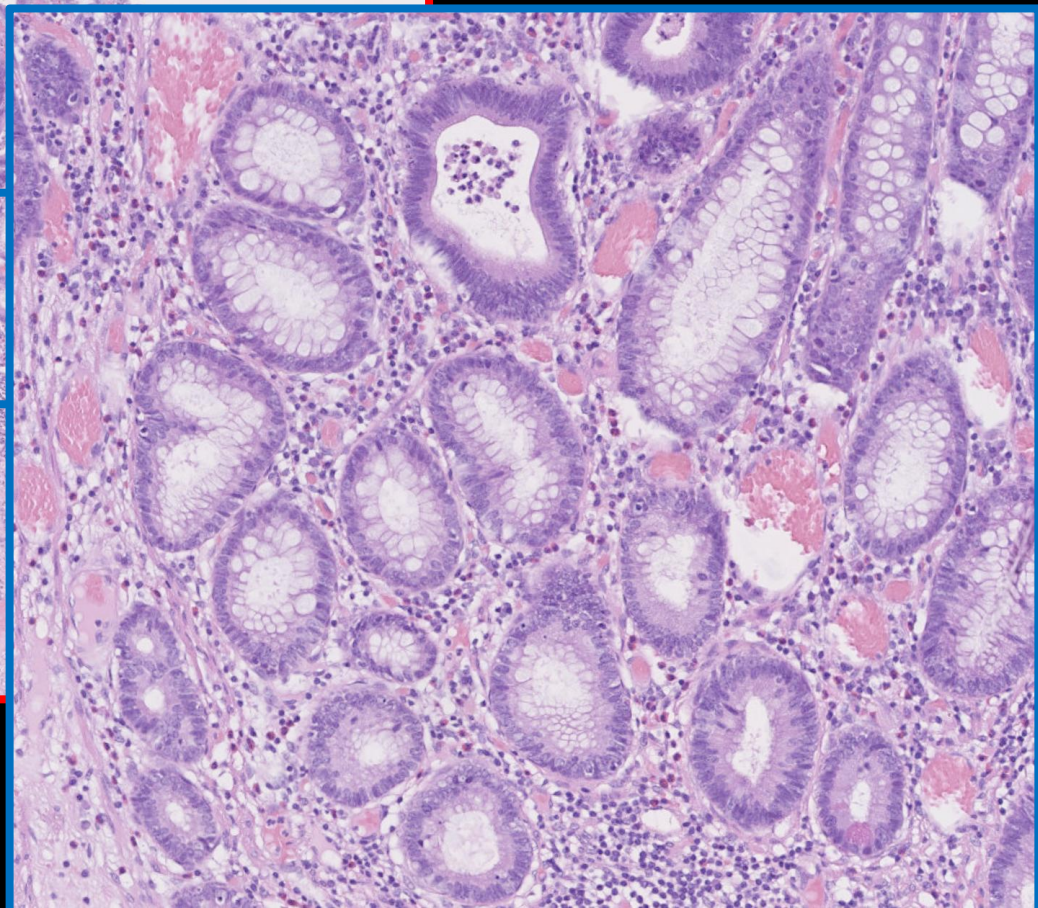
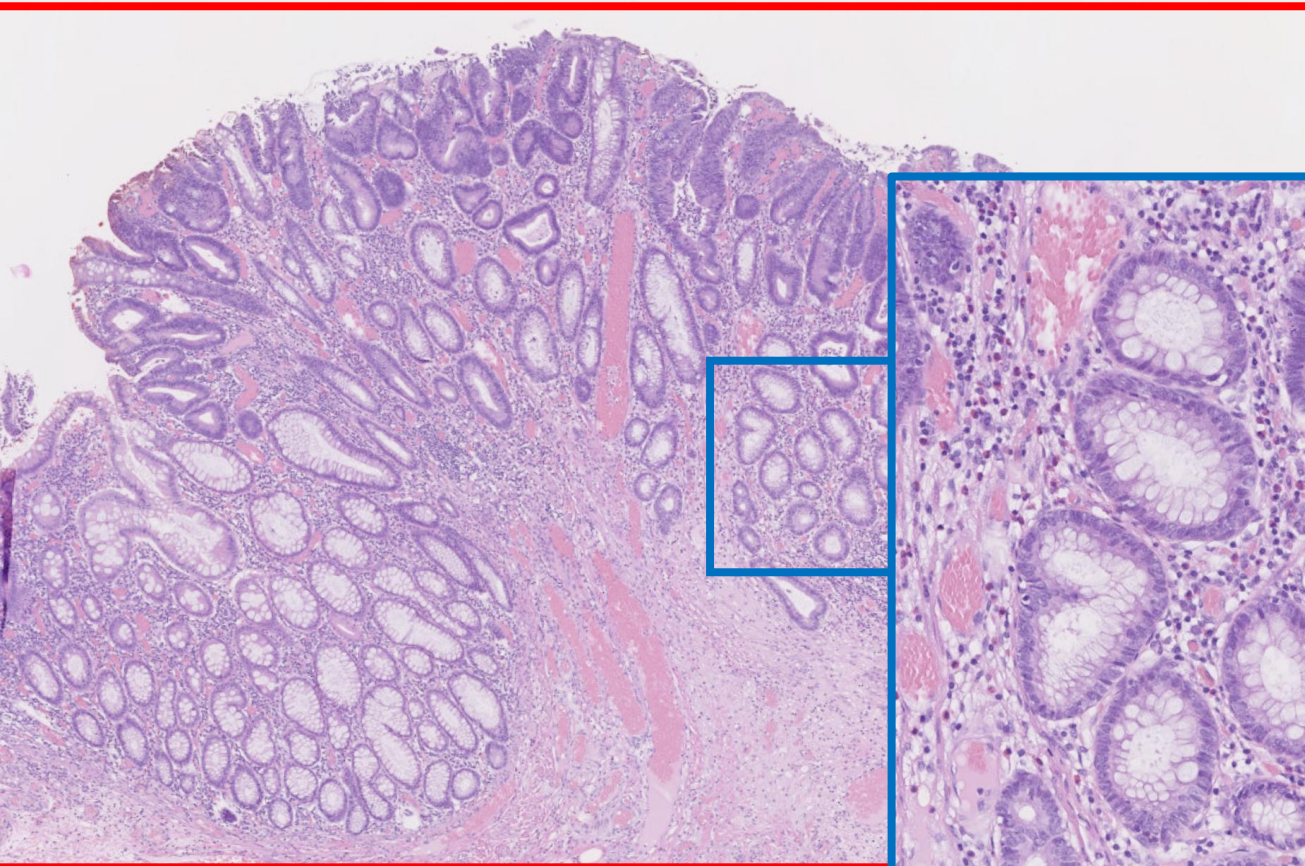
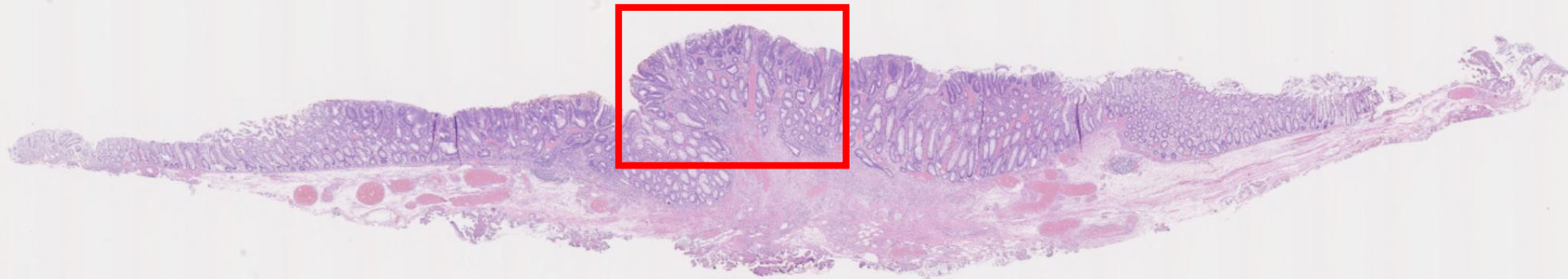


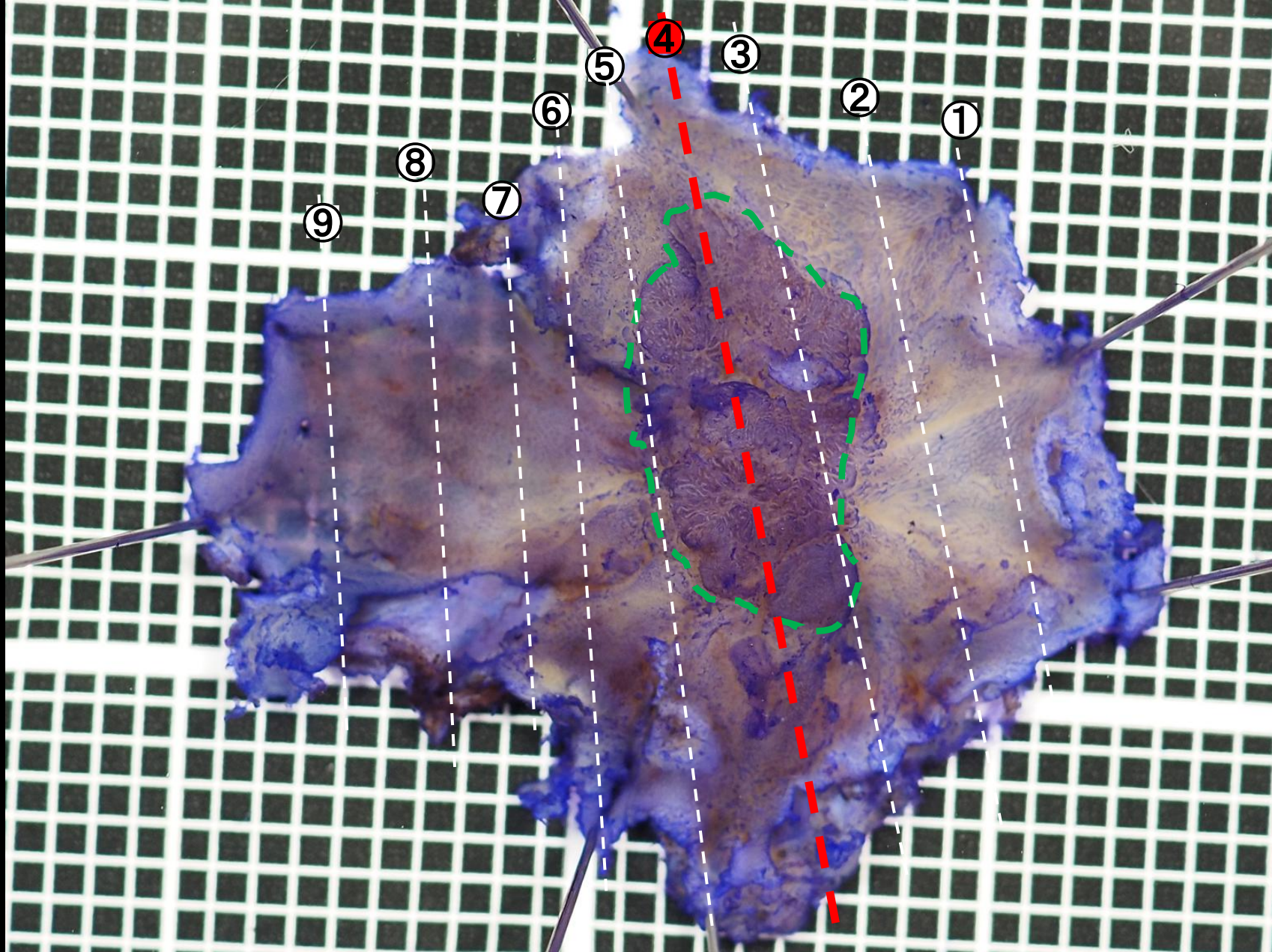
口側







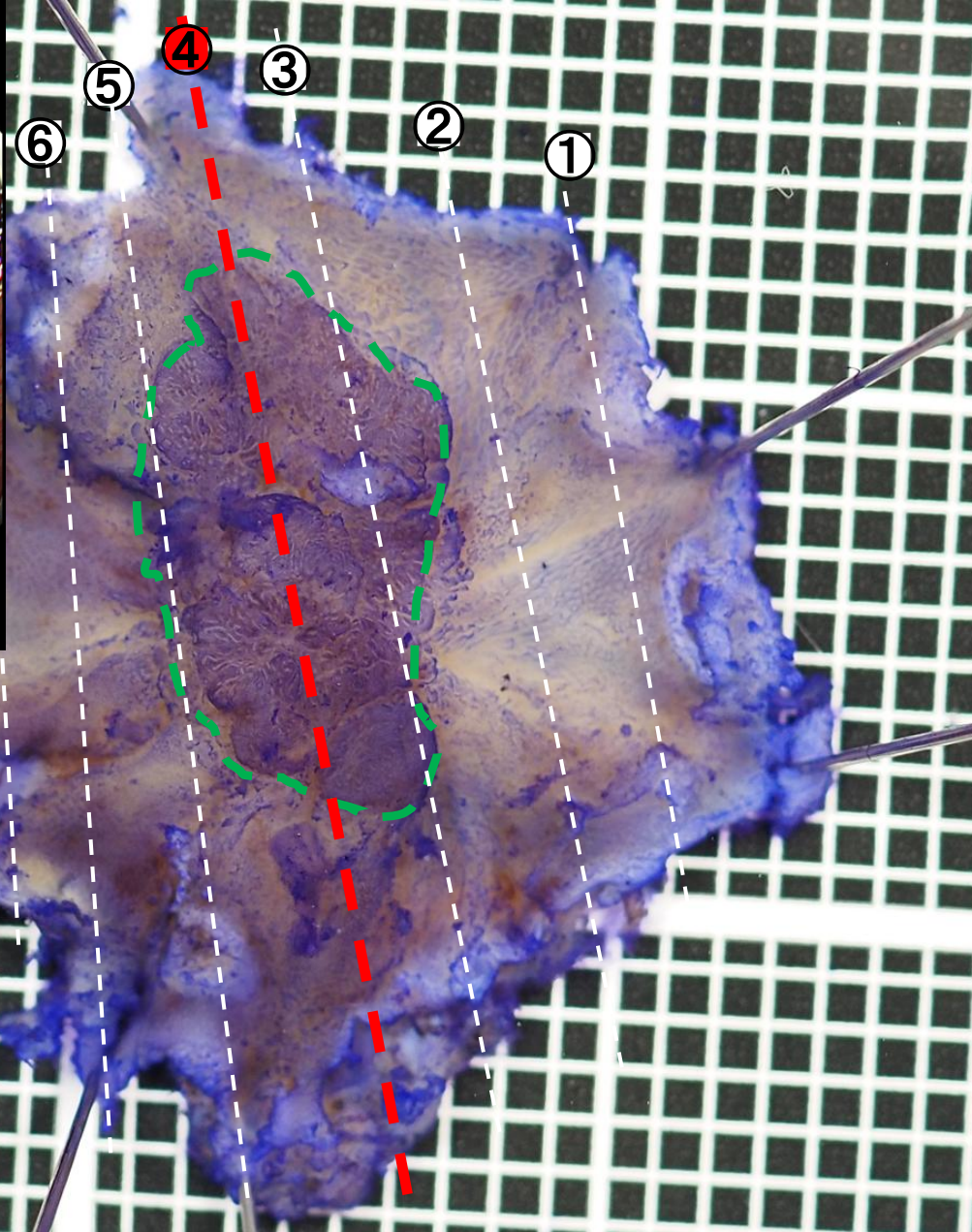
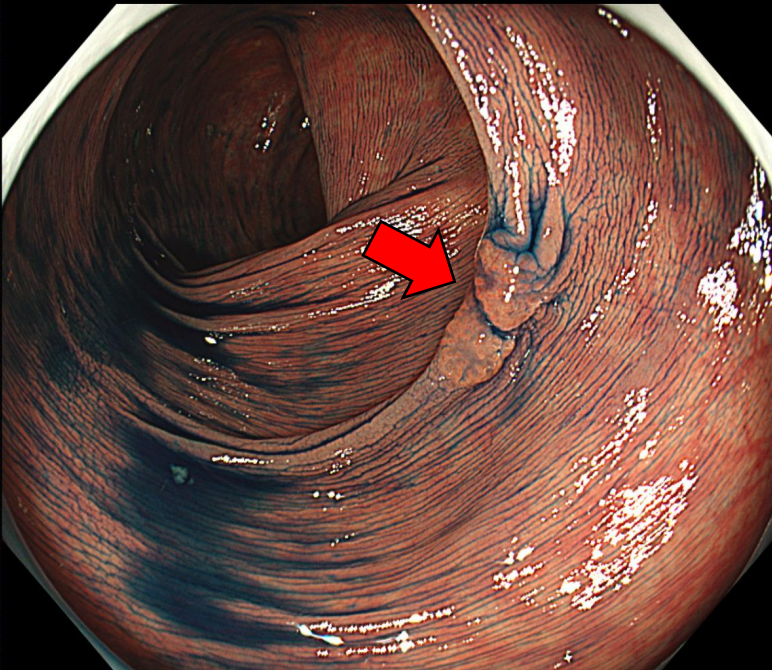




肛門側



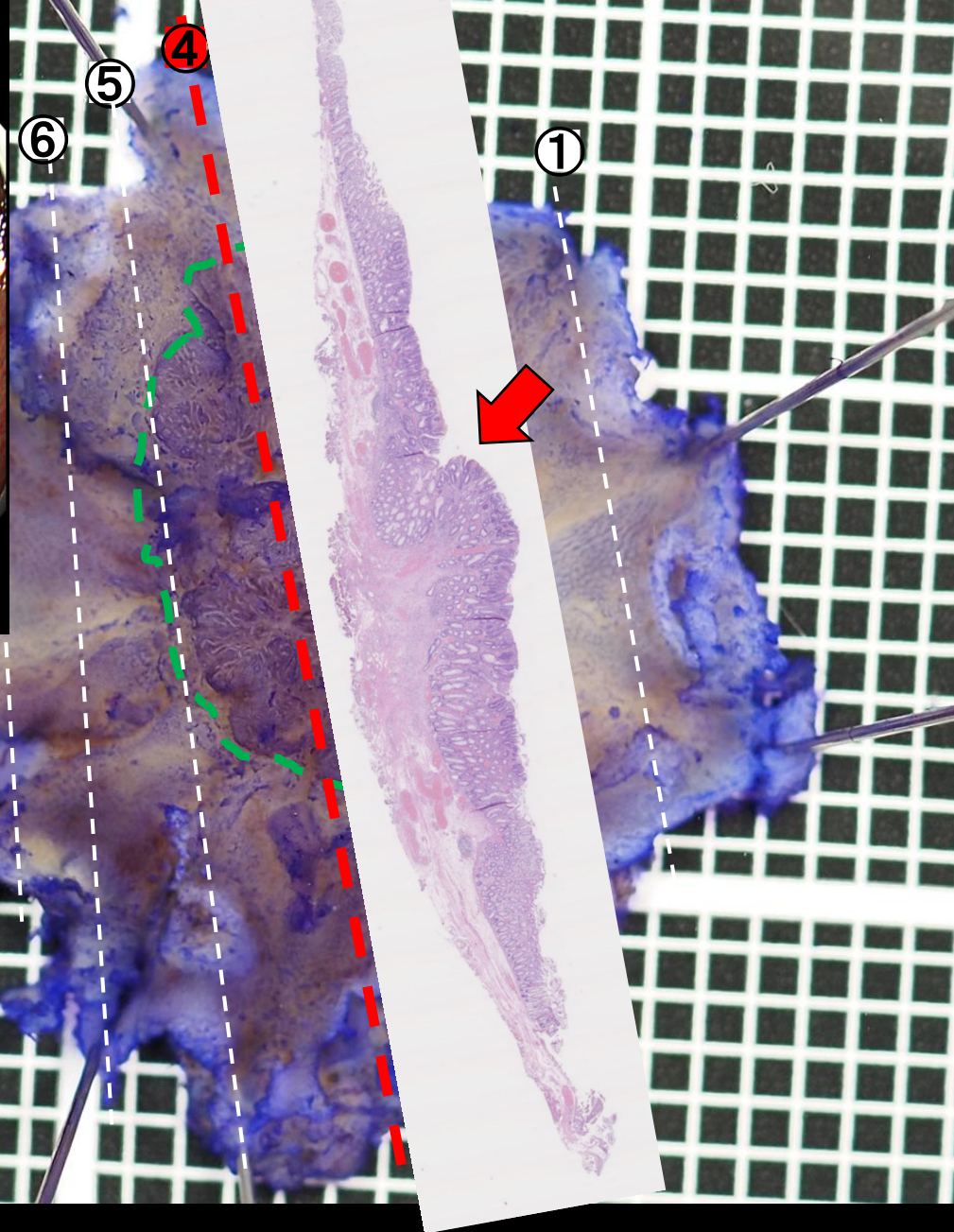
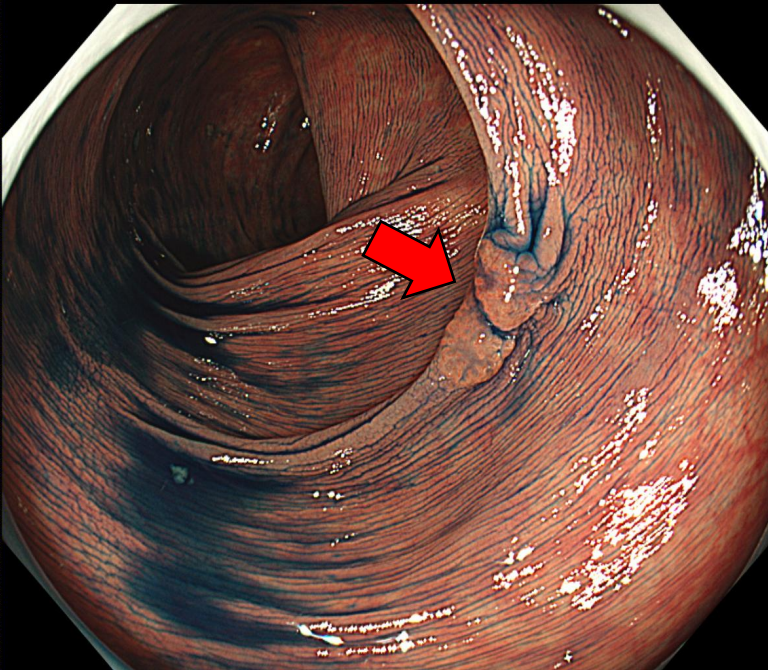
口側



