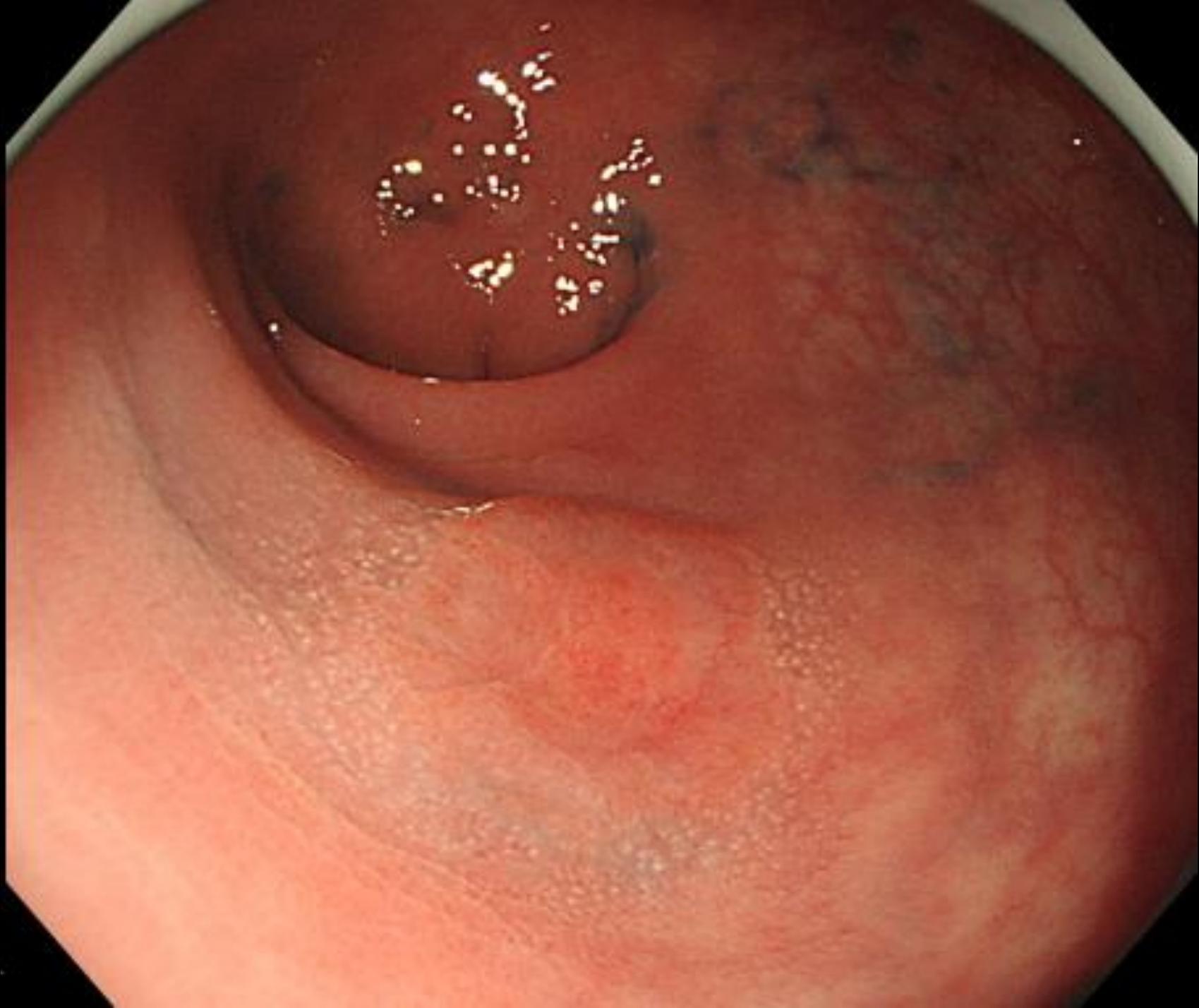