肛門側



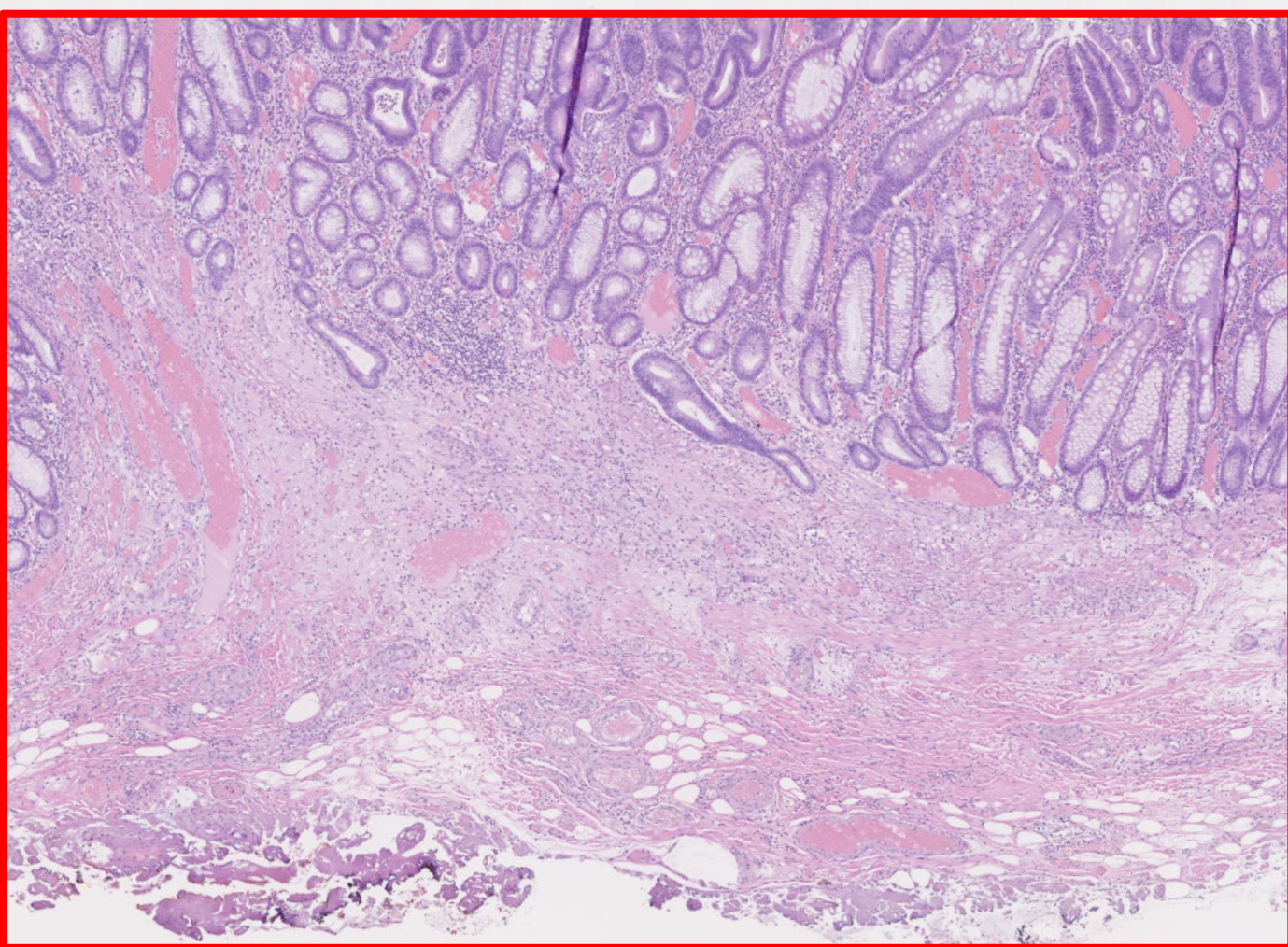
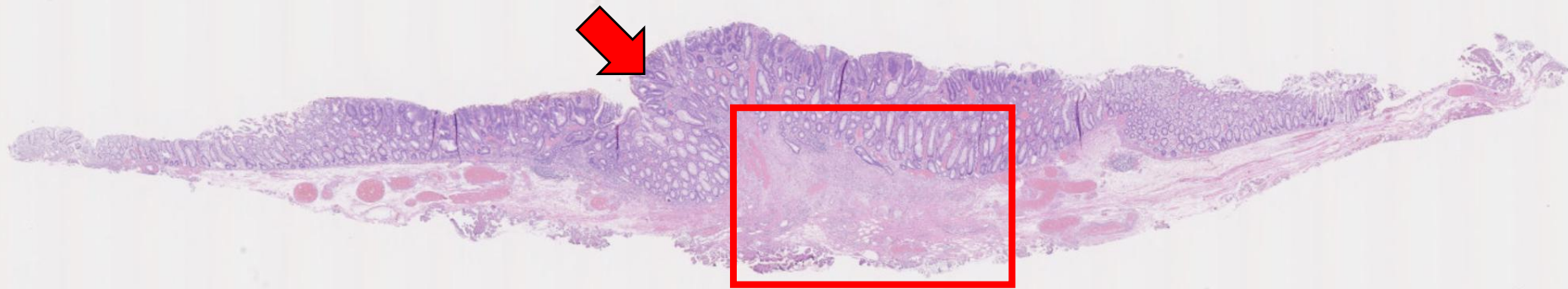
口側

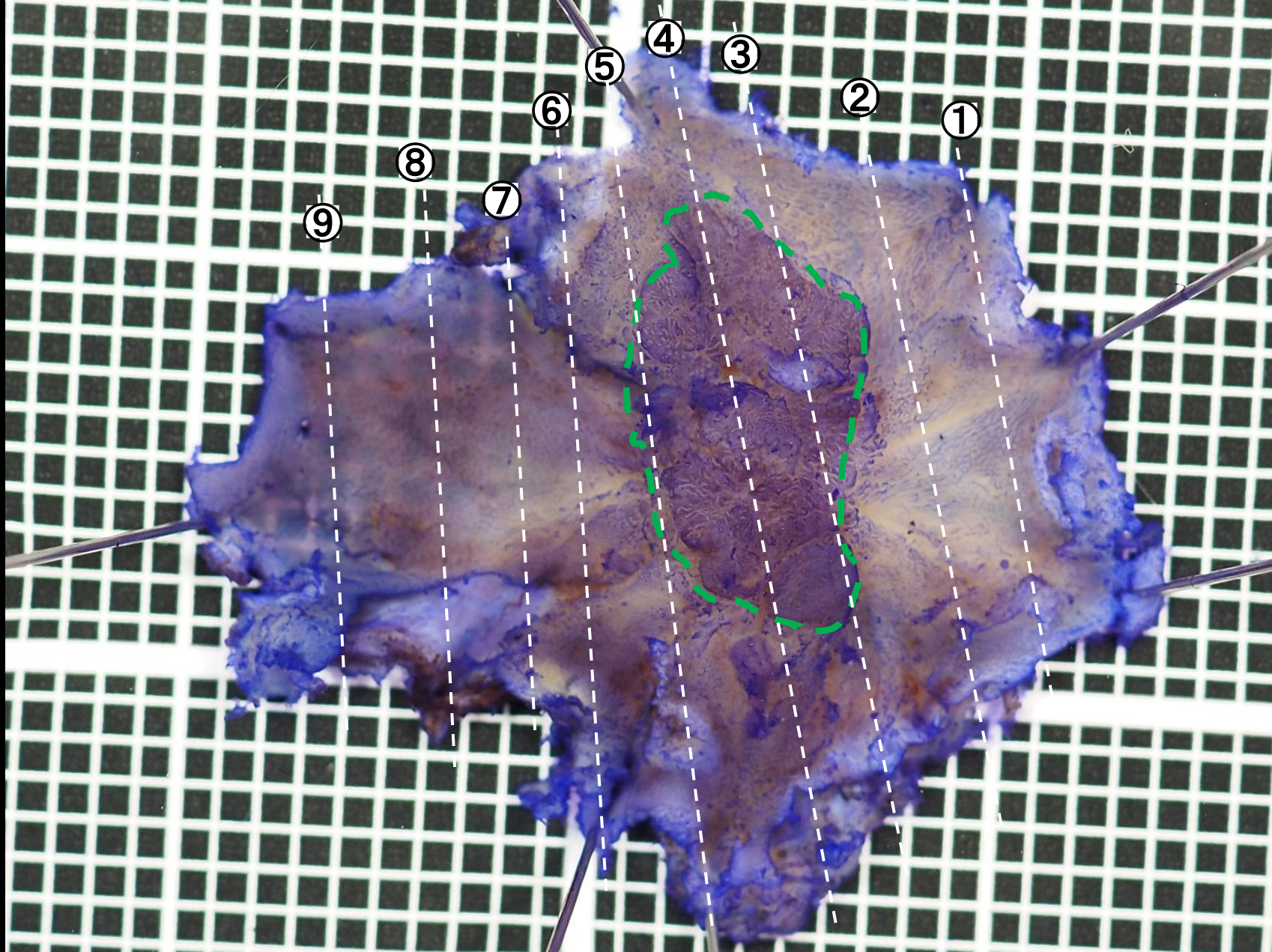


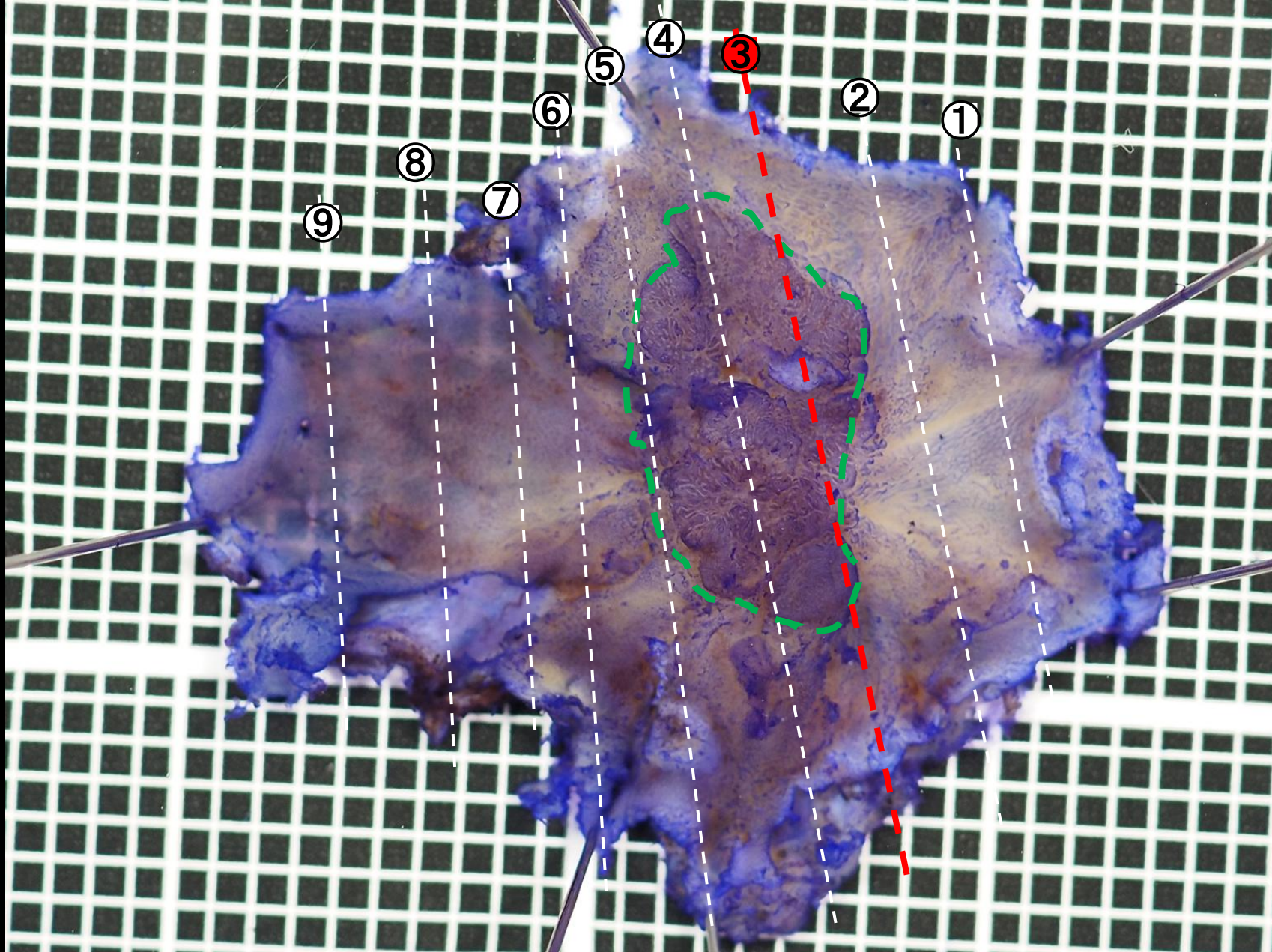
肛門側



口側



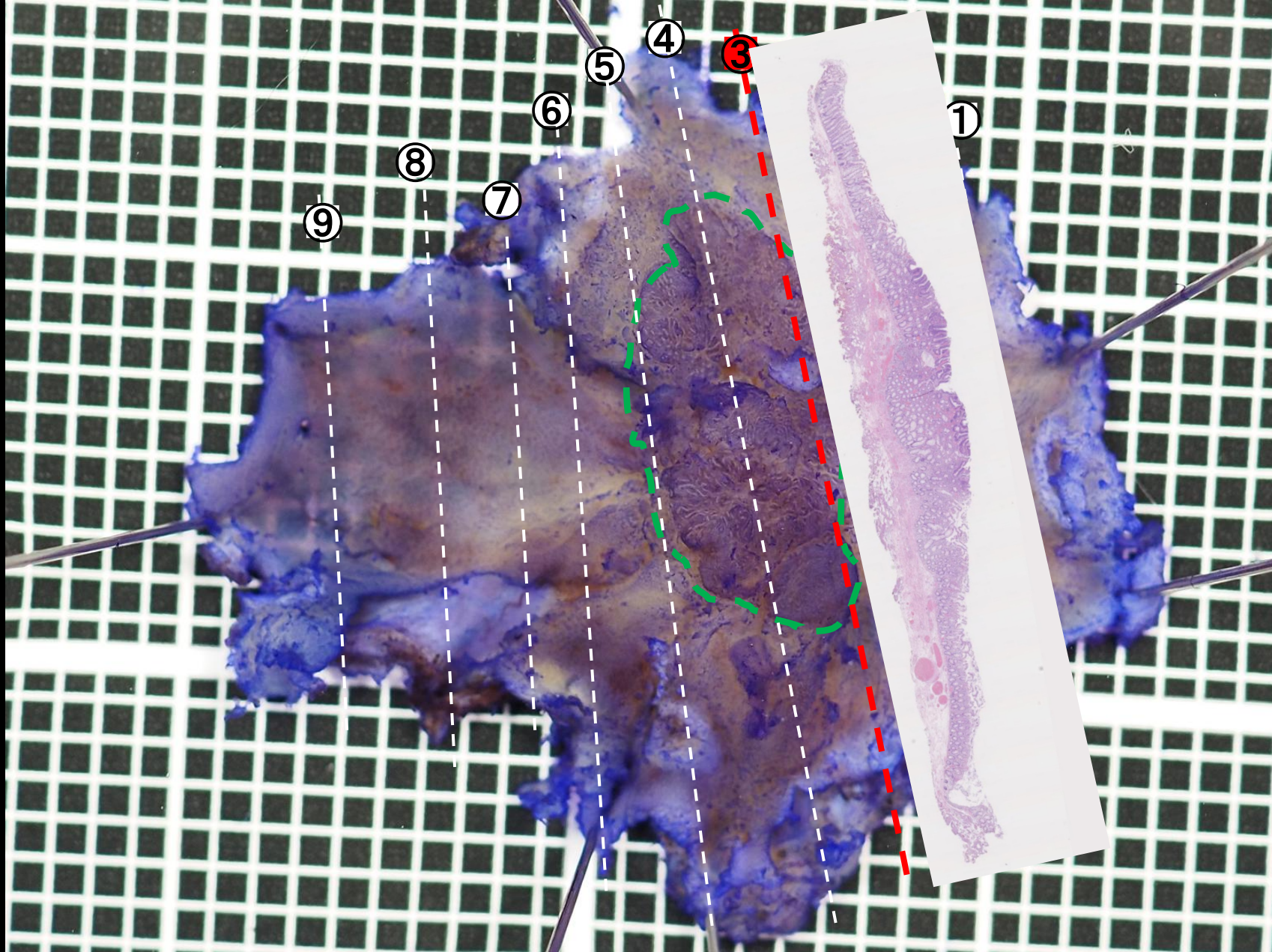




肛門側



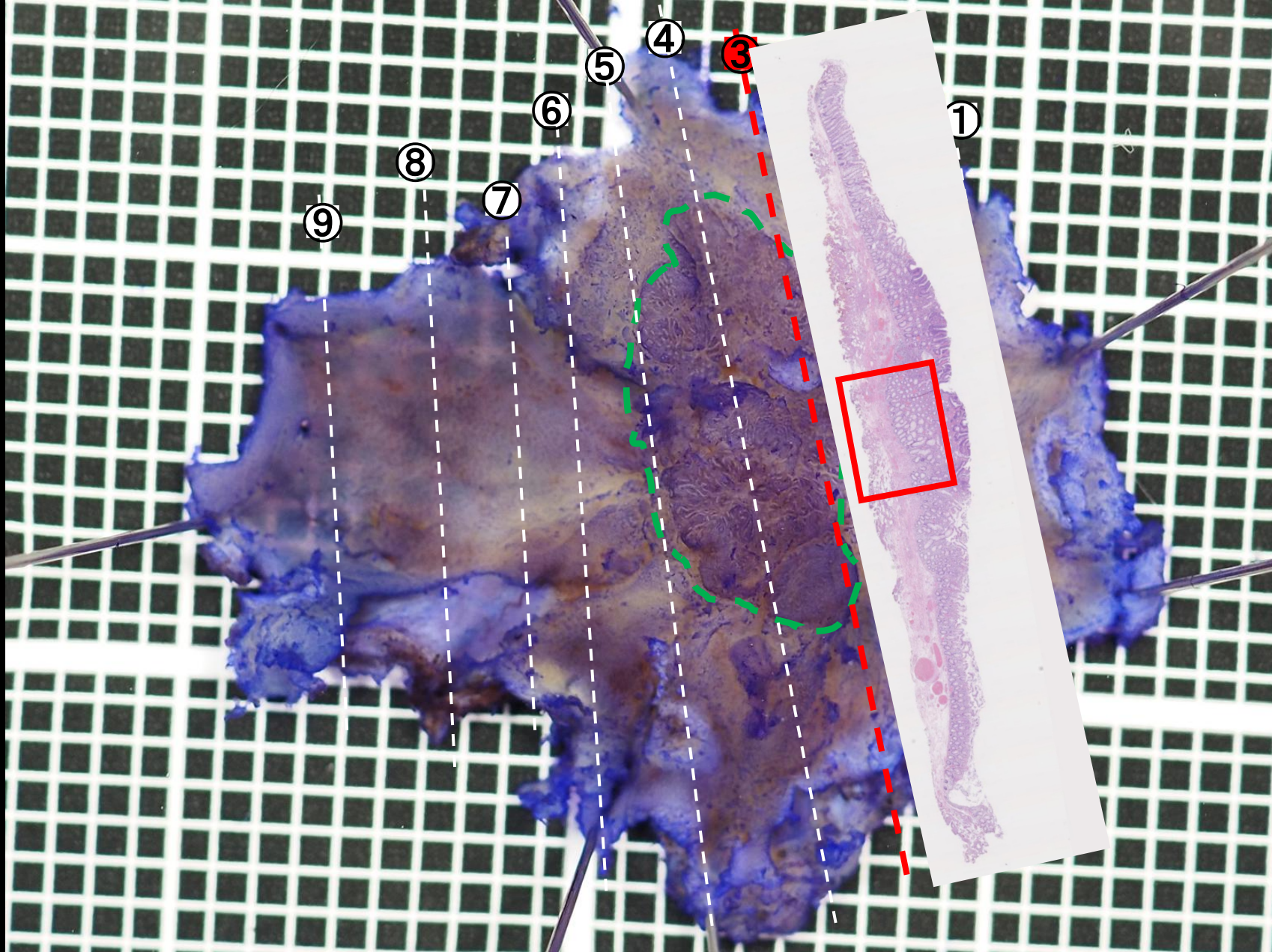
口側



肛門側



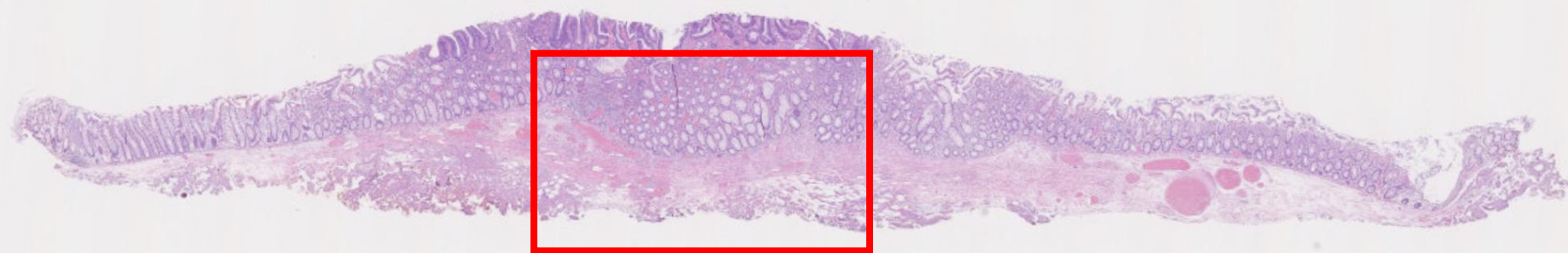
口側

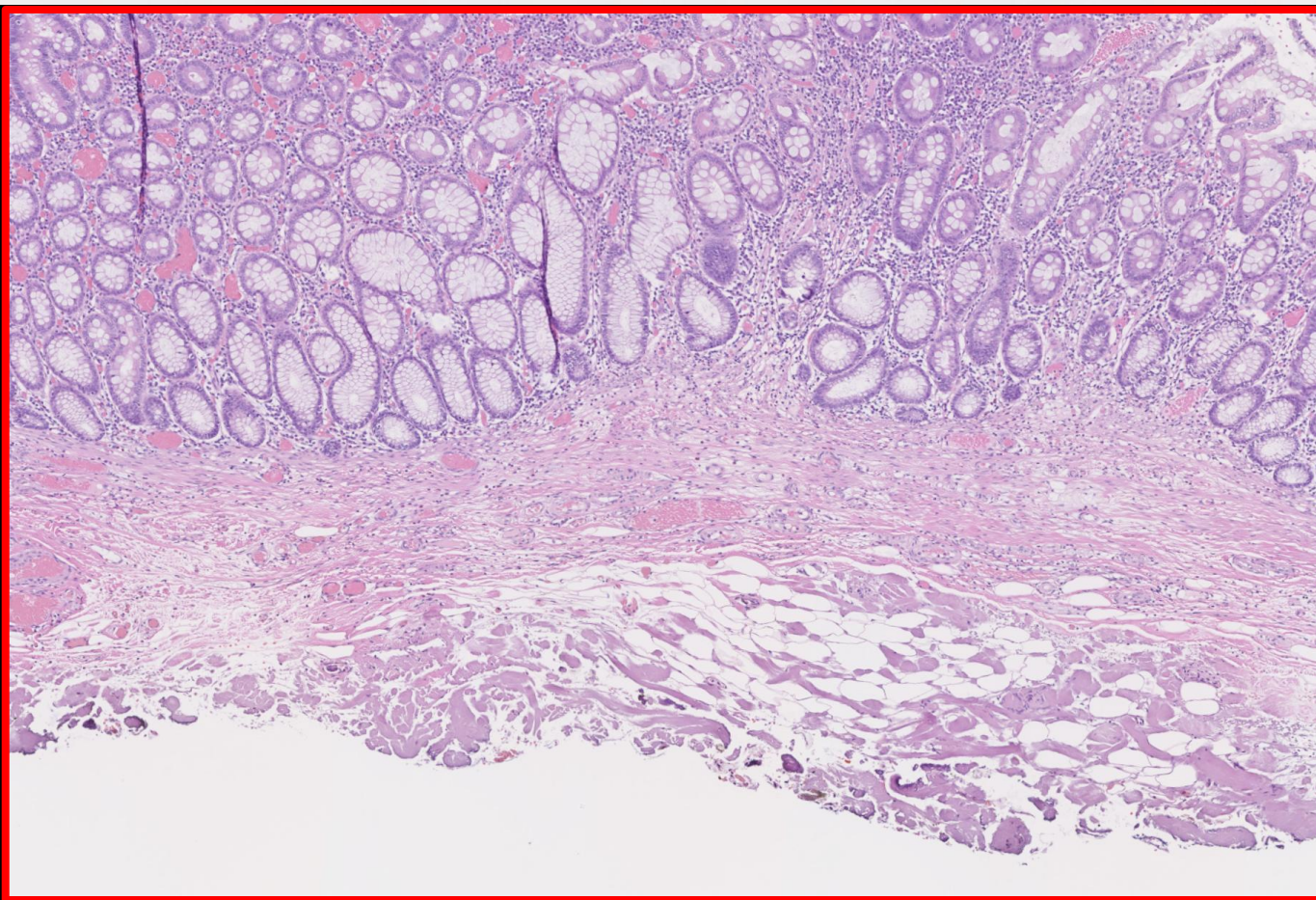
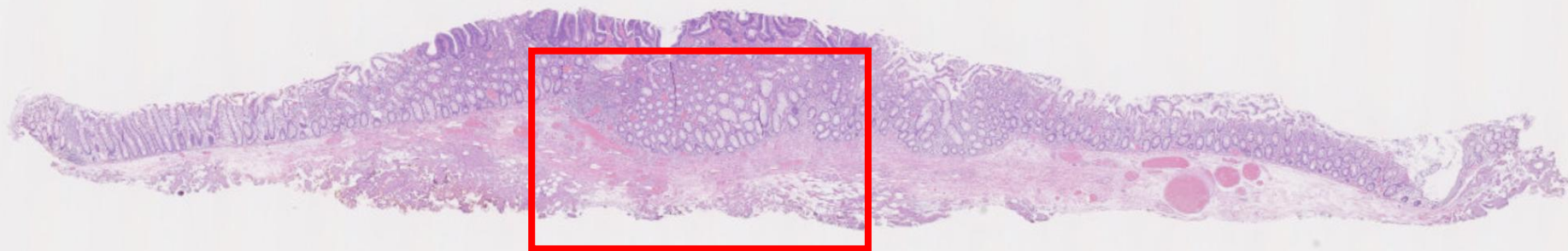


肛門側

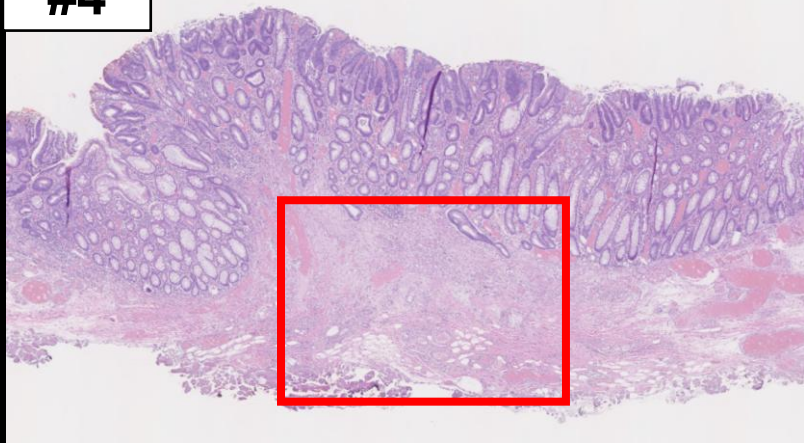


口側

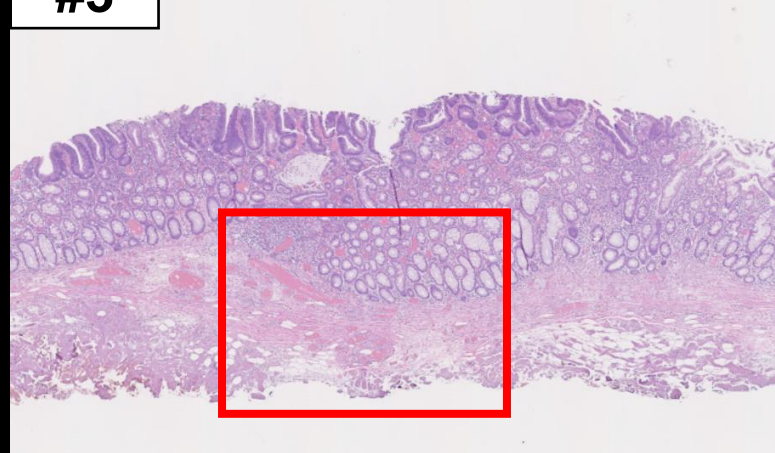




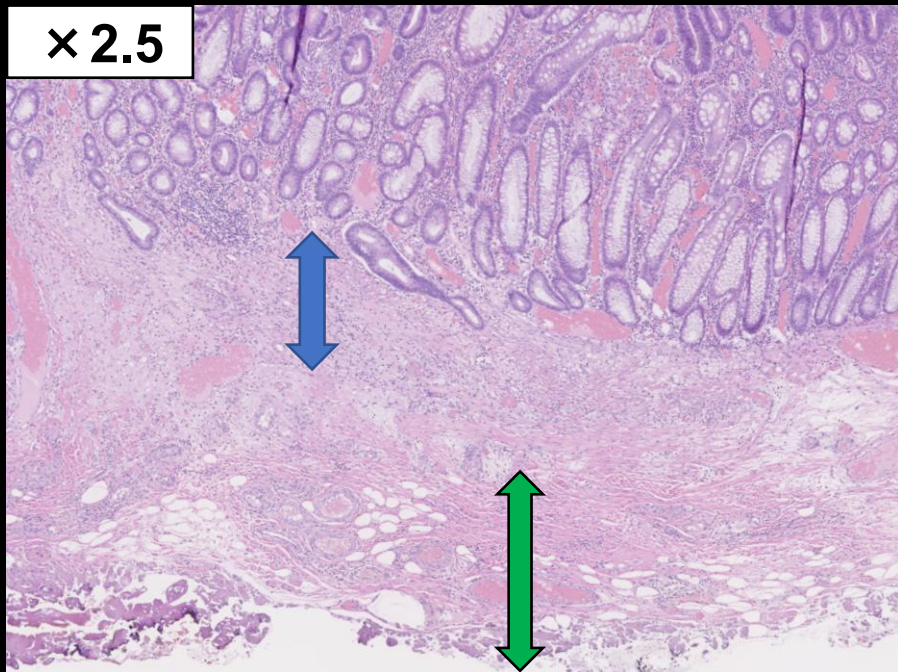
#4



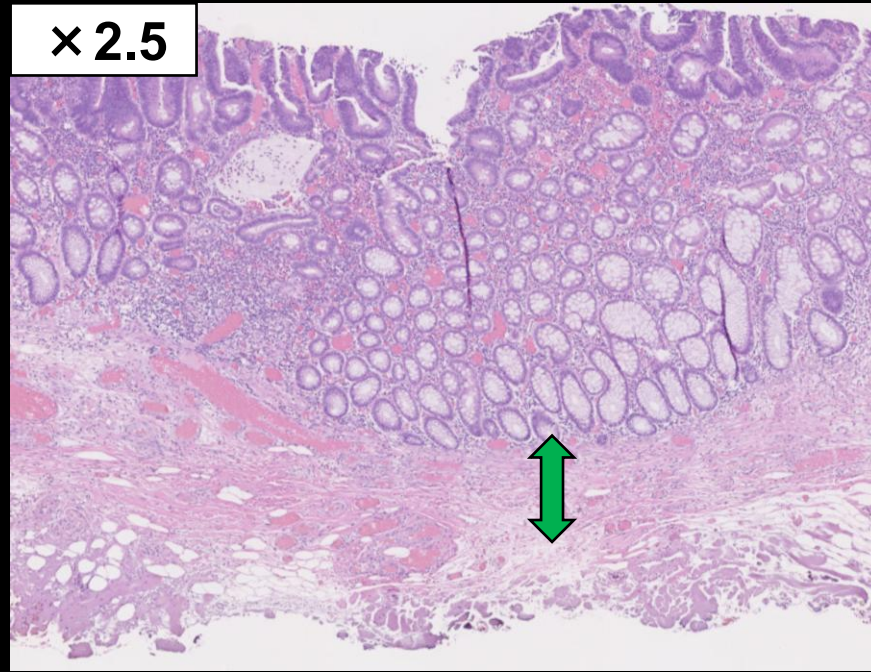
#3



× 2.5



× 2.5

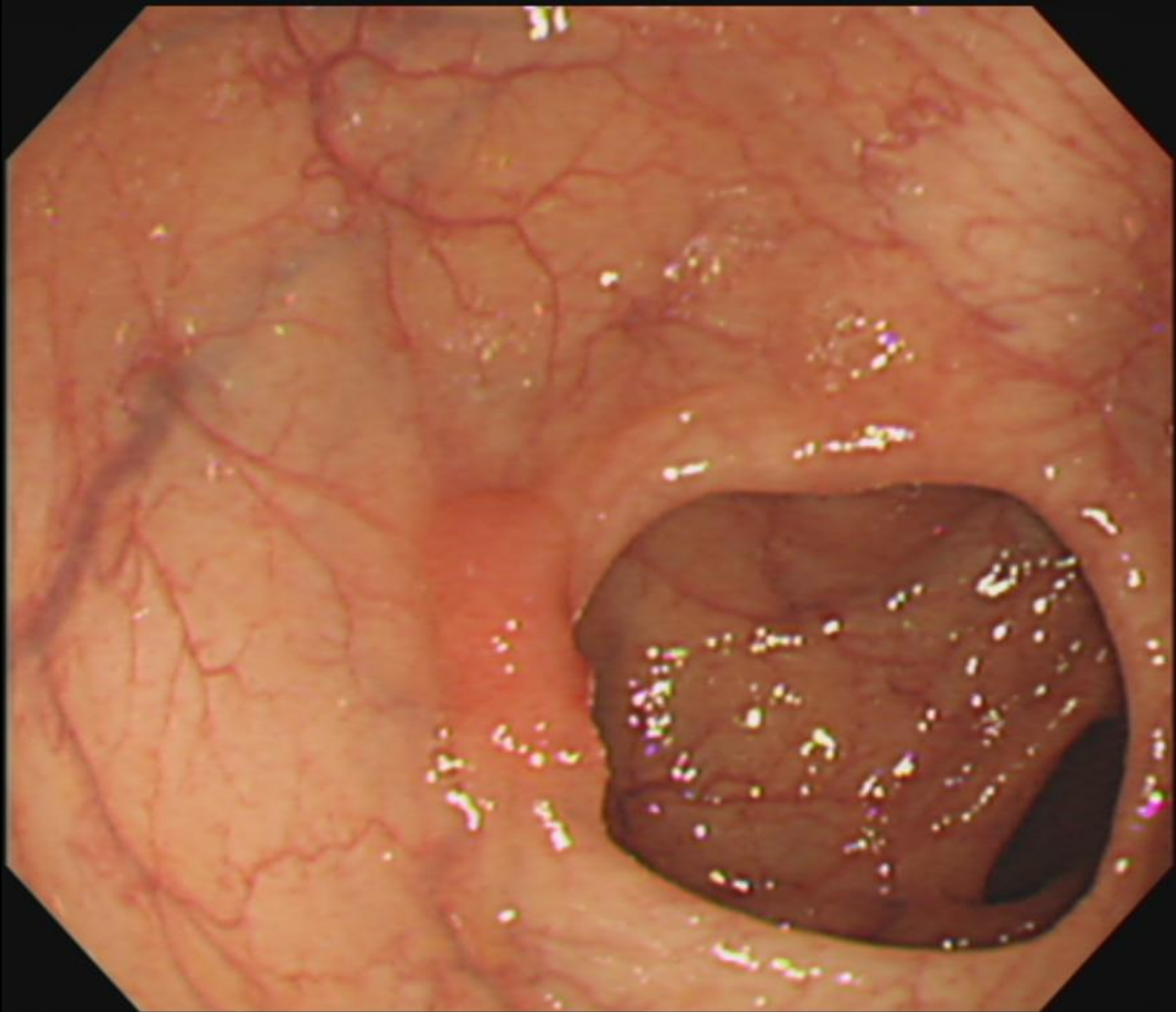


病理診断

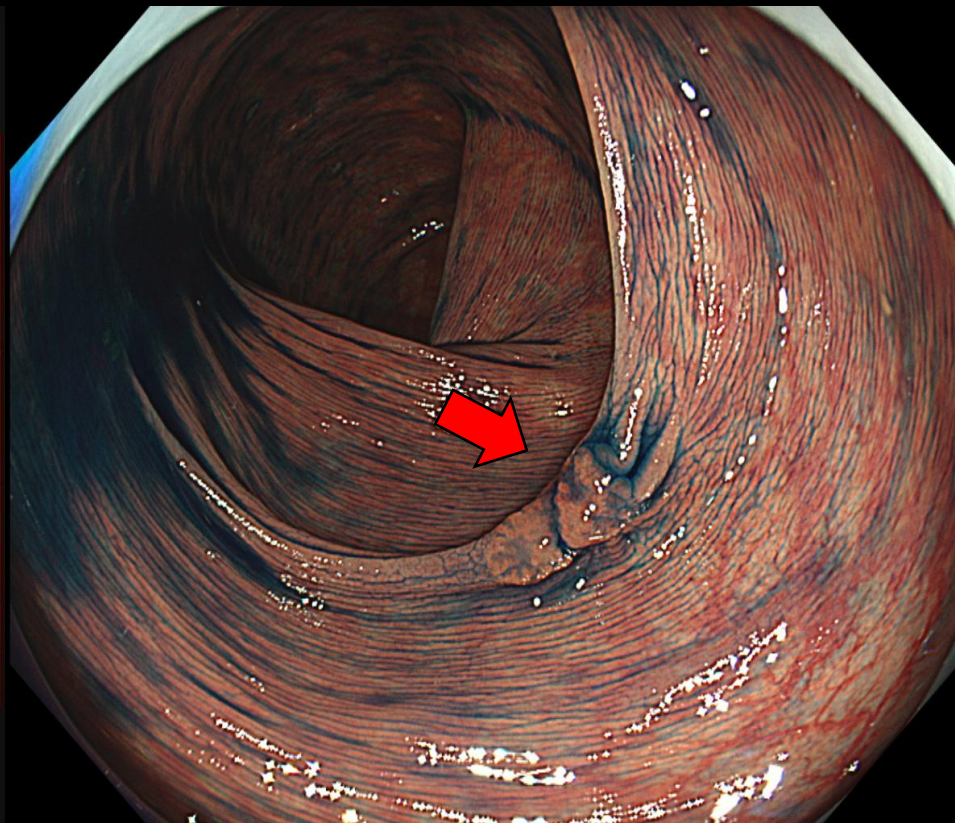
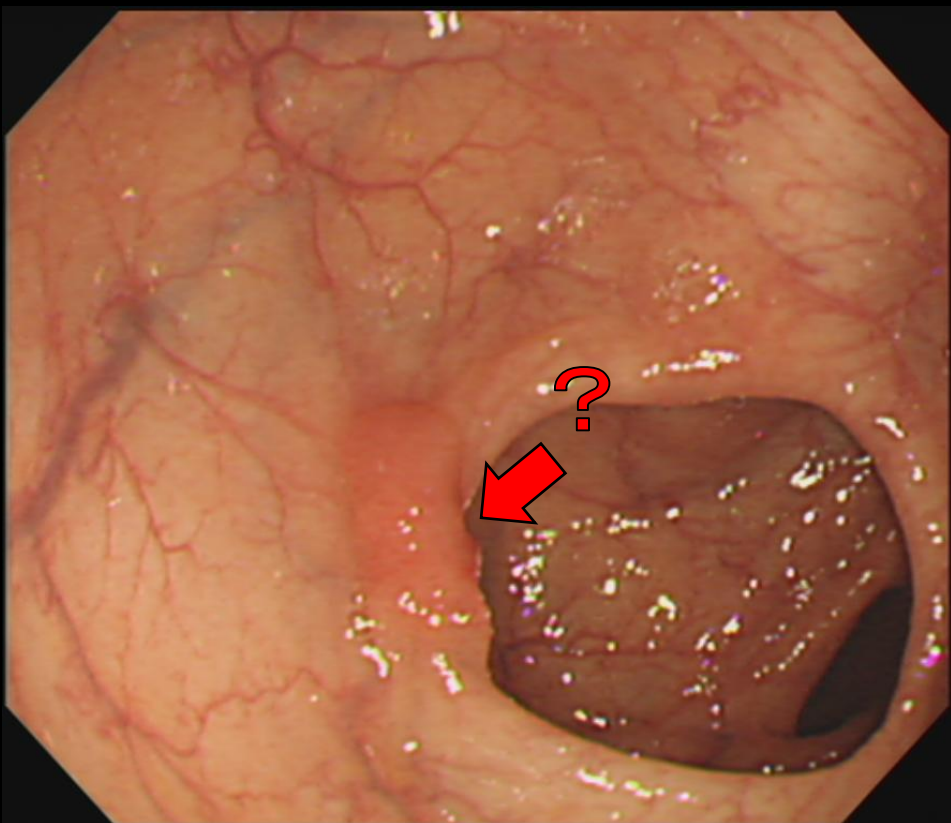
Colon, transverse,
ESD: high grade adenoma

実は・・・

前医での病変



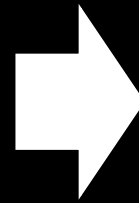
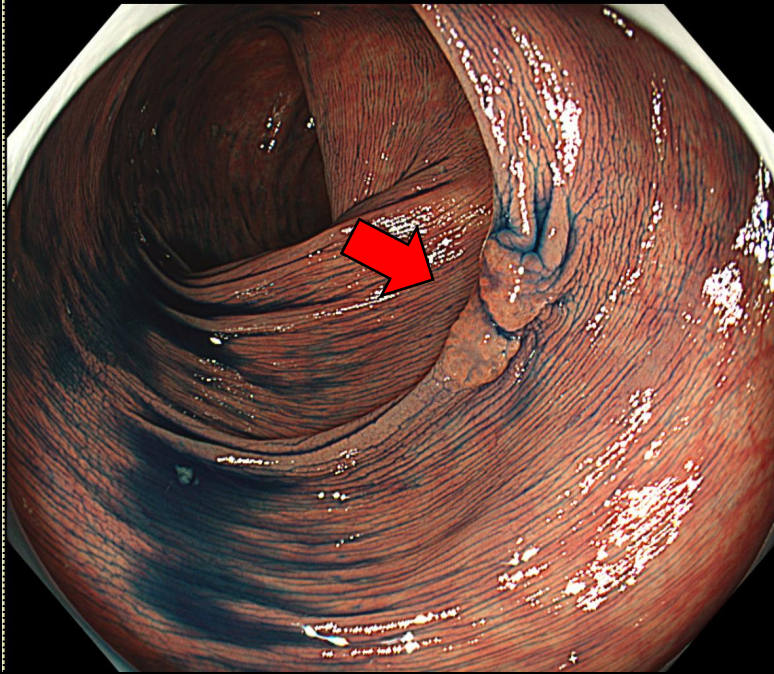
当院での病変と比較