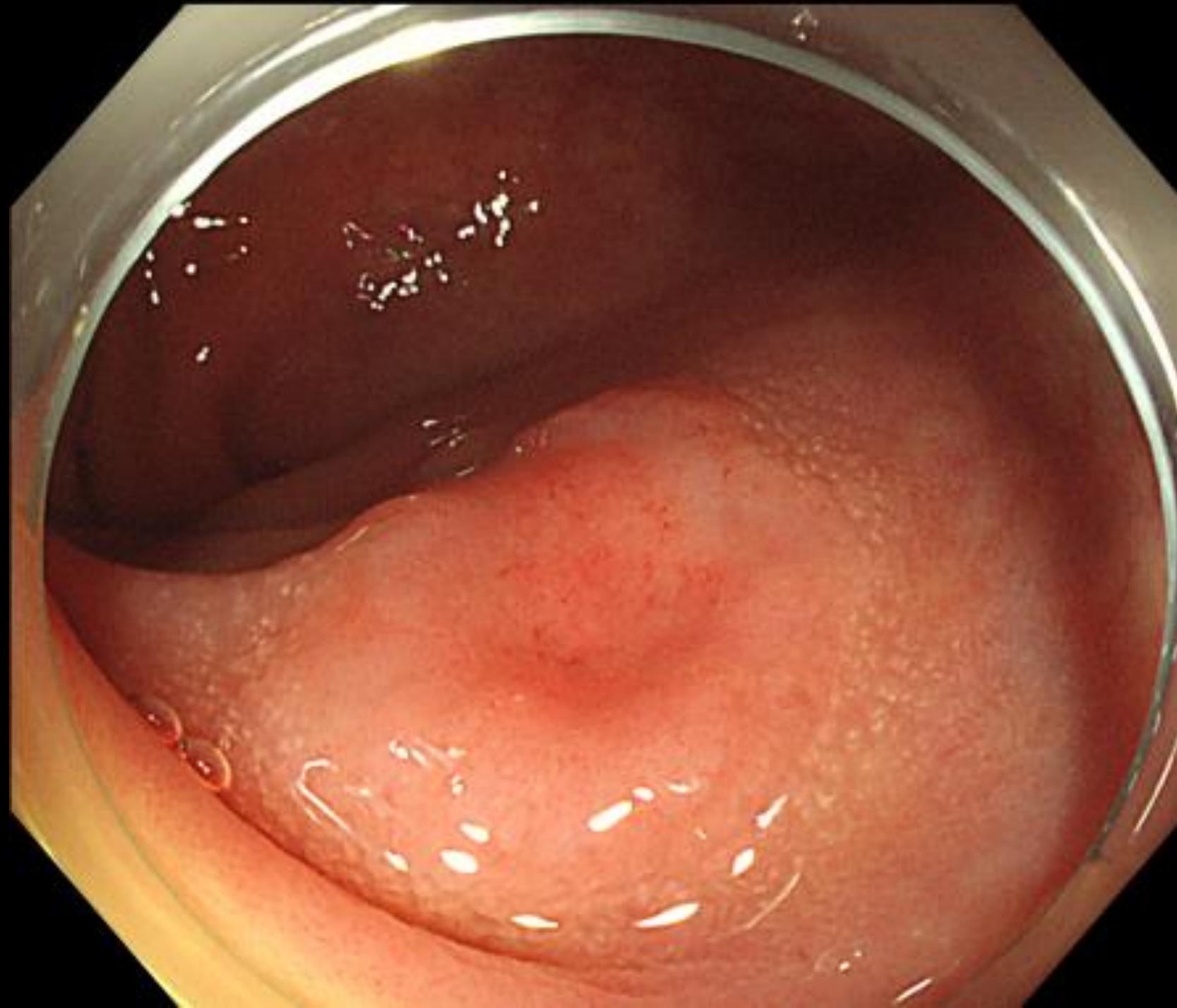


# 消化管mapping S状結腸