前医ではない陥凹・・・？

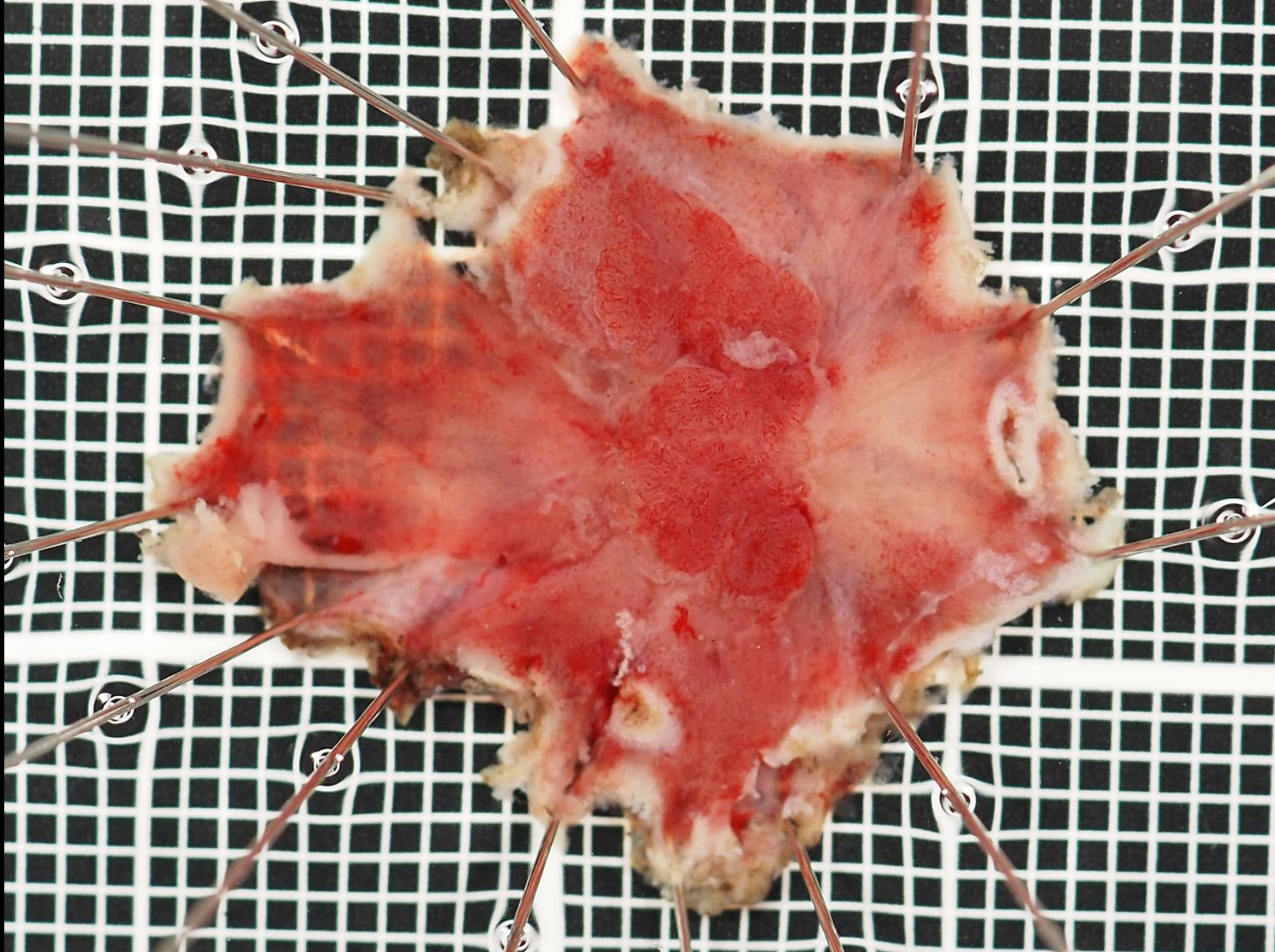
生検の病理診断

Group3:high grade tubular adenoma



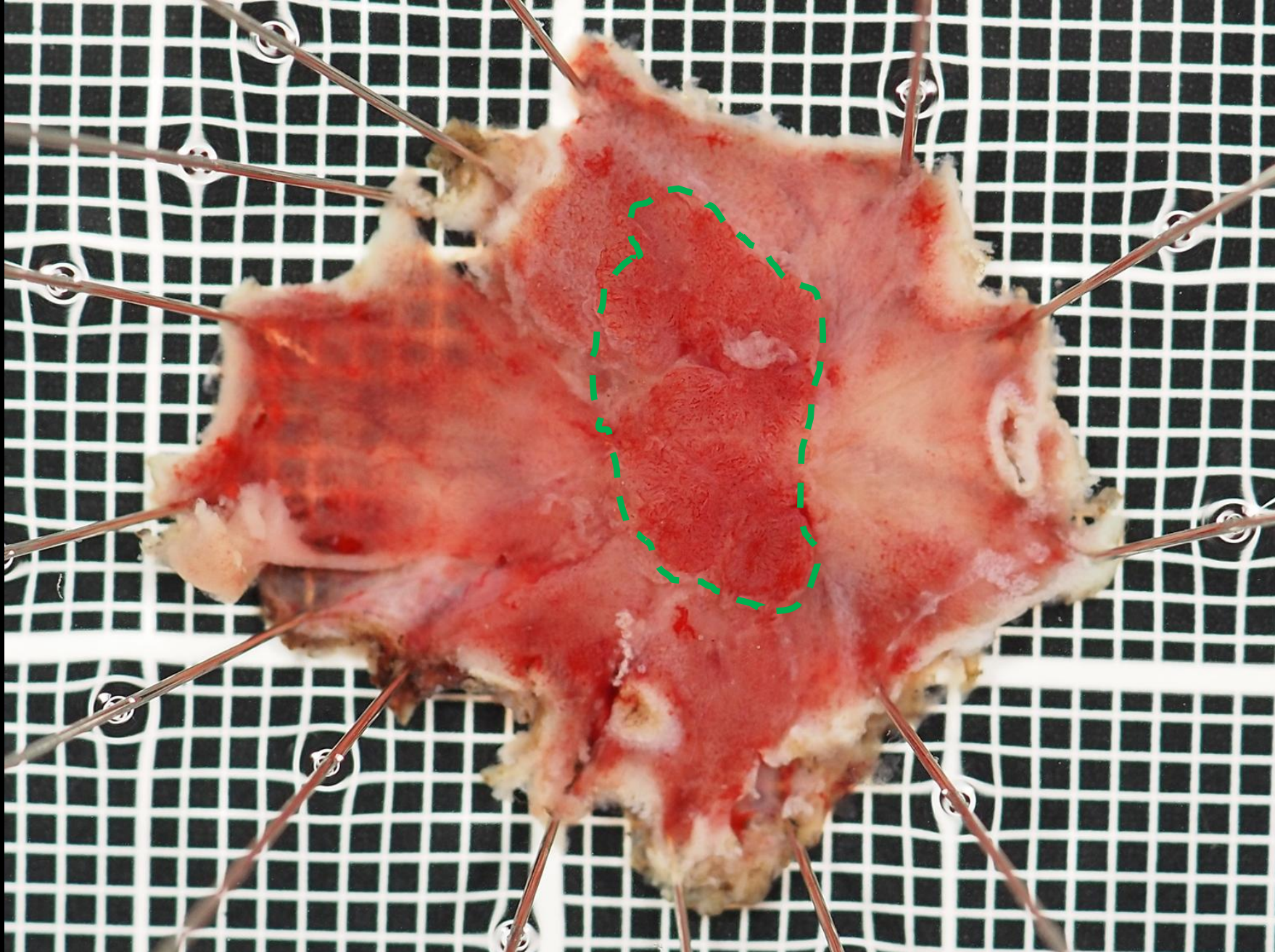
生検瘢痕
でした・・・

Mapping



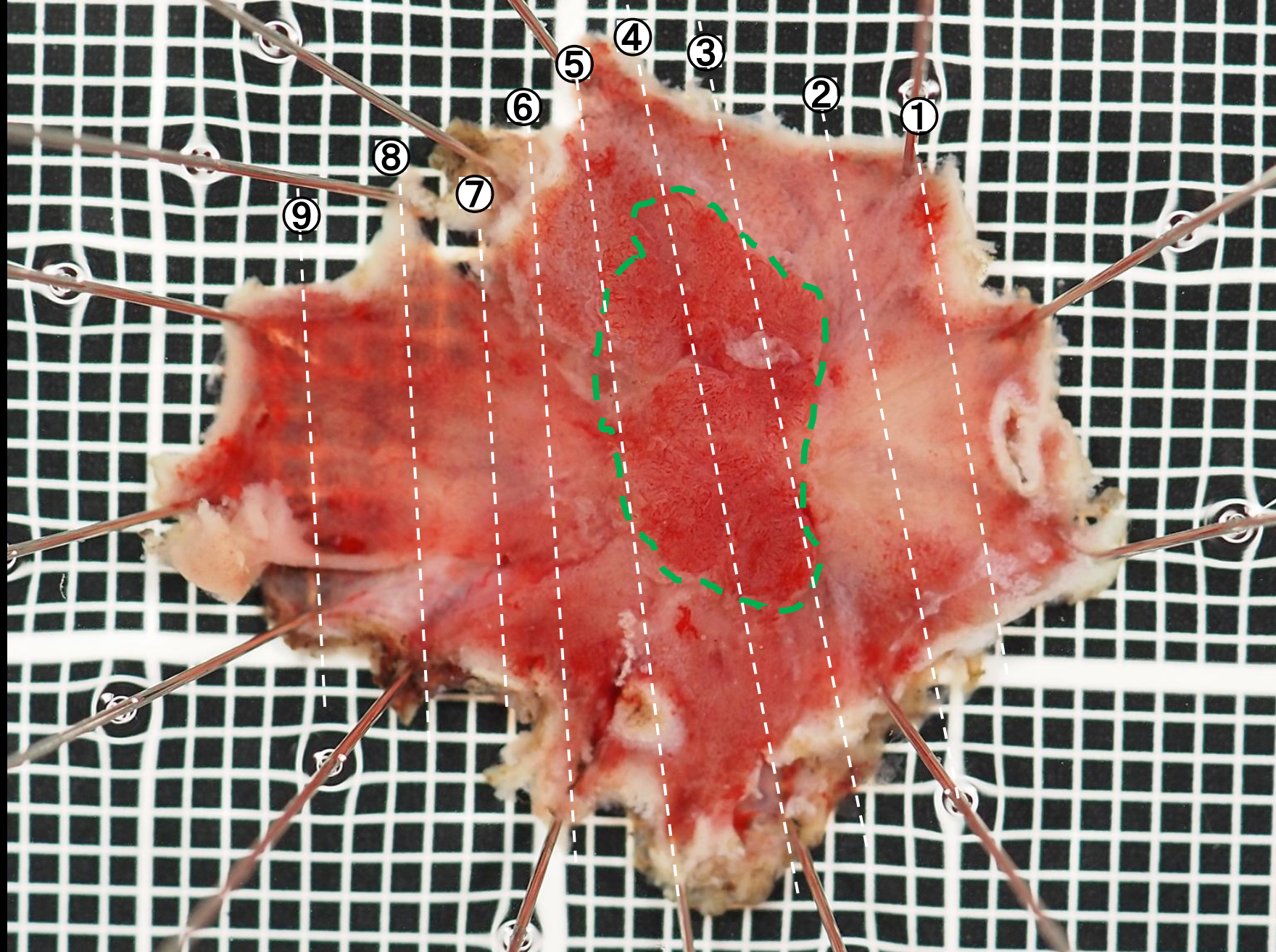
肛門側

口側



肛門側

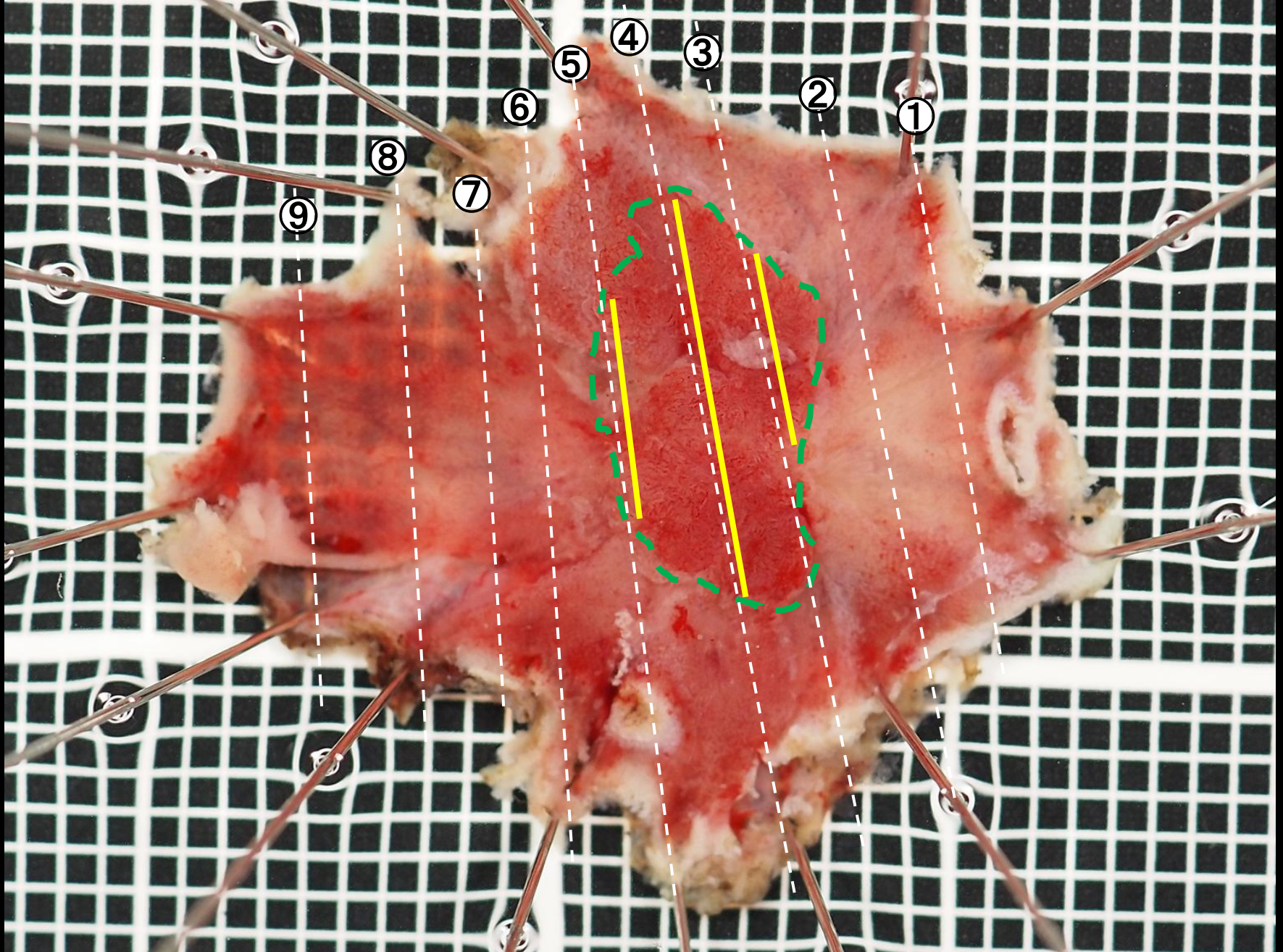
口側



肛門側



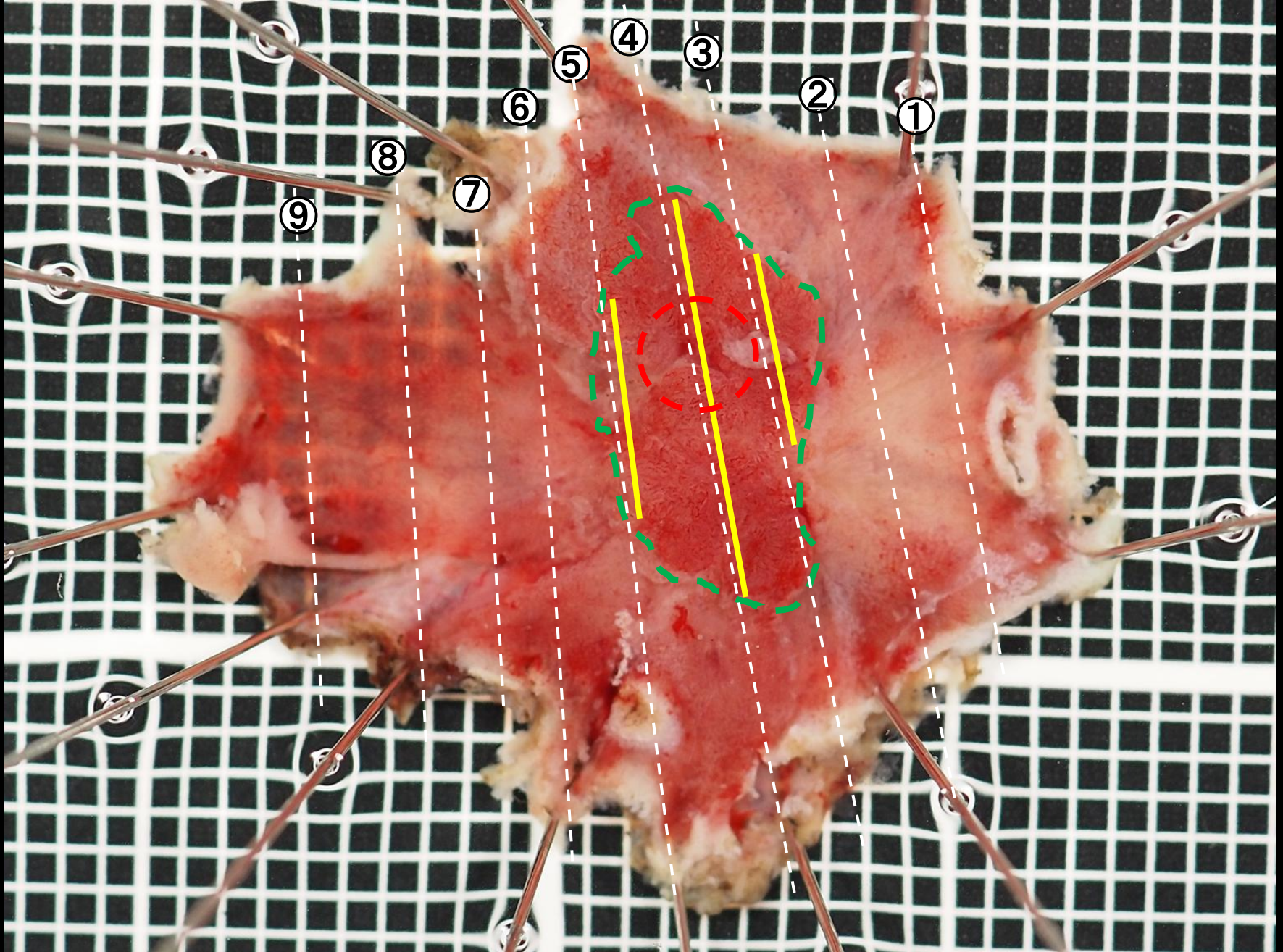
口側



肛門側

— adenoma

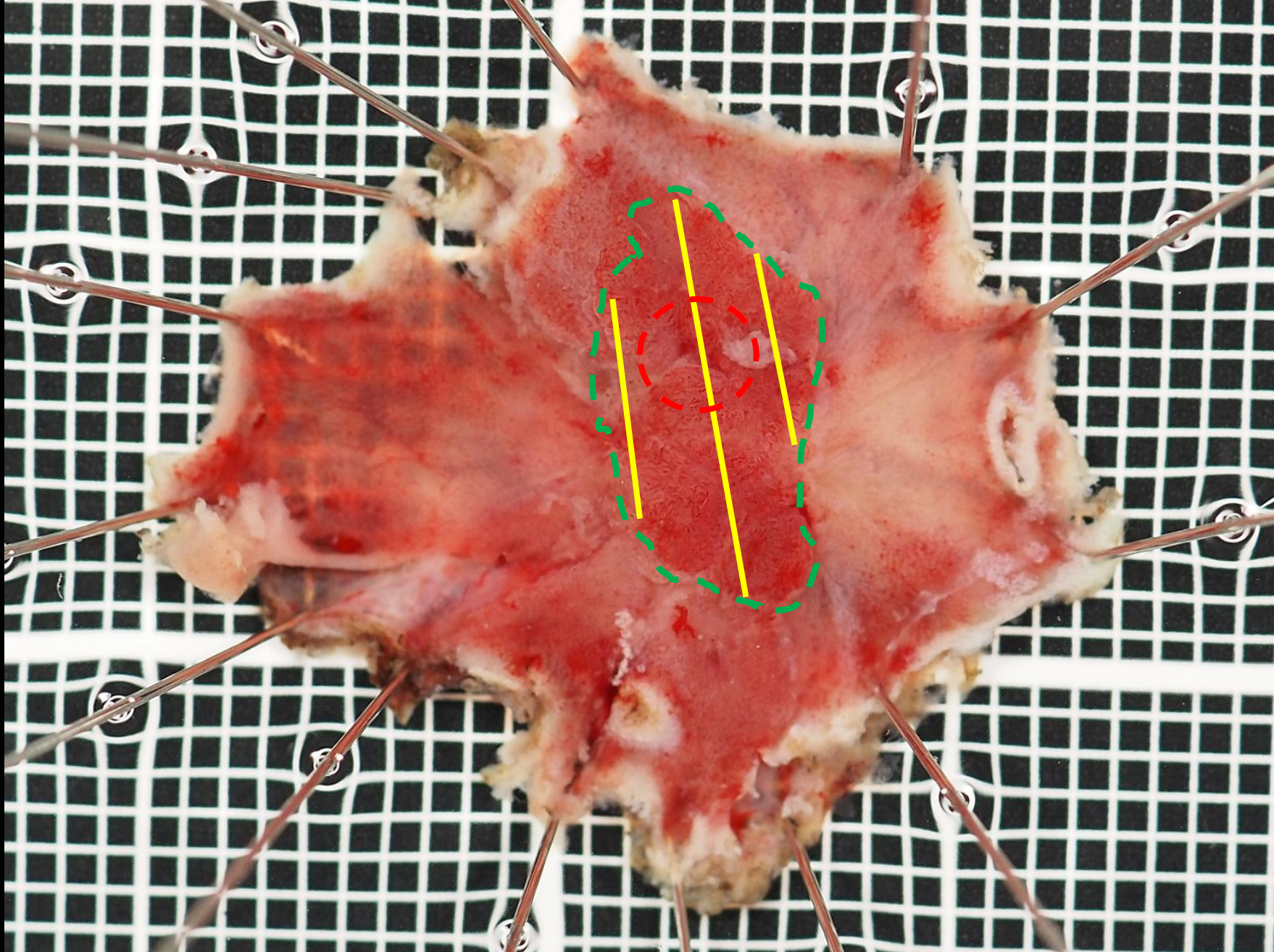
口側



肛門側

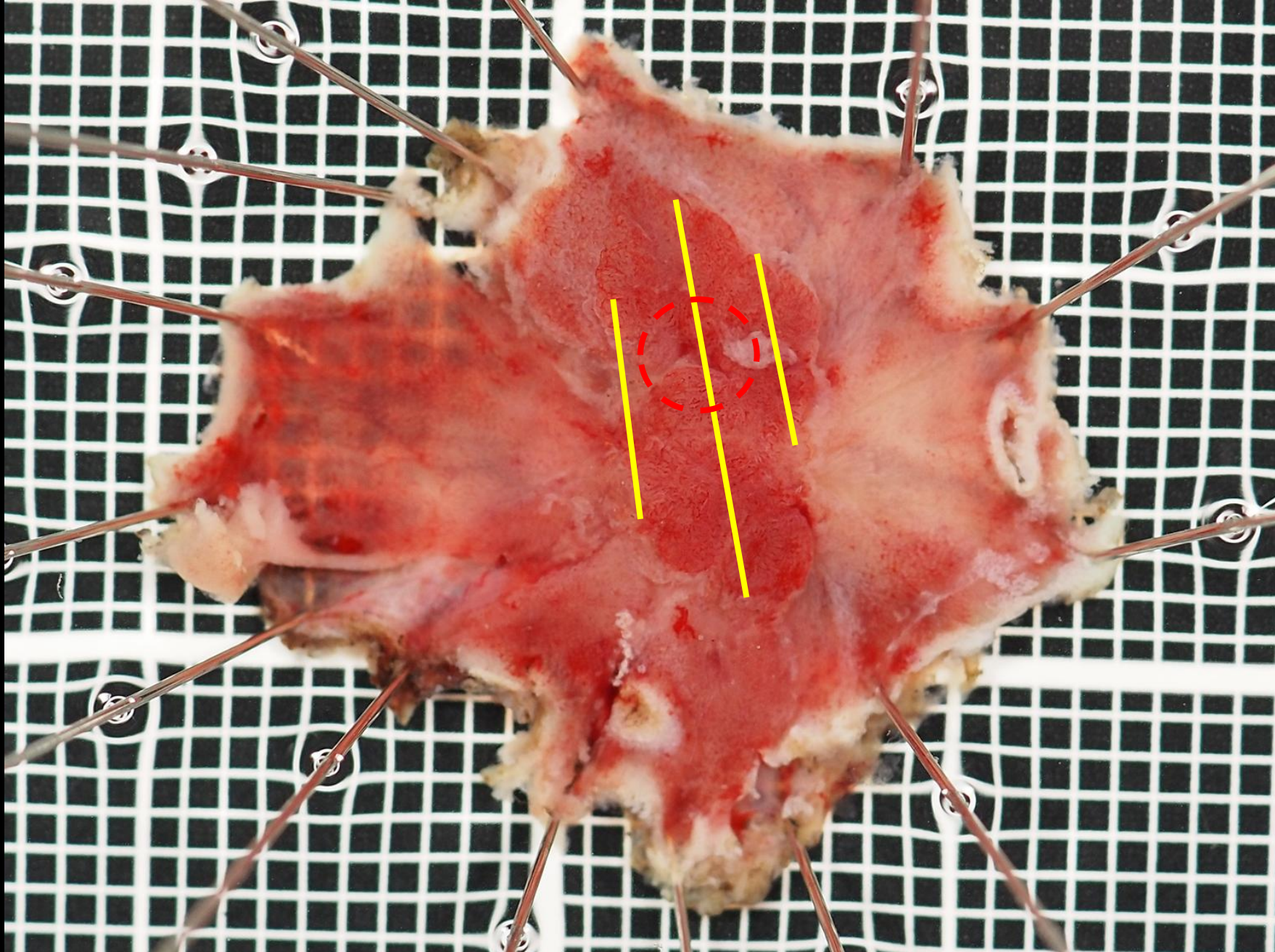
— adenoma

口側



肛門側

口側



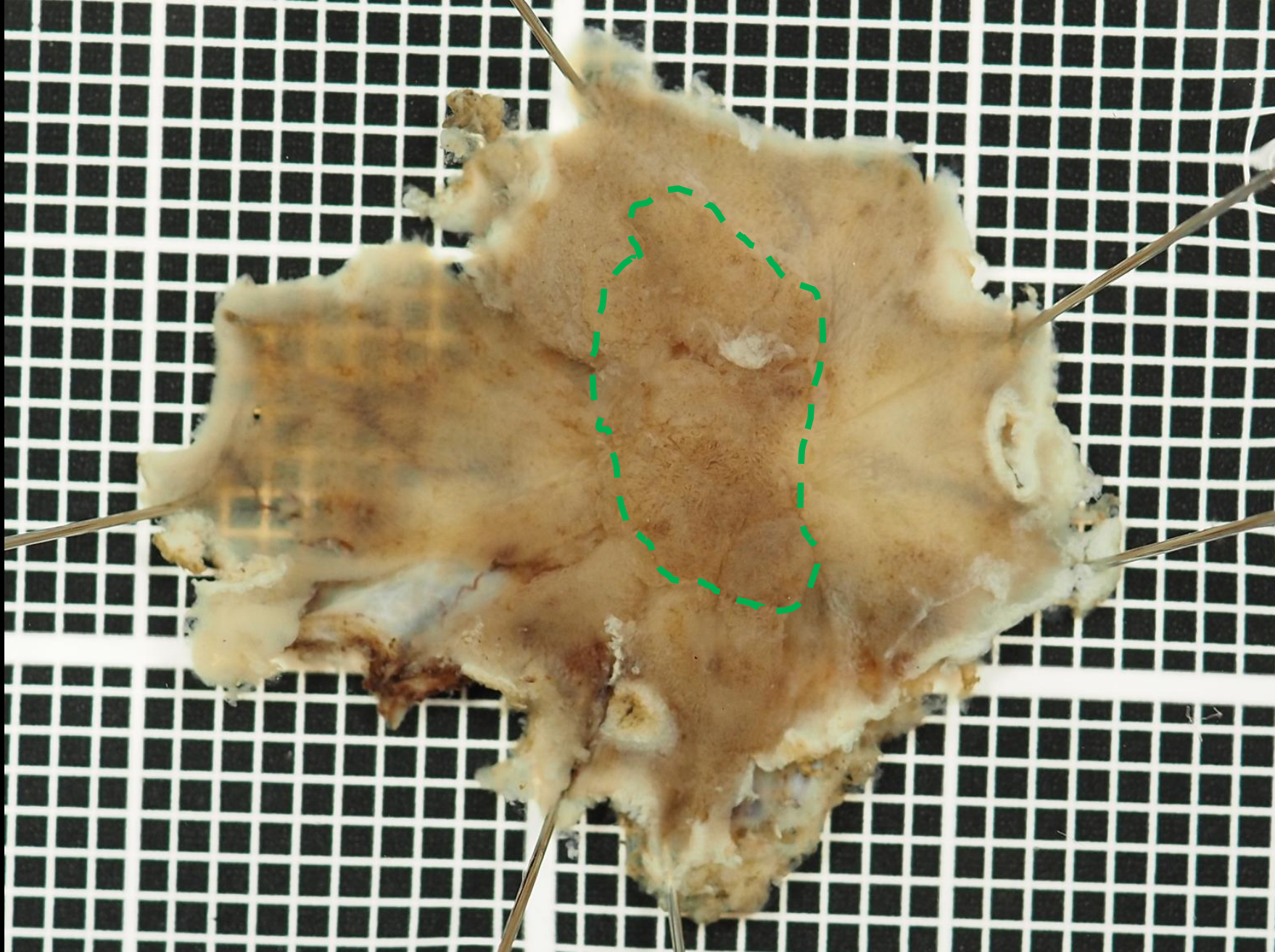
肛門側

口側



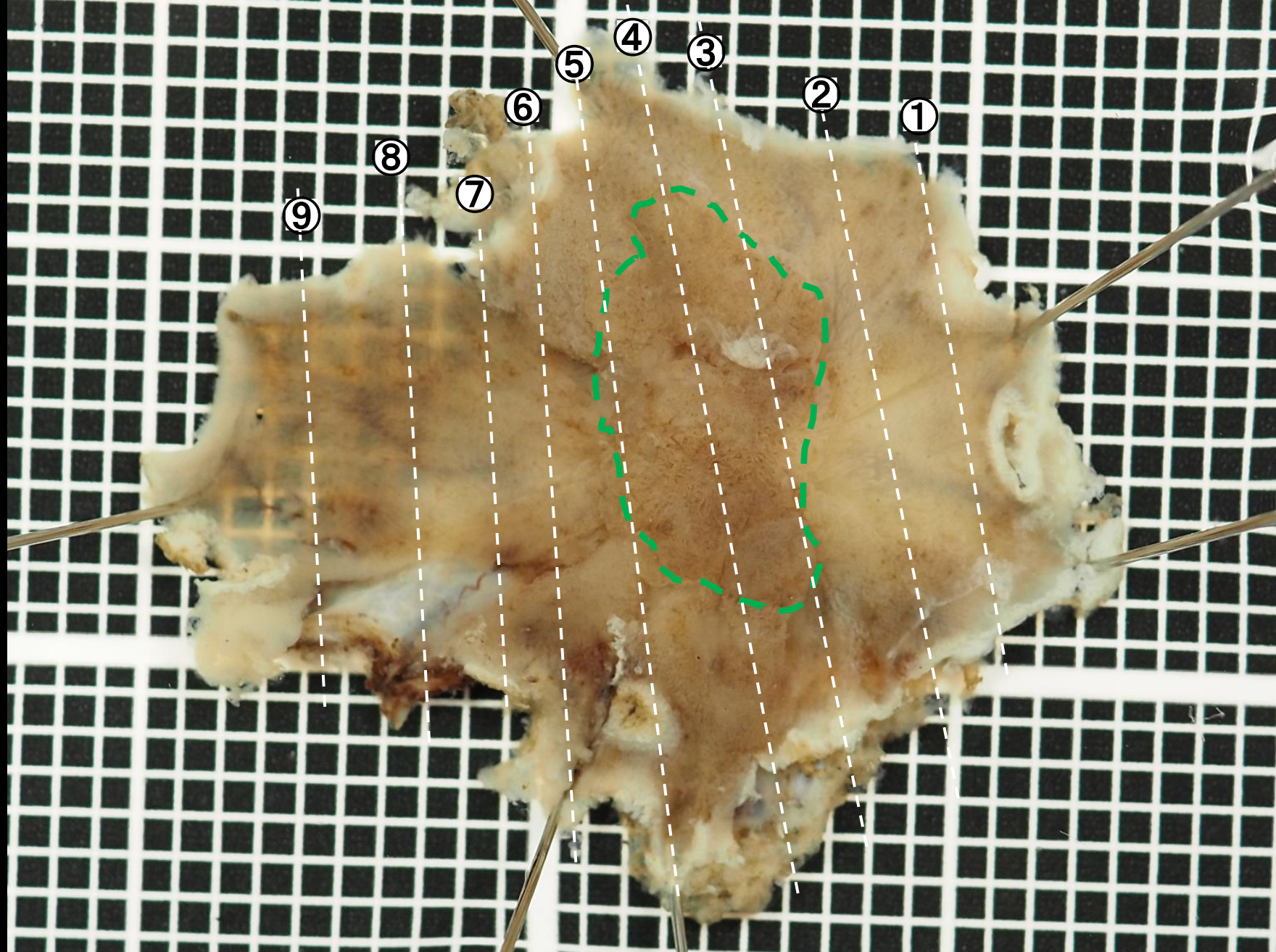
肛門側

口側



肛門側

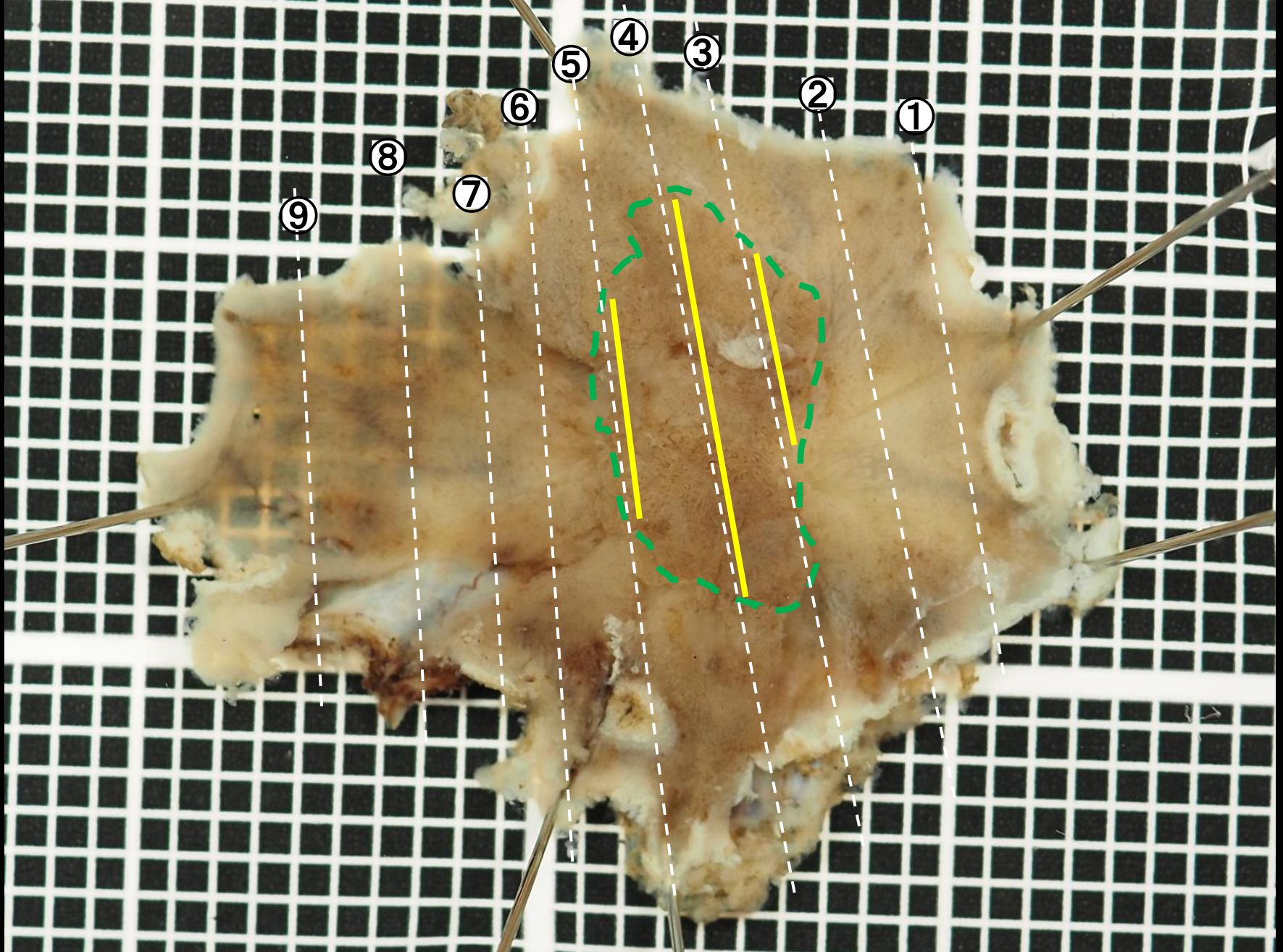
口側



肛門側



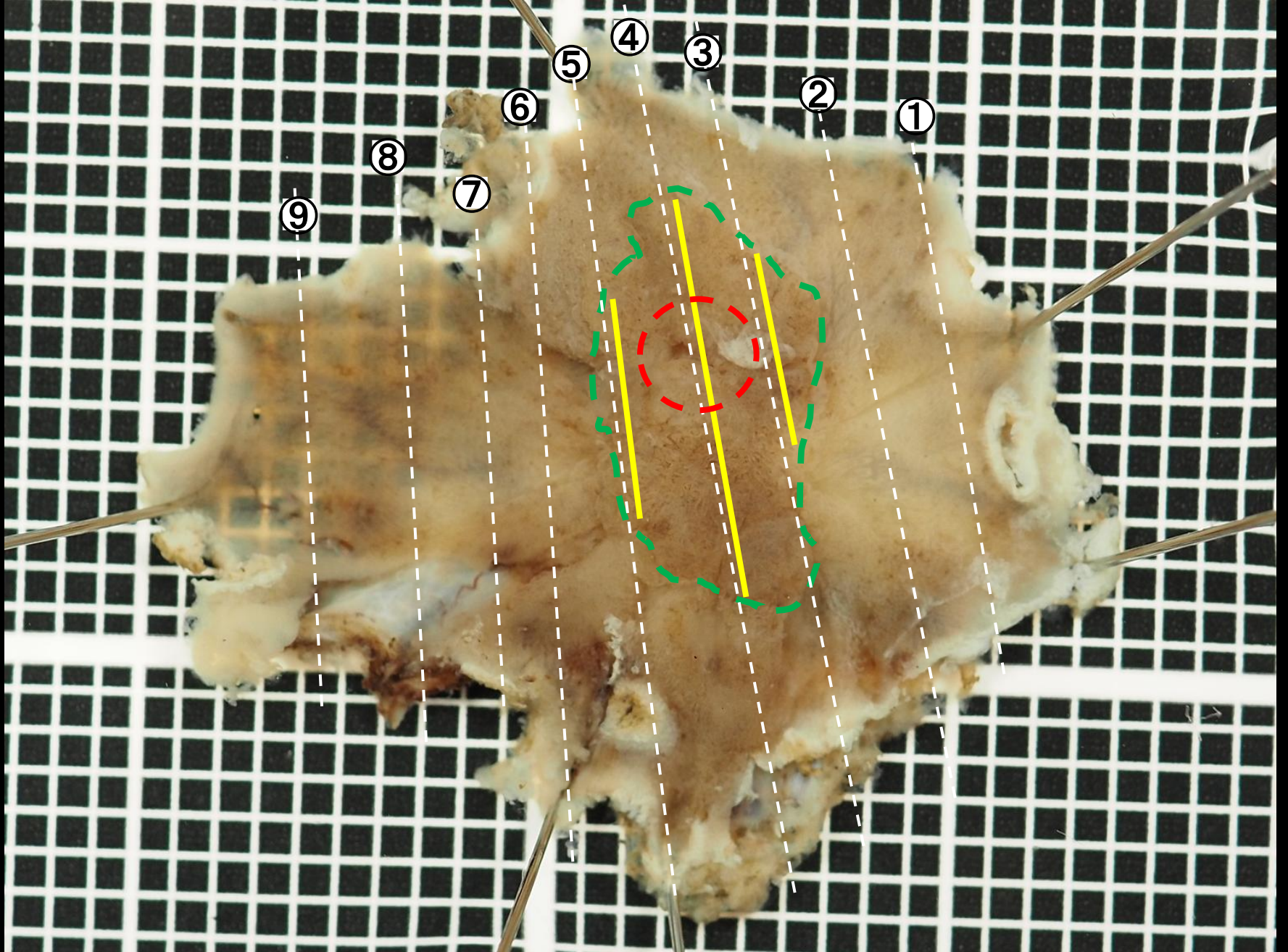
口側



肛門側

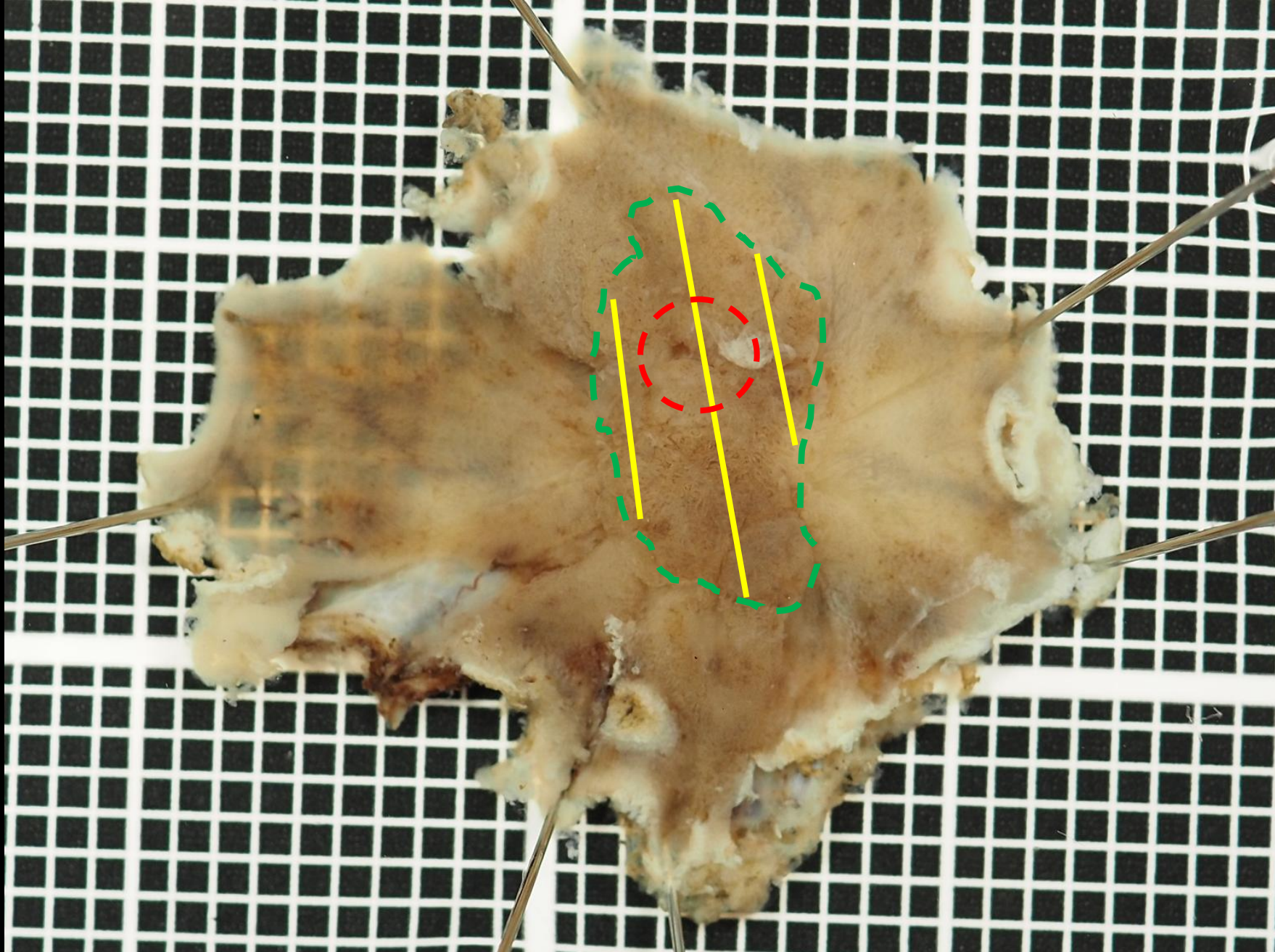
— adenoma

口側



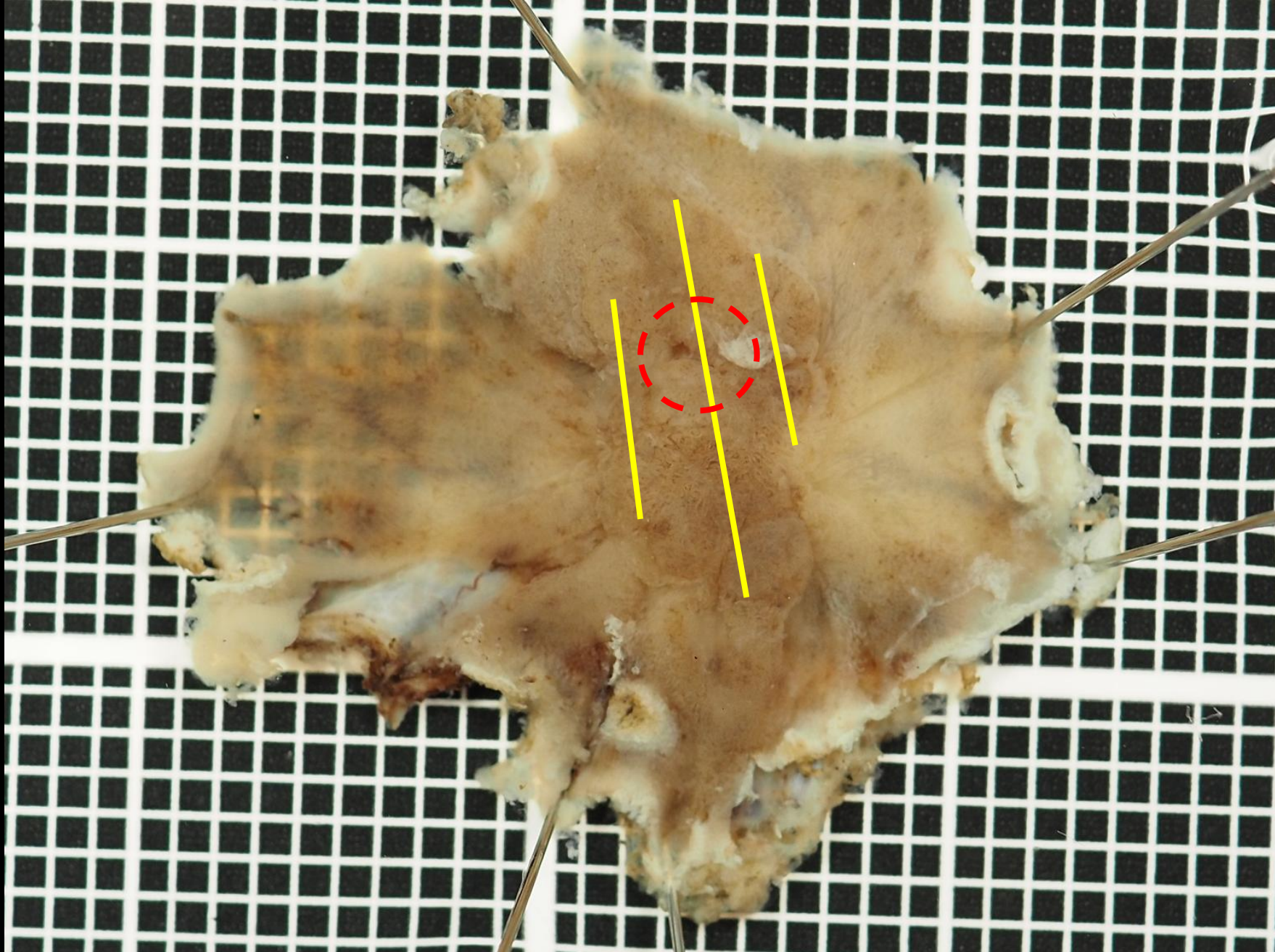
肛門側

口側



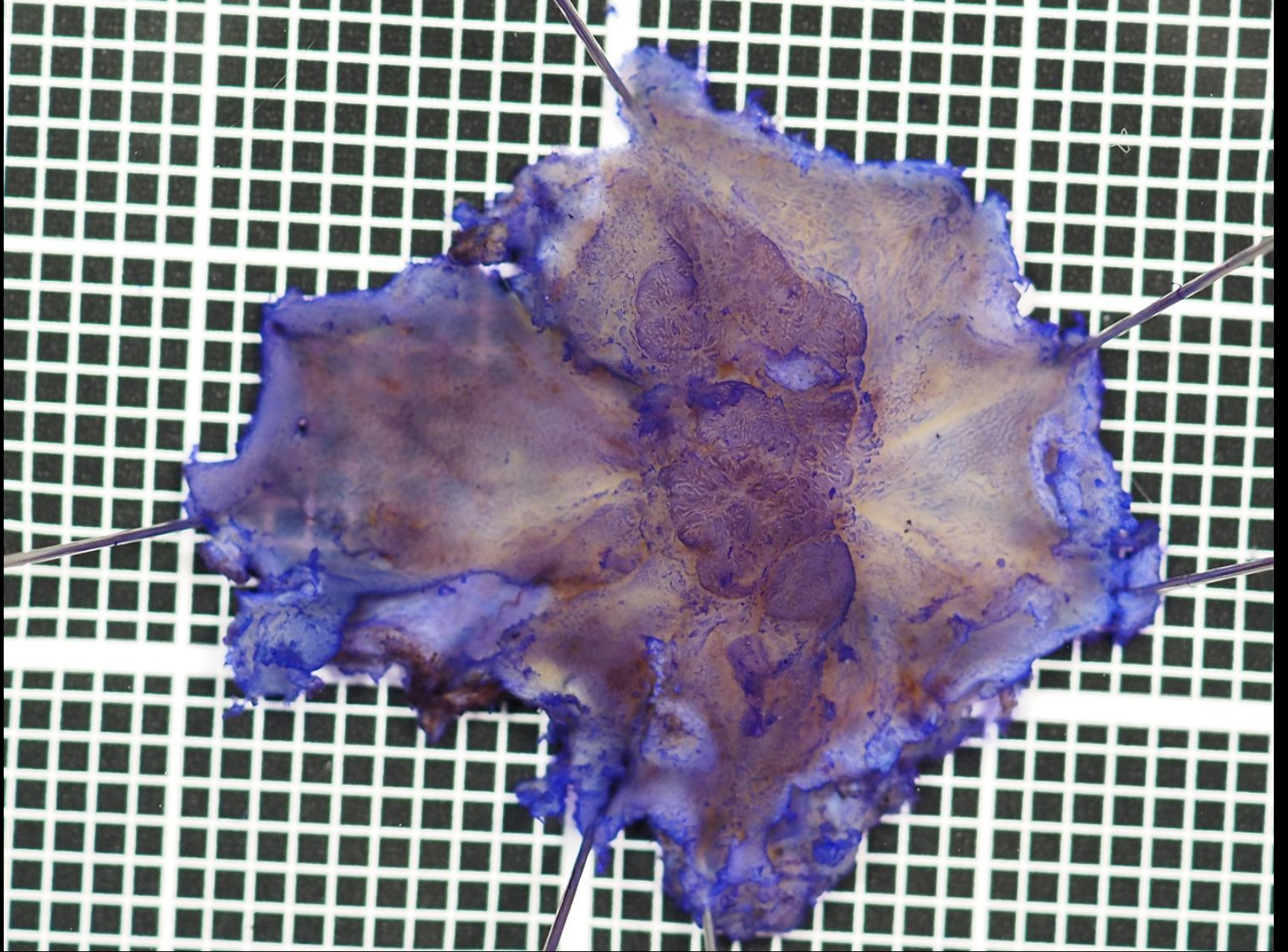
肛門側

口側



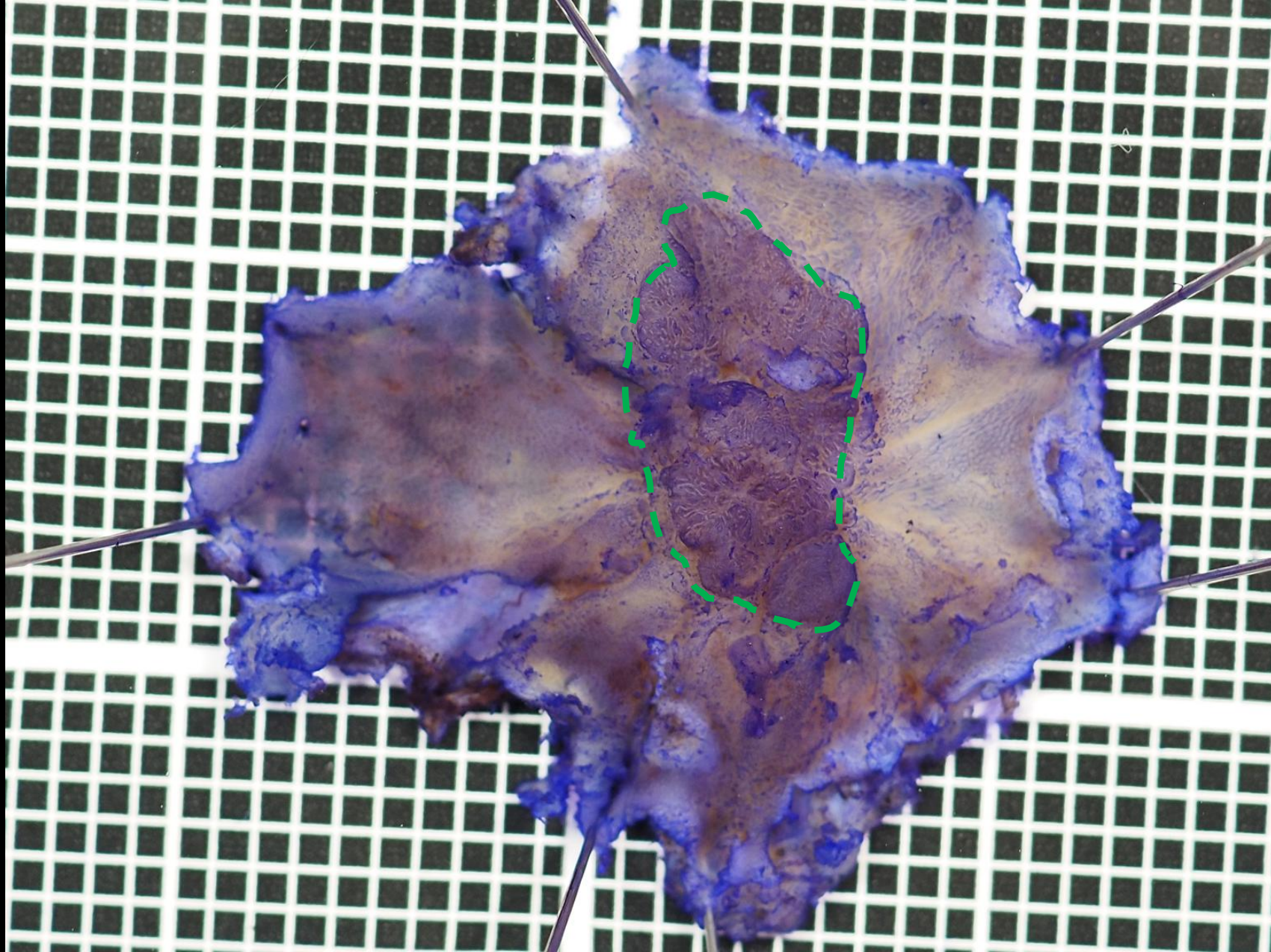
肛門側

口側



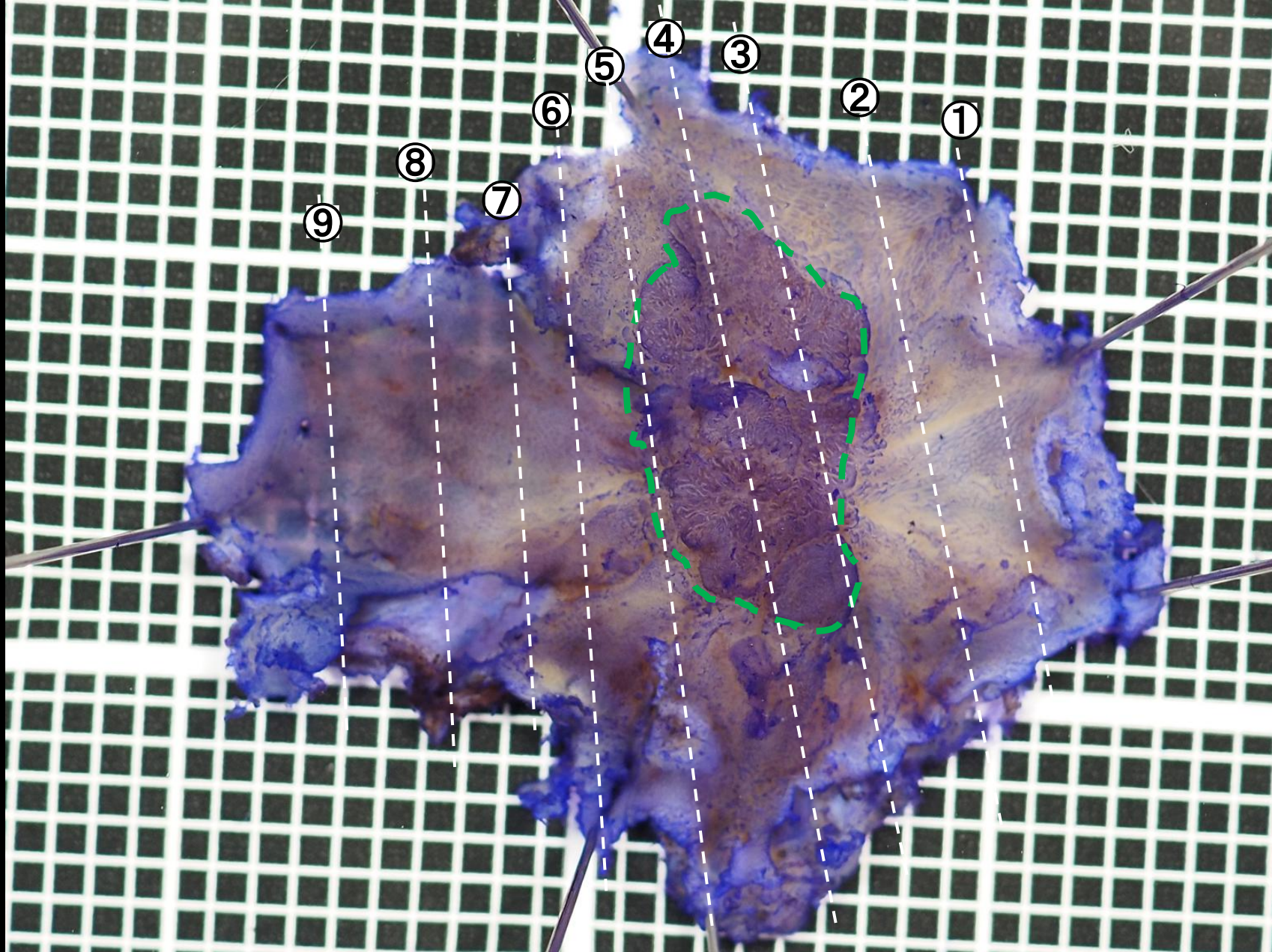
肛門側

口側



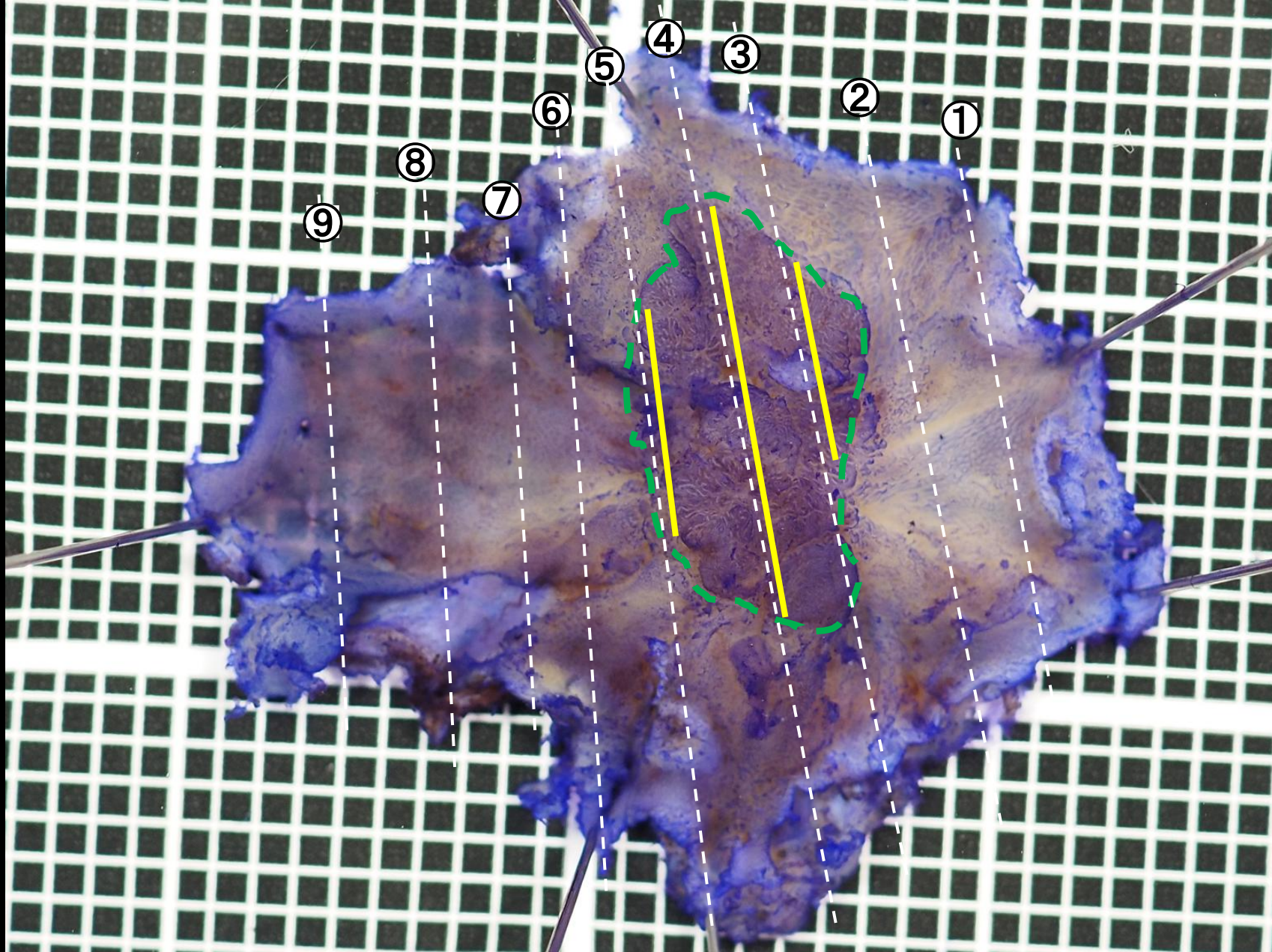
肛門側

口側



肛門側

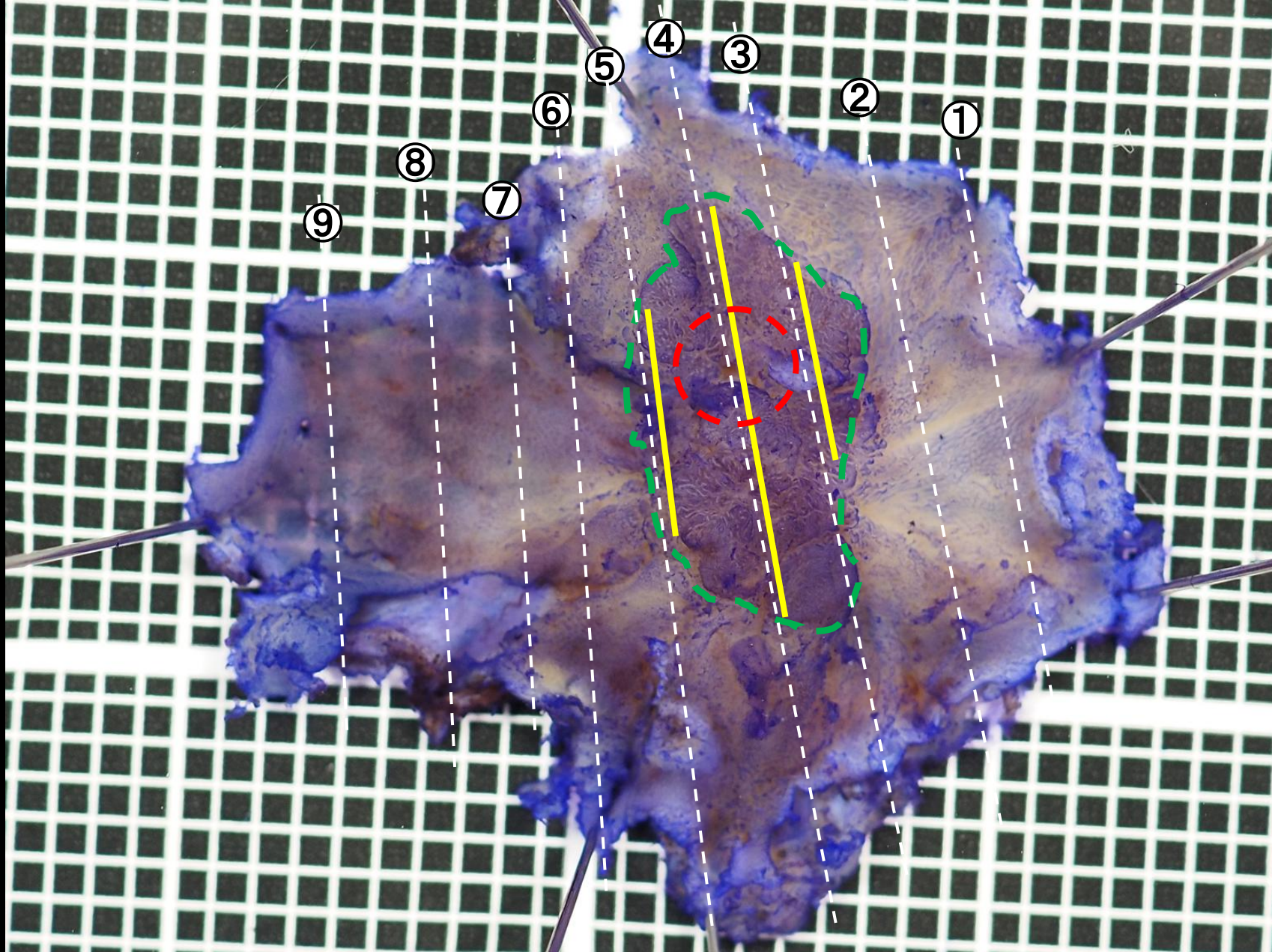
口側



肛門側

— adenoma

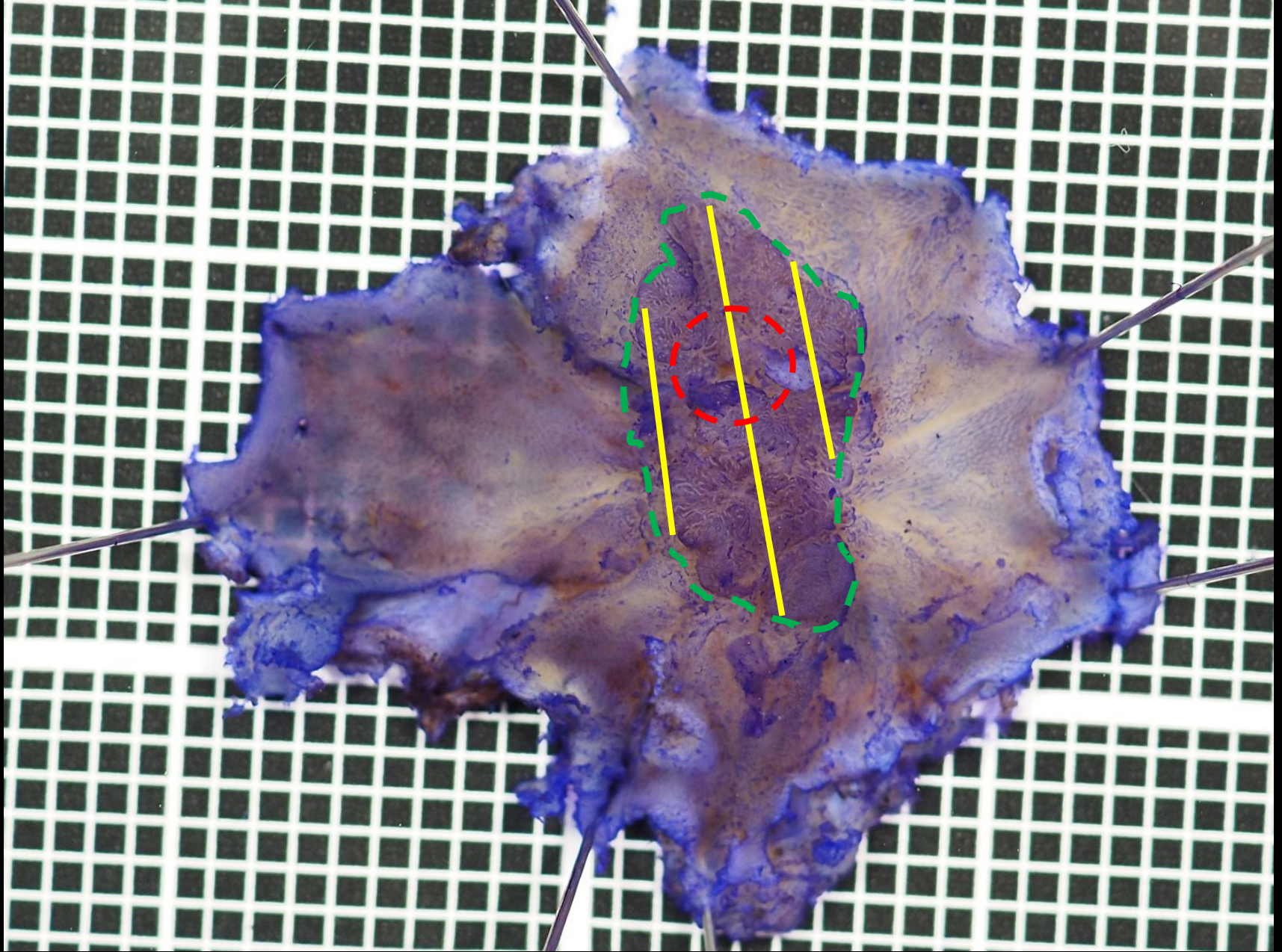
口側



肛門側

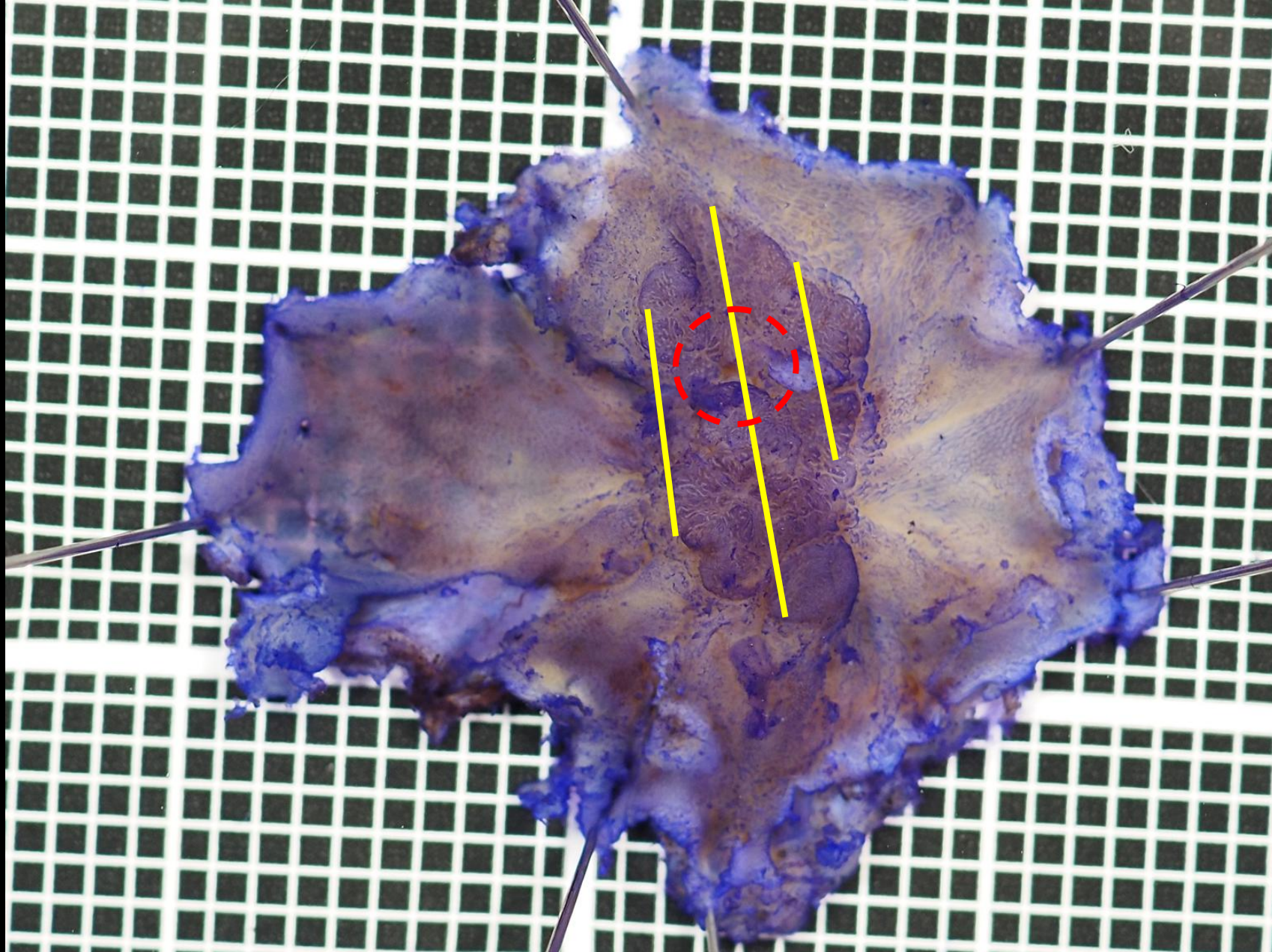


口側



肛門側

口側



肛門側

口側

精査大腸内視鏡
～生検はダメですか・・・？～

精査大腸内視鏡の対象

- 上皮に変化をきたす腫瘍性病変

※ 進行癌については精査は要らない

Ex) 早期大腸癌 (M～SM1 or SM massiveを判断)

悪性リンパ腫