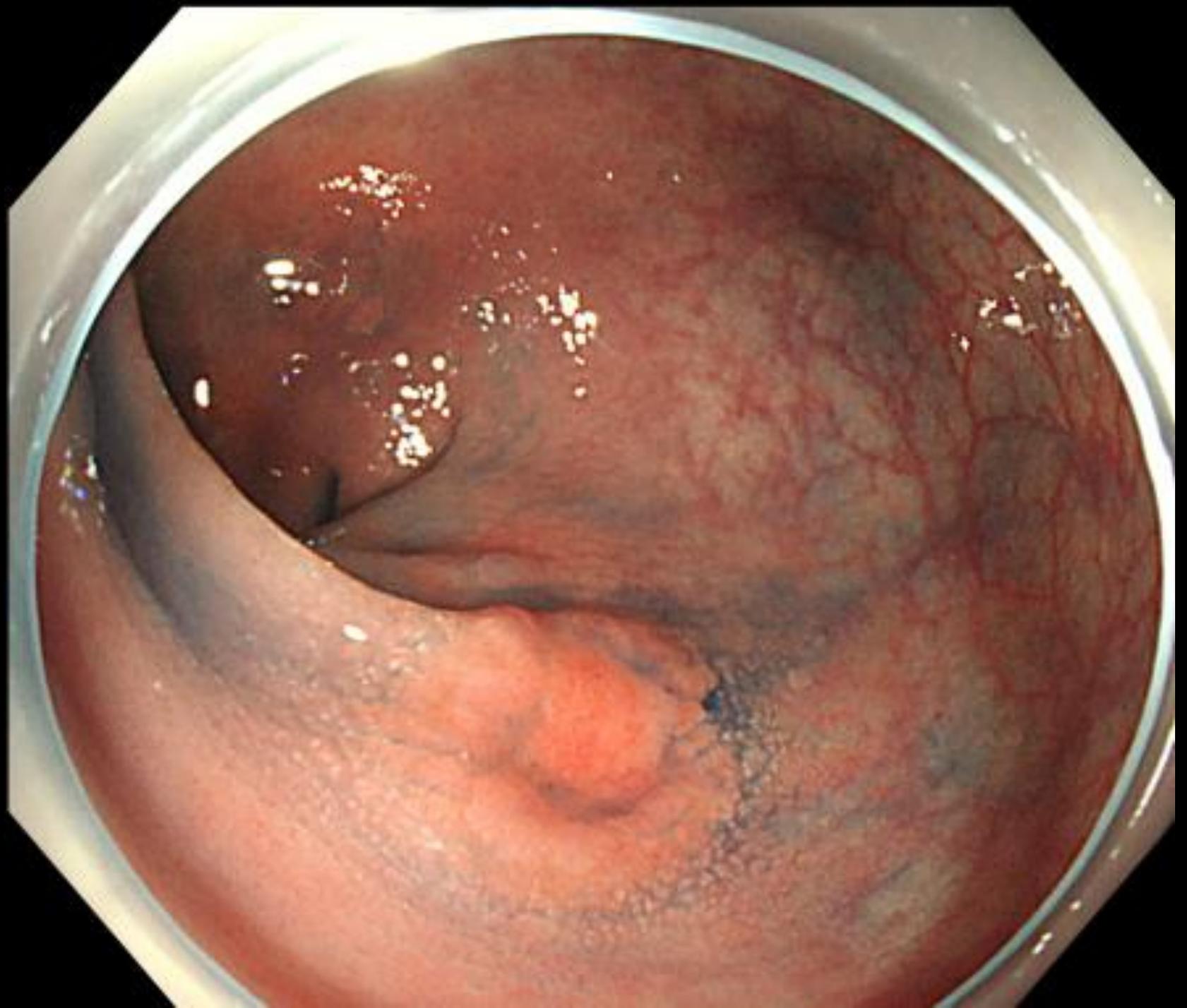
担当:池谷 桃子

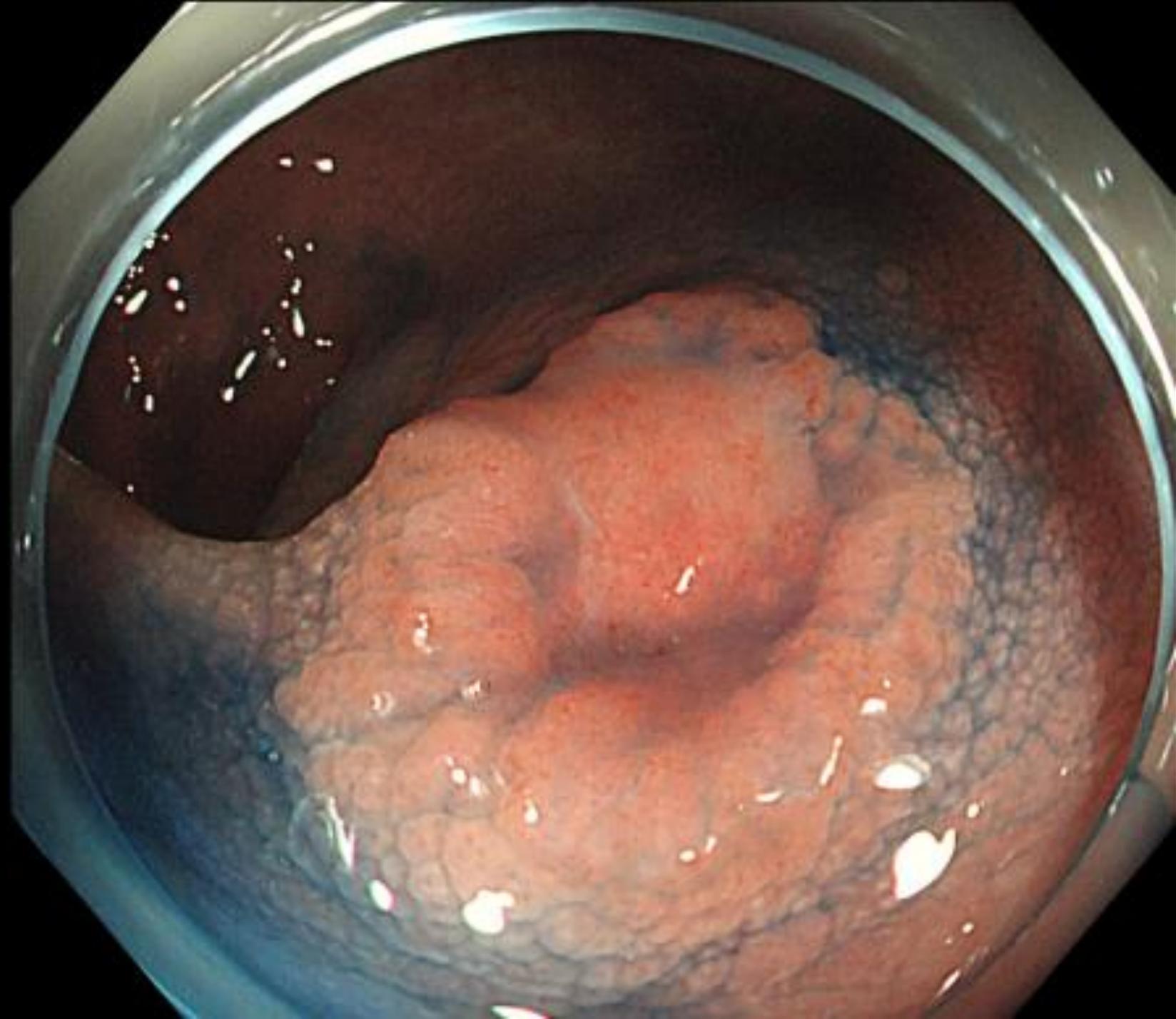
通常觀察 2枚