(転移性大腸癌)

精査大腸内視鏡の手順～通常観察

- ① 病変の遠景(中間)の写真
- ② 病変全体が写っているキレイな写真(近景)
- ③ 病変の深達度診断に必要な写真(吸気・脱気)
- ④ インジゴカルミンをかけた写真

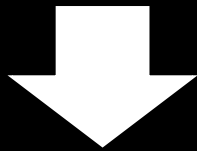
精査大腸内視鏡の手順～拡大観察

② NBI観察

③ Crystal Violet(ピオクタニン[®])染色での
拡大観察

生検はダメですか・・・？

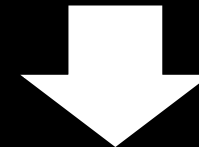
大腸 ESD/EMR ガイドライン (第2版)



なお、質的診断のための生検は原則すべきではない（推奨の強さ 2，エビデンスレベル C）。表面型病変の場合，術前診断としての生検は粘膜下

大腸ポリープ 診療ガイドライン 2020

改訂第2版



内視鏡治療の適応病変に生検は必須か？

回答

- 生検は行わずに治療方針を決定してもよい。

生検はダメですか・・・？

ORIGINAL ARTICLES: PDF ONLY

Epithelial Misplacement After Biopsy of Colorectal Adenomas

Dirschmid, K M.D.; Kiesler, J M.D.; Mathis, G M.D.; Beller, S M.D.; Stoss, F; Schobel, B M.D.