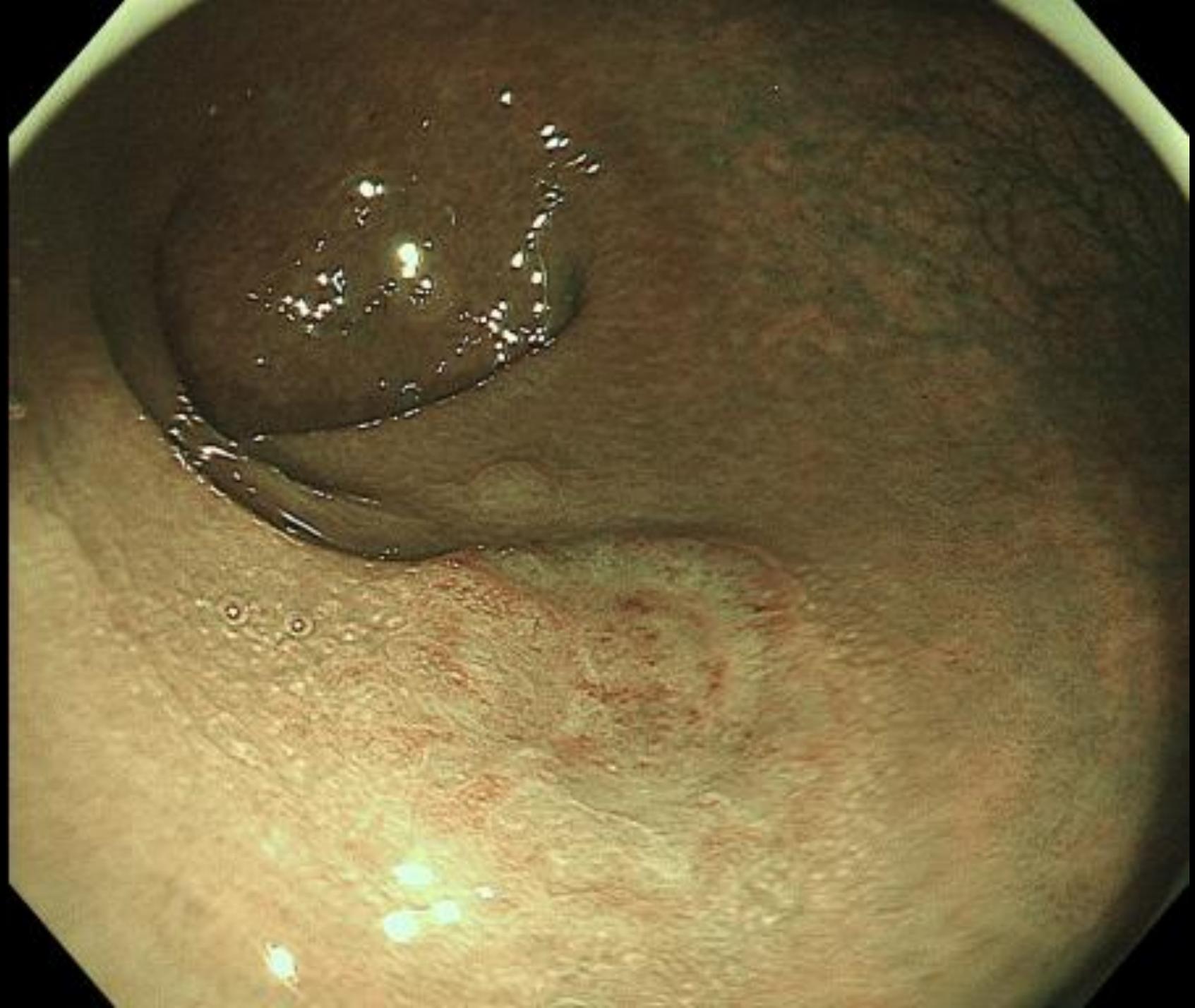


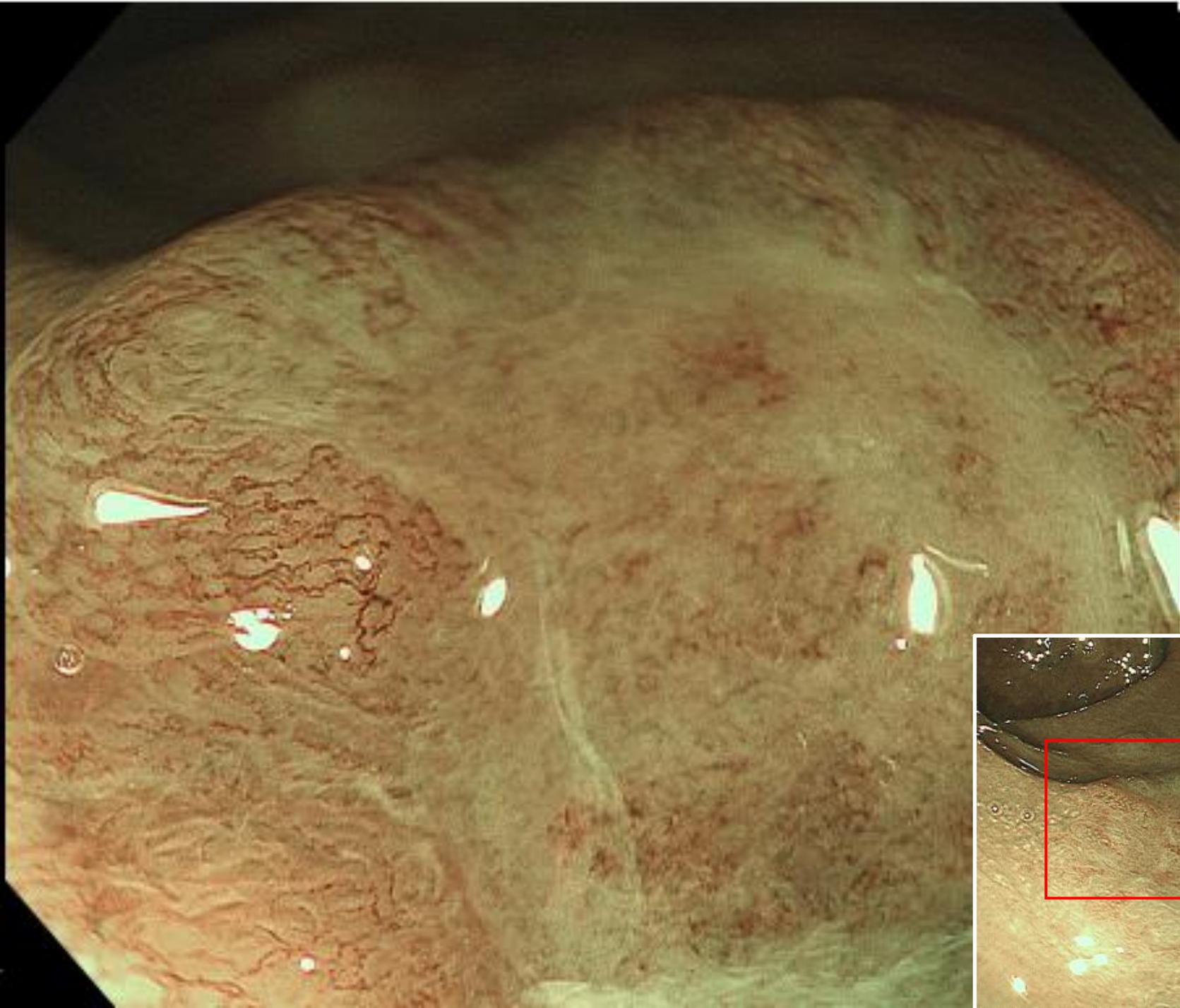