[Author Information](#) 

The American Journal of Surgical Pathology 17(12):p 1262 -1265, December 1993.

tumour cells. After an average of 7 days, we found misplacement of these groups of cells into the submucosa where, during the course of reparative processes, they became embedded within a capillary-rich granulation tissue. Subsequently, fibrosis of the submucosa develops with persistent mucus pools. Our results thus show that removal of biopsy material from adenomas can result in misplacement of tumour particles into the submucosa. These changes were observed in flat or broad-based tumours, and epithelial misplacement appears to be detectable within only a short period after biopsy. For the differential diagnosis, it is important to distinguish these changes from invasive carcinoma

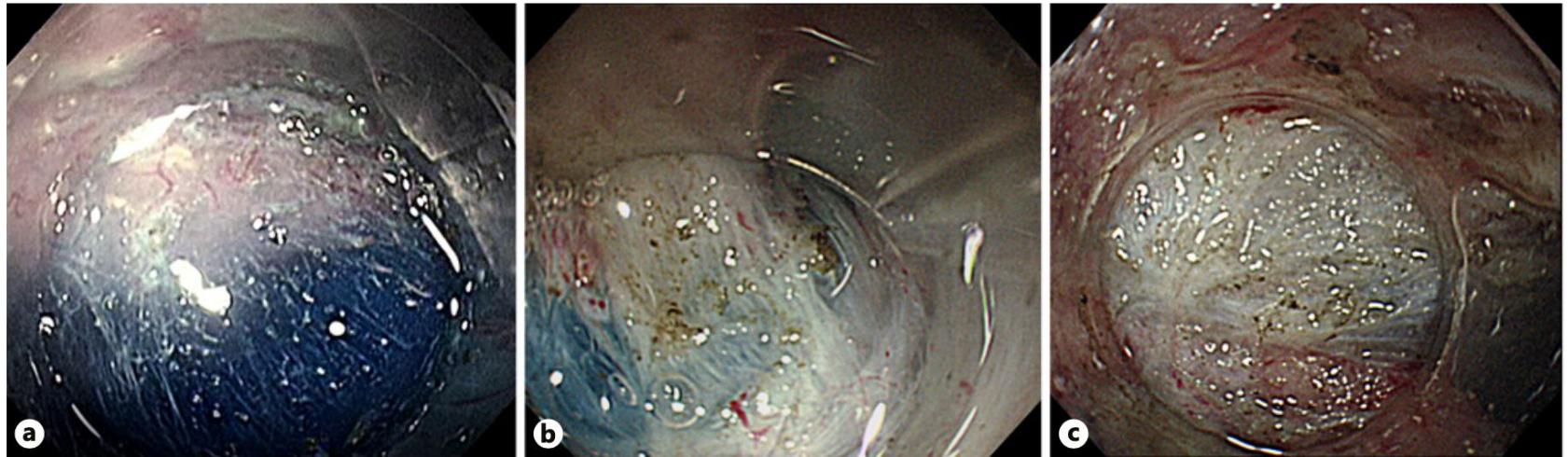
生検はダメですか・・・？

Factors Associated with Fibrosis during Colorectal Endoscopic Submucosal Dissection: Does Pretreatment Biopsy Potentially Elicit Submucosal Fibrosis and Affect Endoscopic Submucosal Dissection Outcomes?

Masatake Kuroha^a Hisashi Shiga^a Yoshitake Kanazawa^a Hiroshi Nagai^a
Tomoyuki Handa^a Ryo Ichikawa^a Motoyuki Onodera^a Takeo Naito^a
Rintaro Moroi^a Tomoya Kimura^a Katsuya Endo^b Yoichi Kakuta^a
Yoshitaka Kinouchi^c Tooru Shimosegawa^a Atsushi Masamune^a

^aDivision of Gastroenterology, Tohoku University Graduate School of Medicine, Sendai, Japan; ^bDepartment of Gastroenterology, Tohoku Medical and Pharmaceutical University, Sendai, Japan; ^cHealth Administration Center, Center for the Advancement of Higher Education, Tohoku University, Sendai, Japan

ESD中の線維化を示す所見



低



線維化



高

Table 2. Risk factors associated with mild fibrosis during ESD procedure

	Mild fibrosis	Univariate* <i>p</i> value	Multivariate**		
			ORs	<i>p</i> value	95% CI
Pretreatment biopsy, <i>n</i> (%)					
Absent	46/294 (15.7)	<0.001	Reference		
Present	26/54 (48.2)		7.21	<0.001	3.51 14.8

Table 3. Risk factors associated with severe fibrosis during ESD procedure

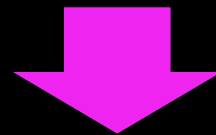
	Severe fibrosis	Univariate* <i>p</i> value	Multivariate**		
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Pretreatment biopsy, <i>n</i> (%)					
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Present	9/37 (24.3)		8.30	0.002	2.17 31.7

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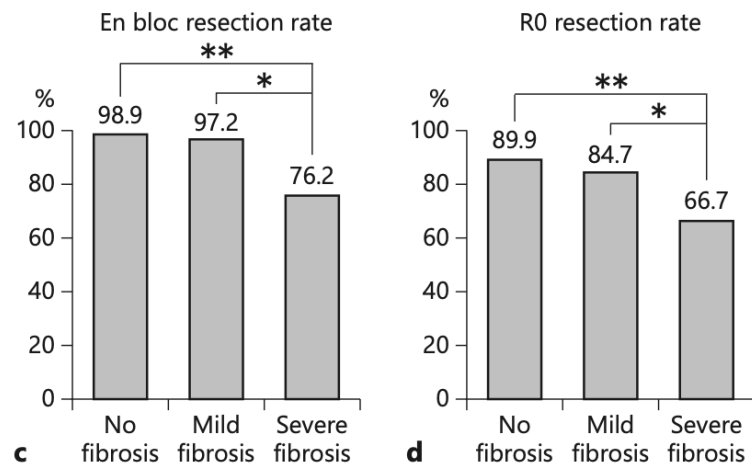
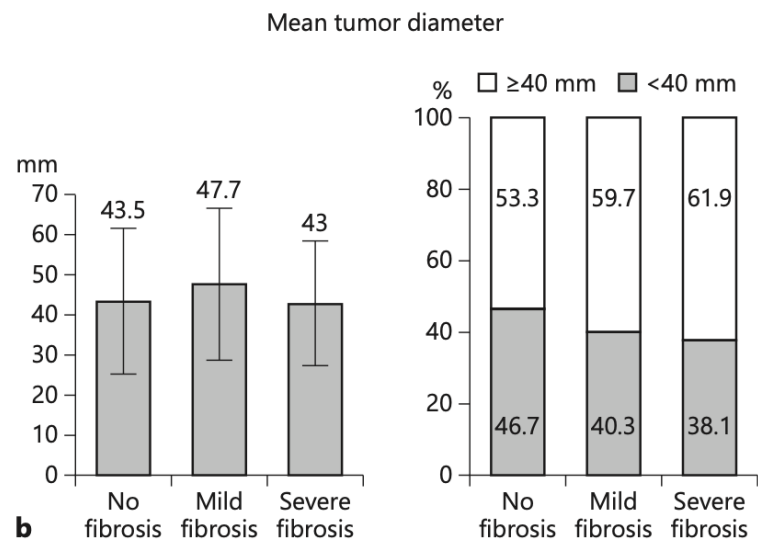
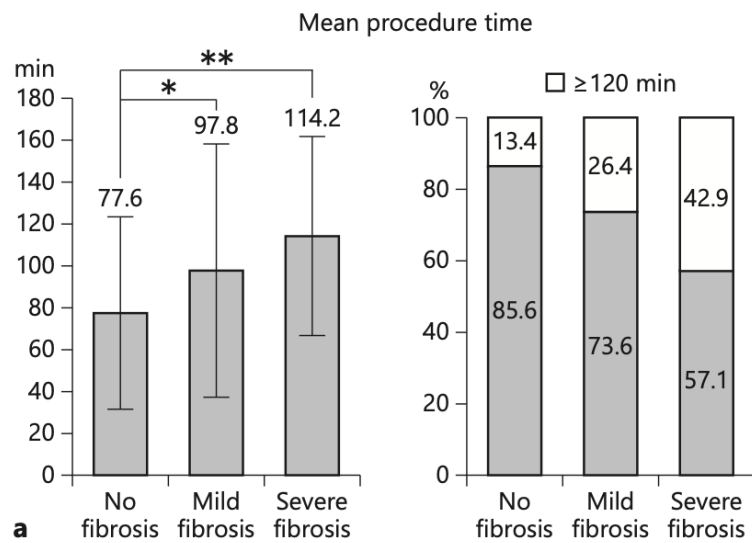
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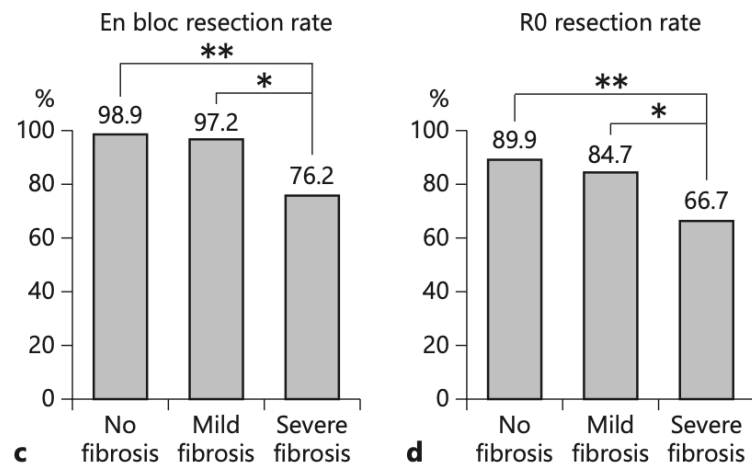
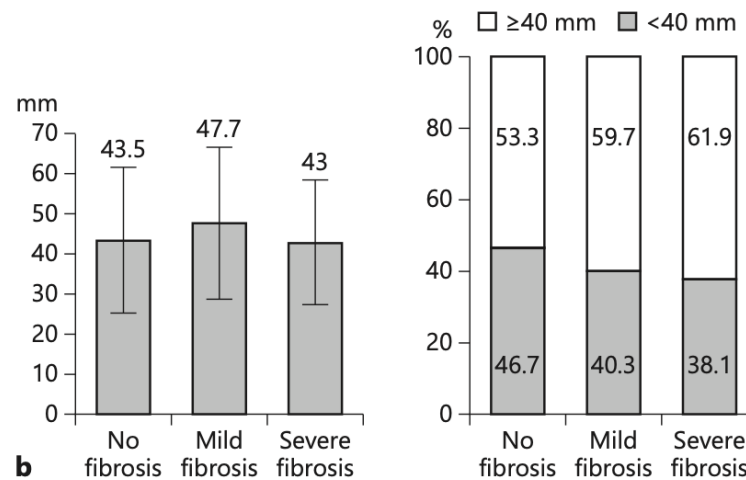
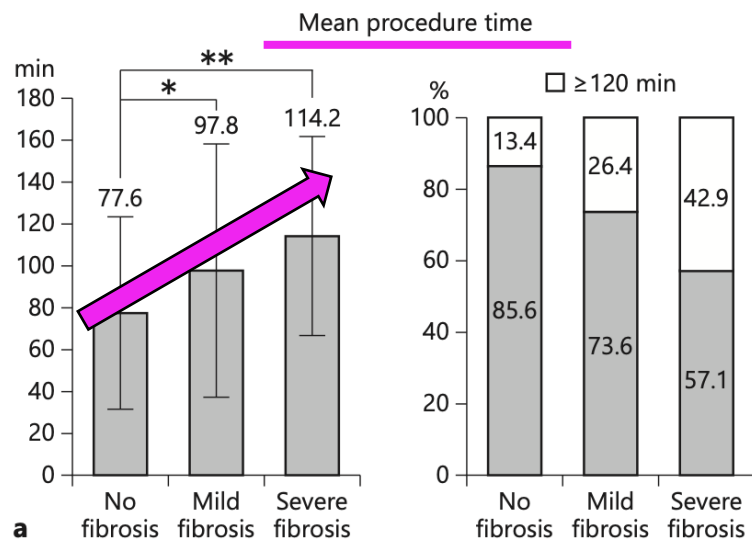


肉眼型、組織型、**生検**が線維化のリスク



e Adverse events

	No fibrosis (n = 276)	Mild fibrosis (n = 72)	Severe fibrosis (n = 21)	p value
Perforation, n (%)	5 (1.8%)	3 (4.2%)	1 (4.8%)	0.25
Delayed bleeding, n (%)	8 (2.9%)	0	0	0.36



d

En bloc resection rate

%

100

80

60

40

20

0

No fibrosis

Mild fibrosis

Severe fibrosis

R0 resection rate

%

100

80

60

40

20

0

No fibrosis

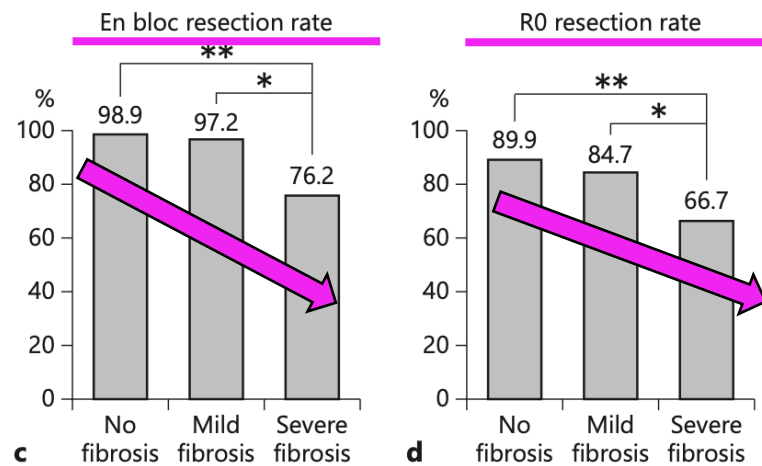
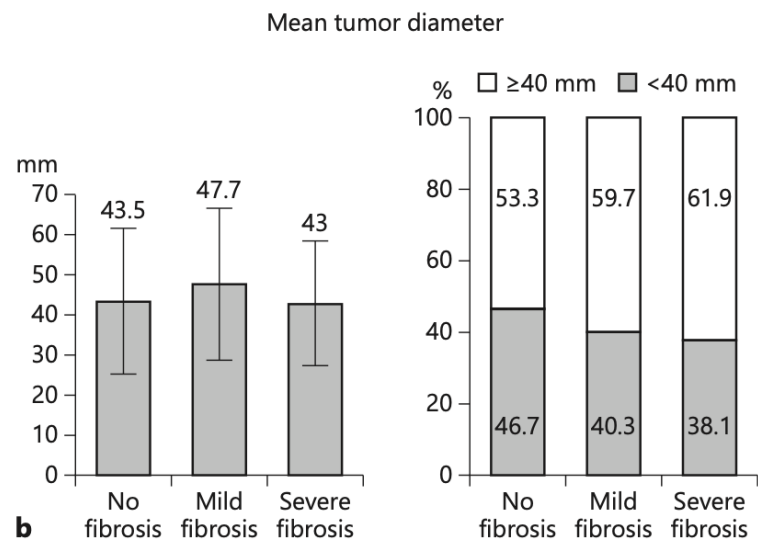
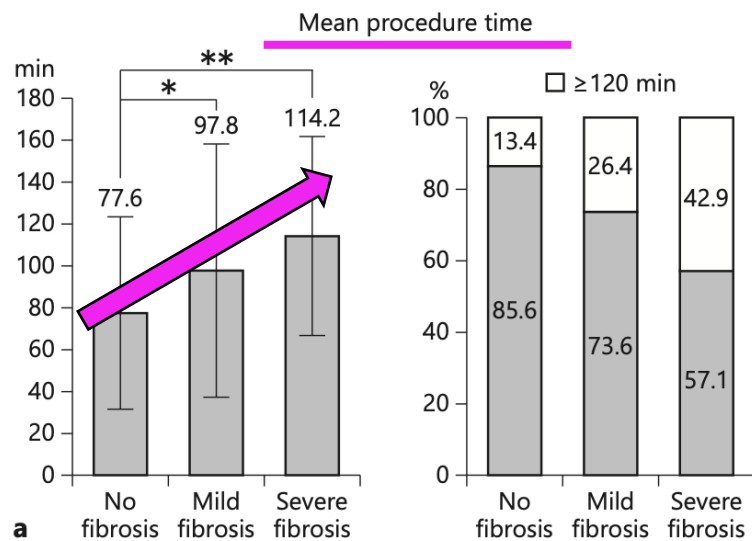
Mild fibrosis

Severe fibrosis

Adverse events

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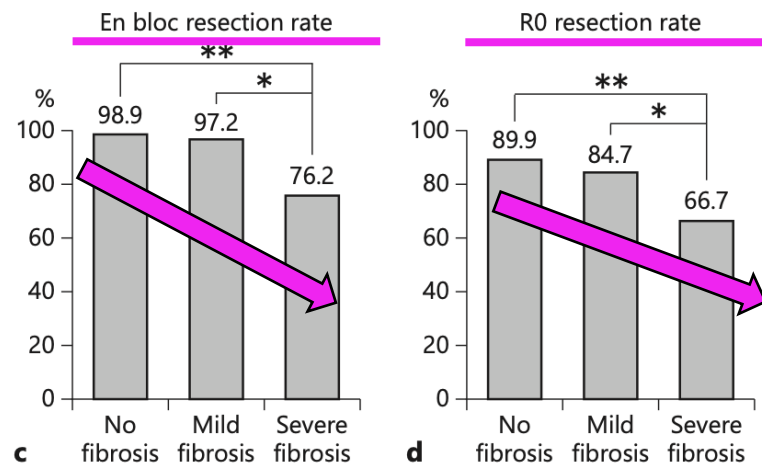
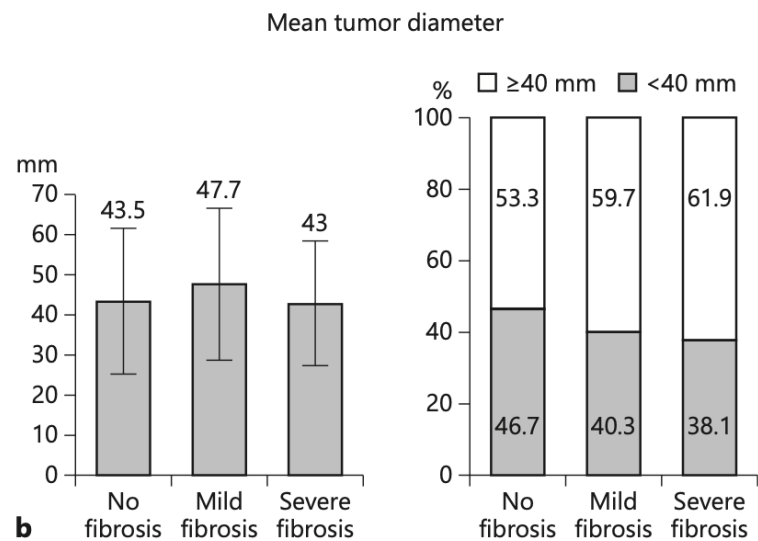
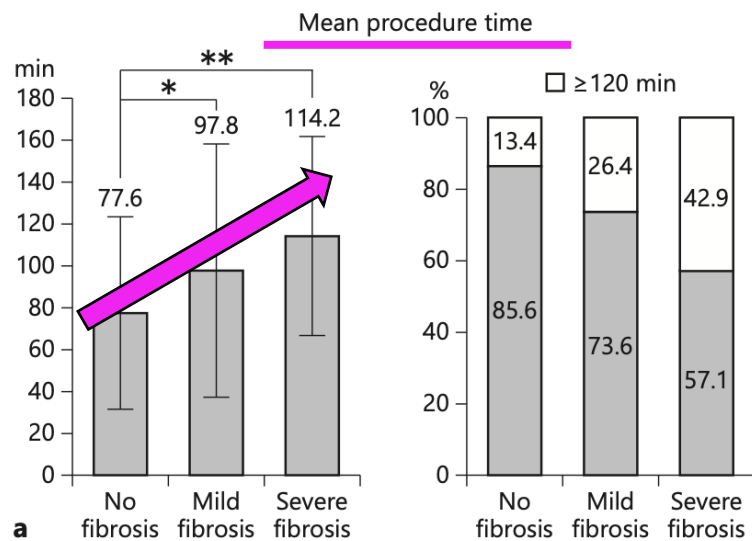
e



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e



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線維化が強いほど処置時間増、
一括切除率とR0切除率は減

では生検のメリットは・・・？

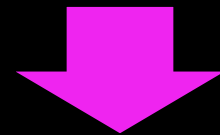
Table 5. Comparison of diagnosis based on pretreatment biopsy specimens and histologic diagnosis of resected specimens

	Histological diagnosis of resected specimens	
	carcinoma	adenoma
Pretreatment diagnosis based on biopsy specimens		
Carcinoma	15	2
Adenoma	26	19

では生検のメリットは・・・？

Table 5. Comparison of diagnosis based on pretreatment biopsy specimens and histologic diagnosis of resected specimens

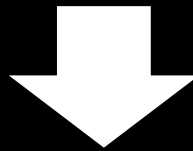
	Histological diagnosis of resected specimens	
	carcinoma	adenoma
Pretreatment diagnosis based on biopsy specimens		
Carcinoma	15	2
Adenoma	26	19



生検の結果と切除検体の病理結果は一致しない

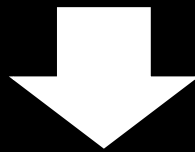
生検はダメですか・・・？

内視鏡治療適応病変において
線維化が生じることにより
浸潤癌との鑑別が困難になる
内視鏡治療が困難になる



生検はダメですか・・・？

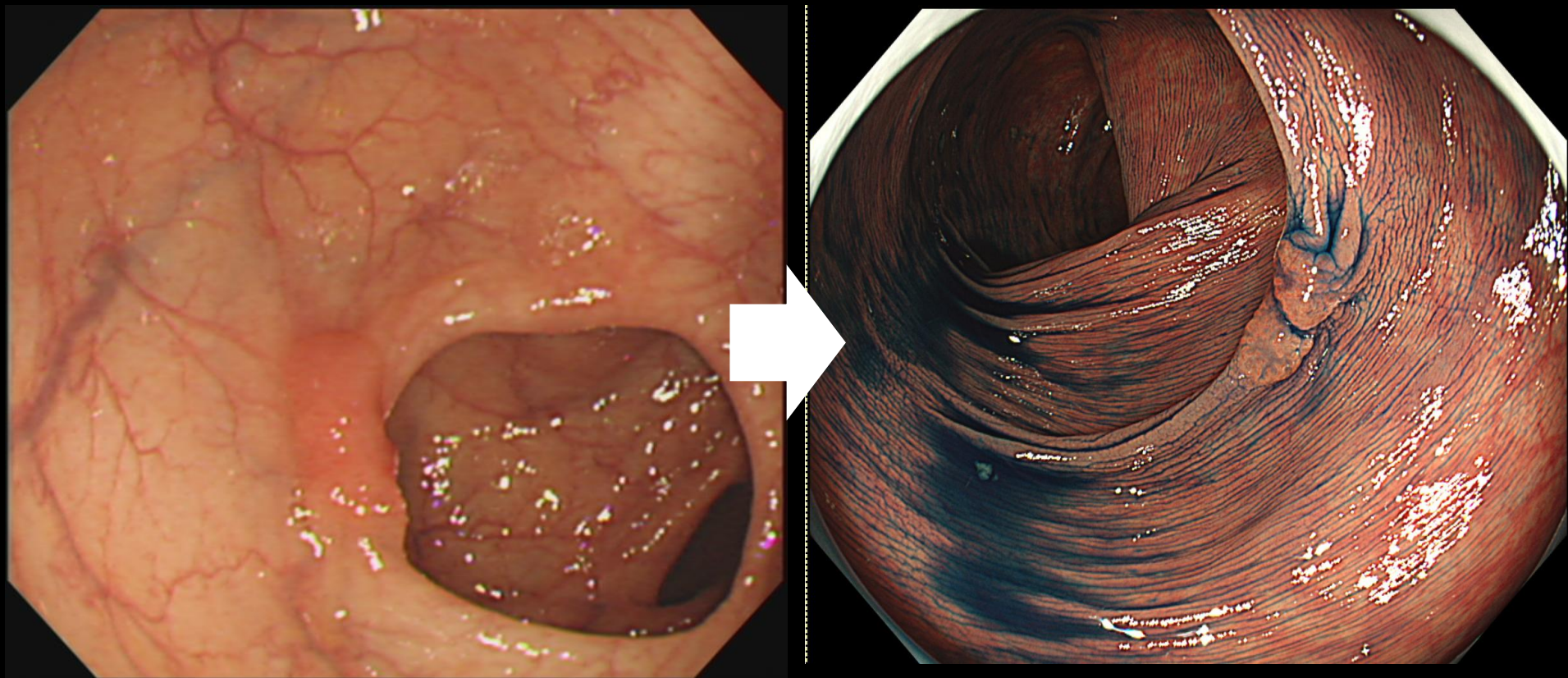
内視鏡治療適応病変において
線維化が生じることにより
浸潤癌との鑑別が困難になる
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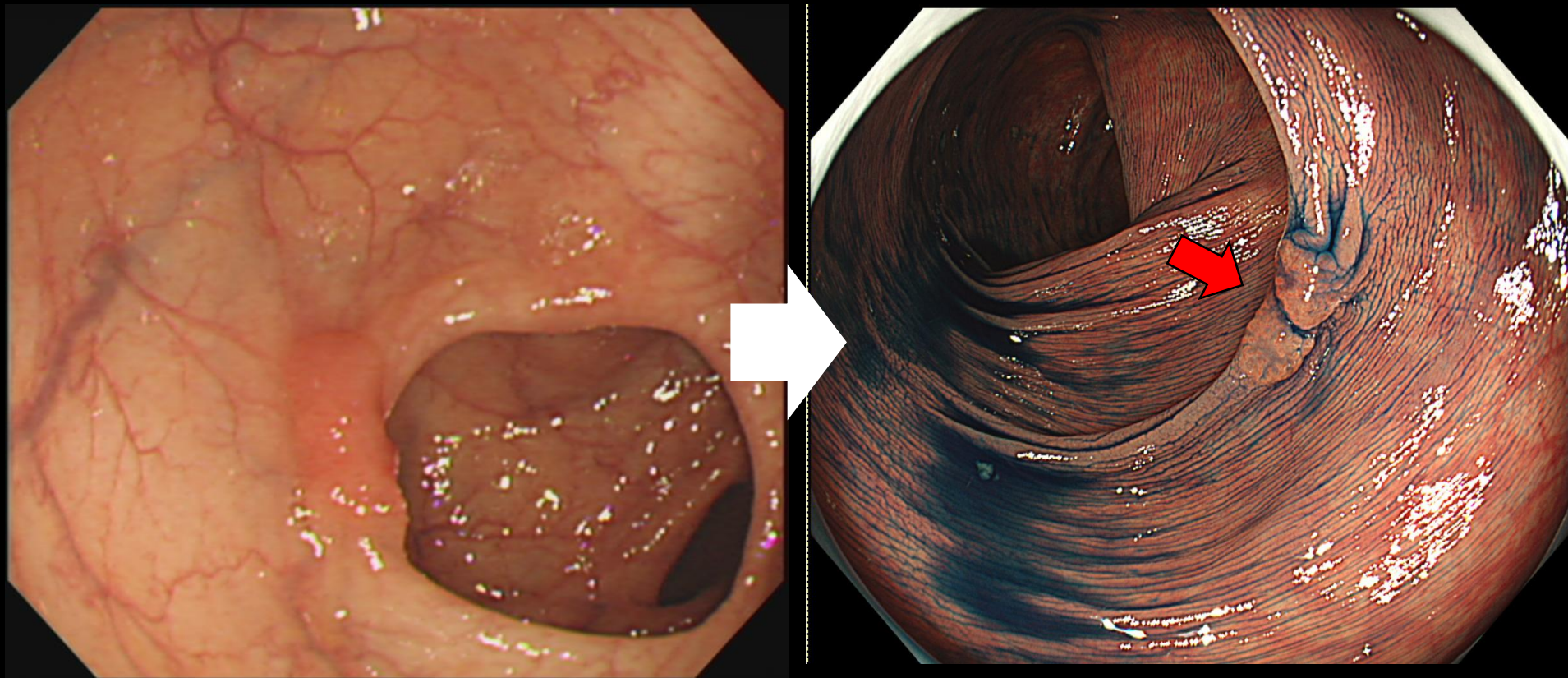
生検はダメです！！

本症例

生検による変化～内視鏡像

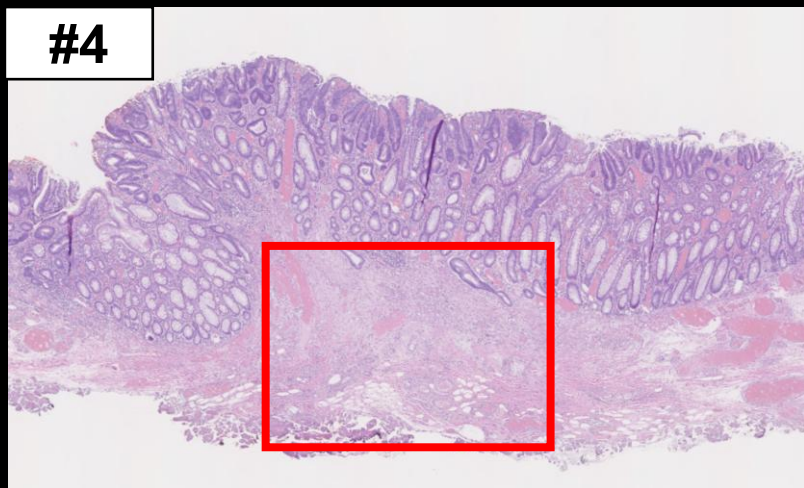


生検による変化～内視鏡像

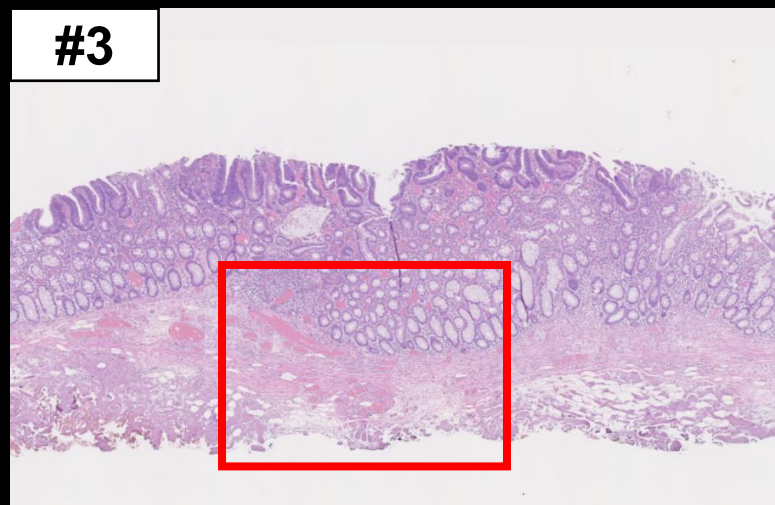


生検による変化～病理

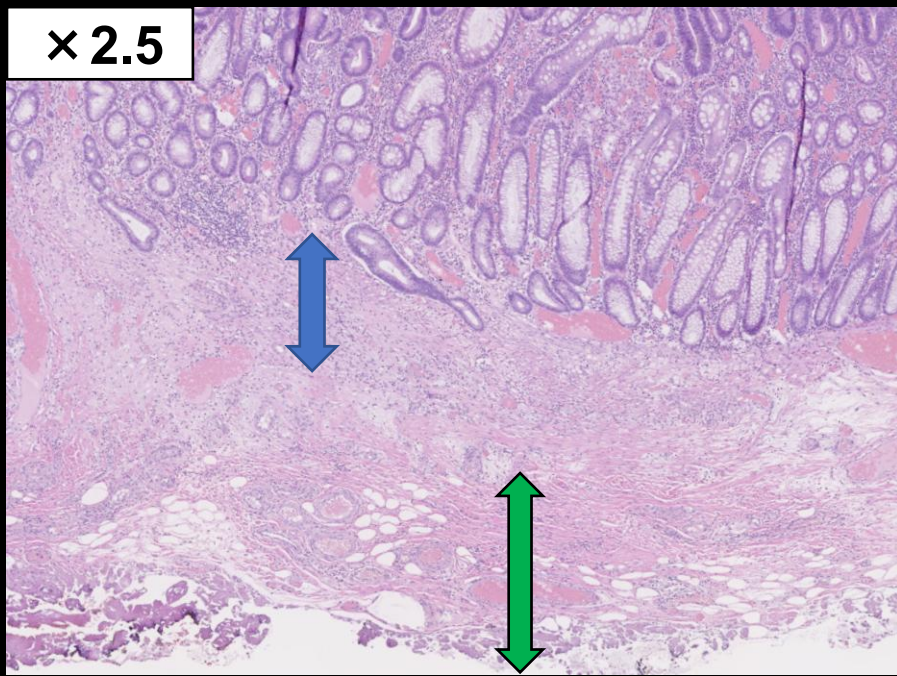
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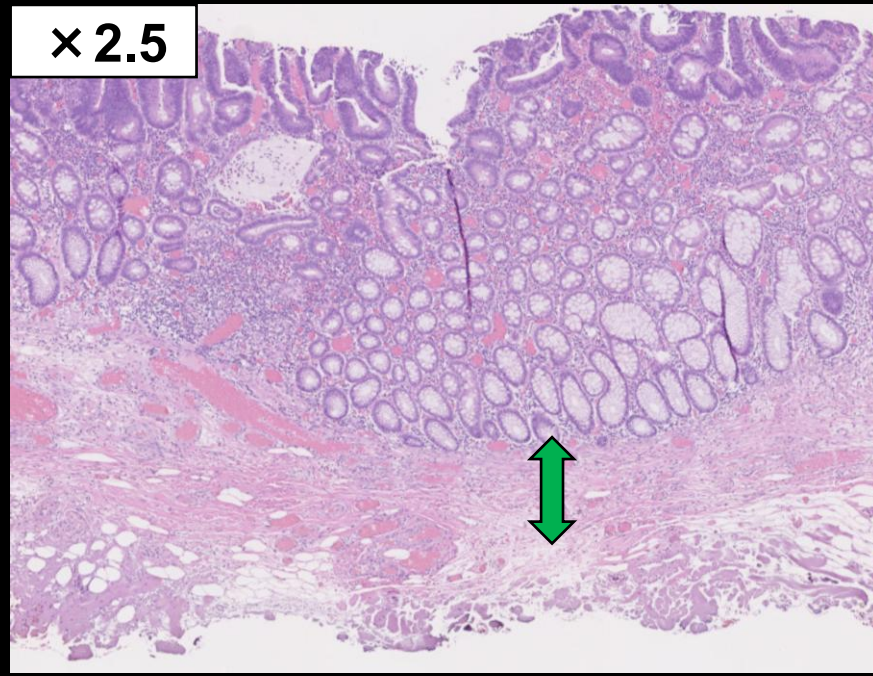
#3



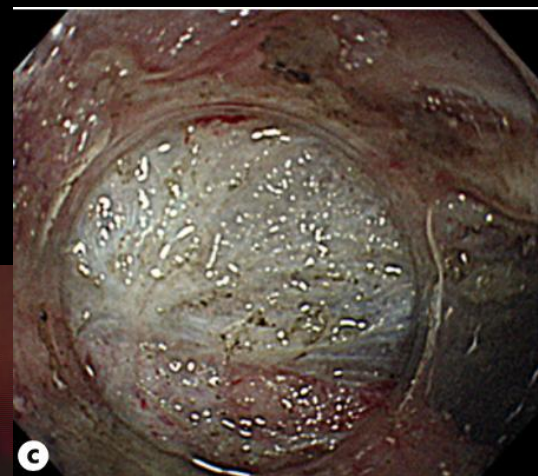
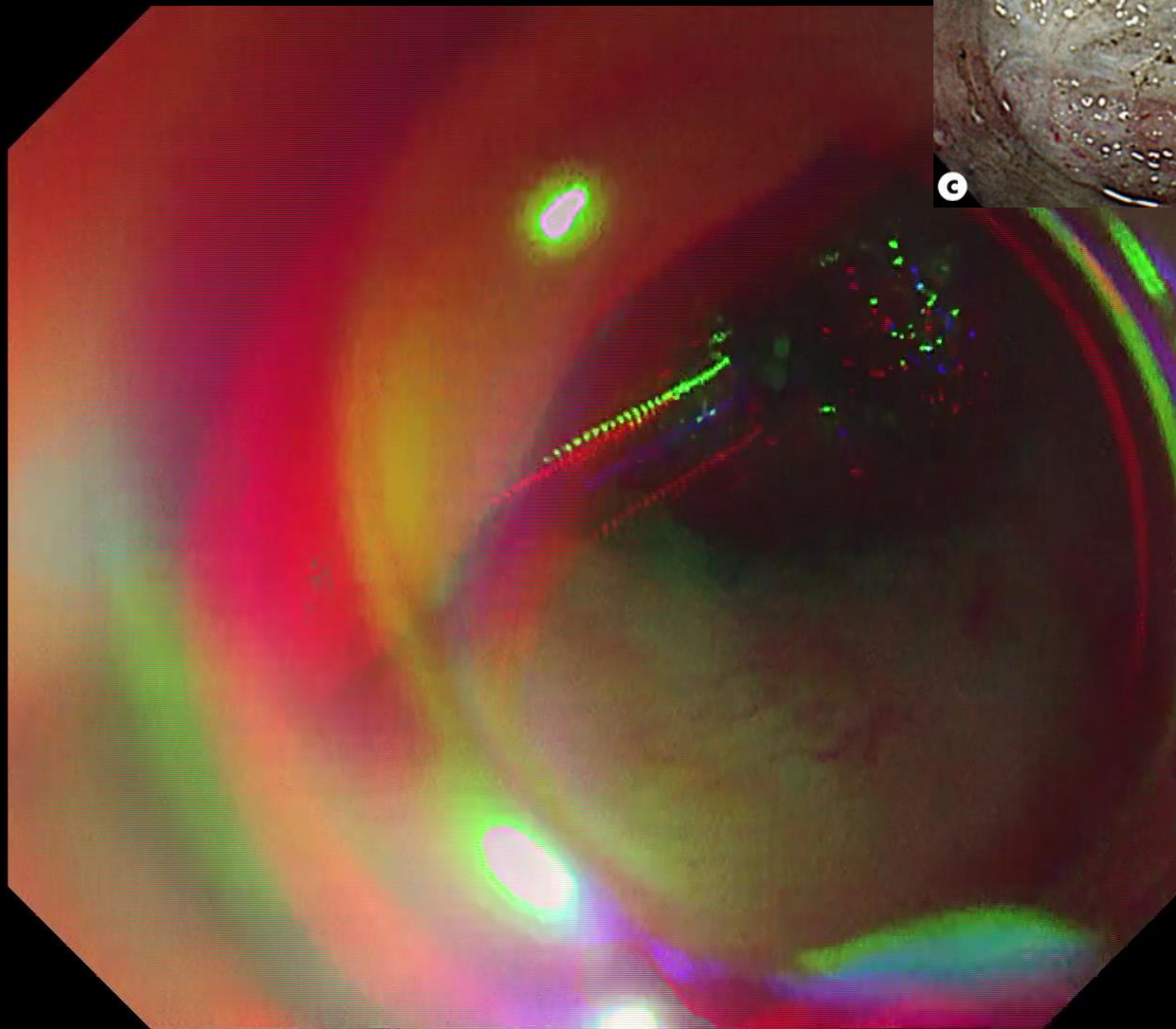
× 2.5



× 2.5



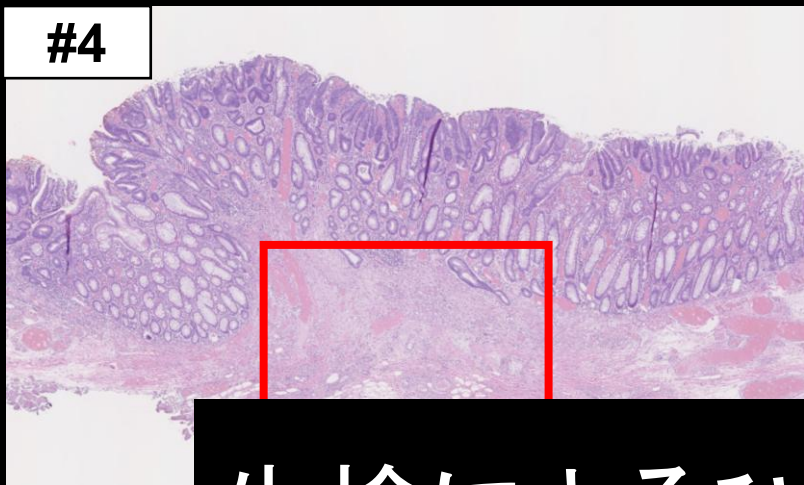
線維化



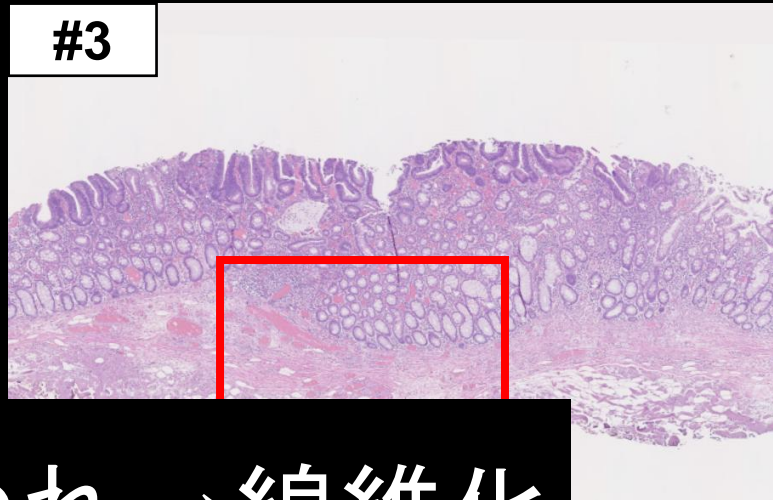
c

生検による変化～病理

#4

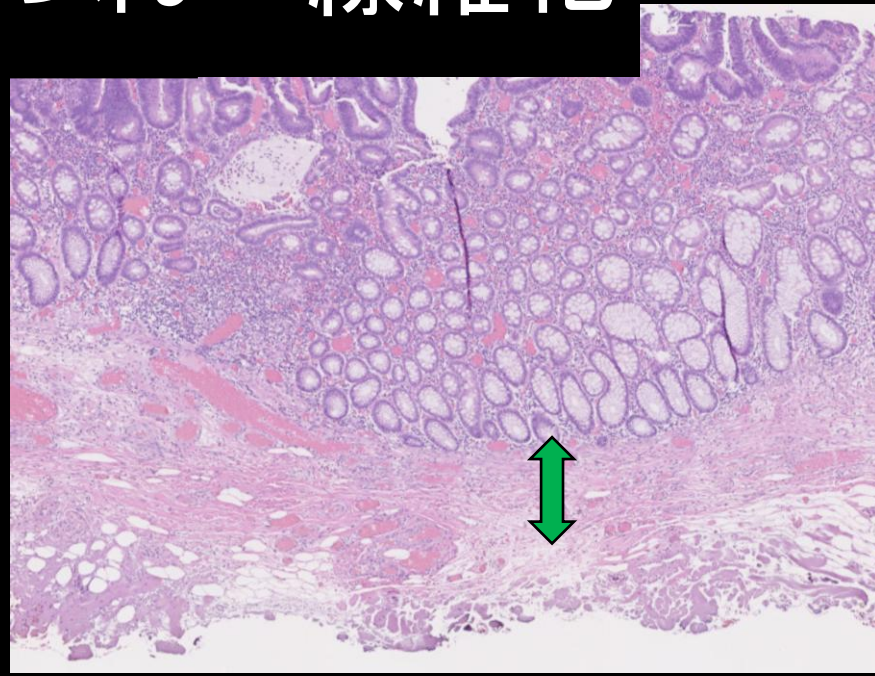
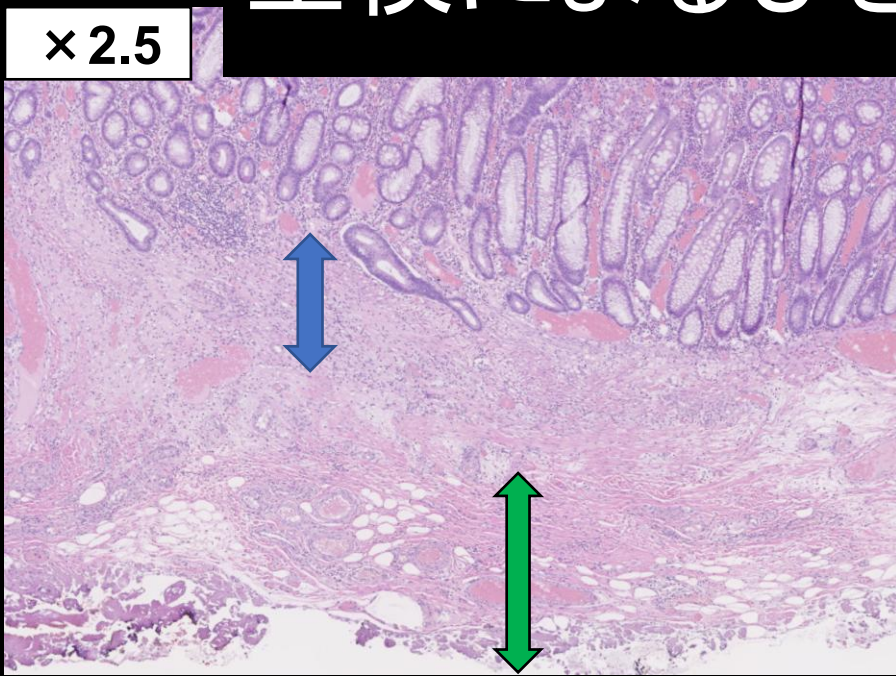


#3



生検によるひきつれ→線維化

×2.5



Take Home Message

- ・大腸病変において、内視鏡治療適応病変は生検すべきではない。
- ・生検により浸潤性大腸癌との鑑別が困難になり、ひいては内視鏡治療が困難になる。