インジゴ散布観察 2枚

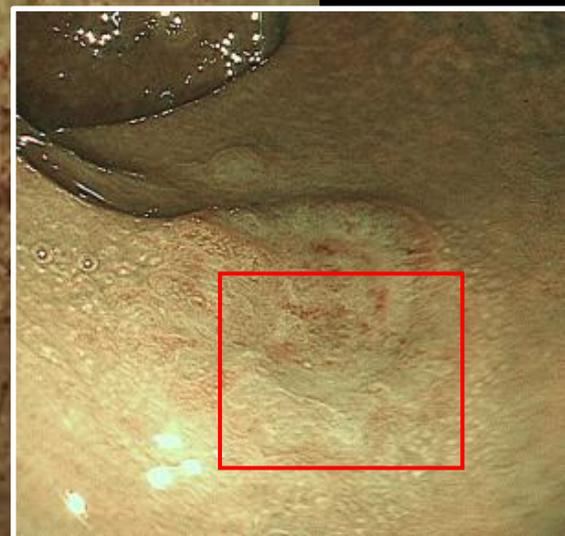
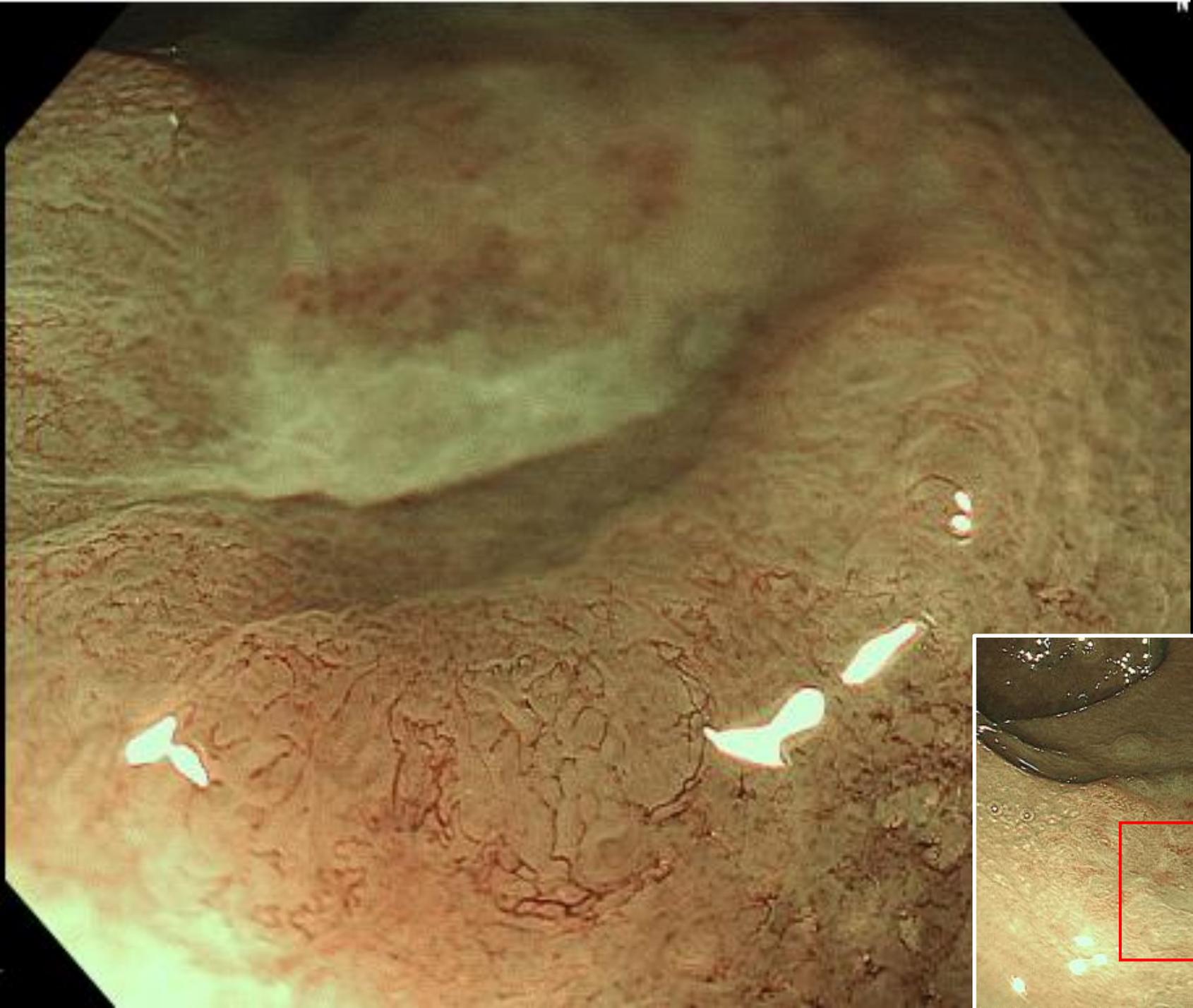


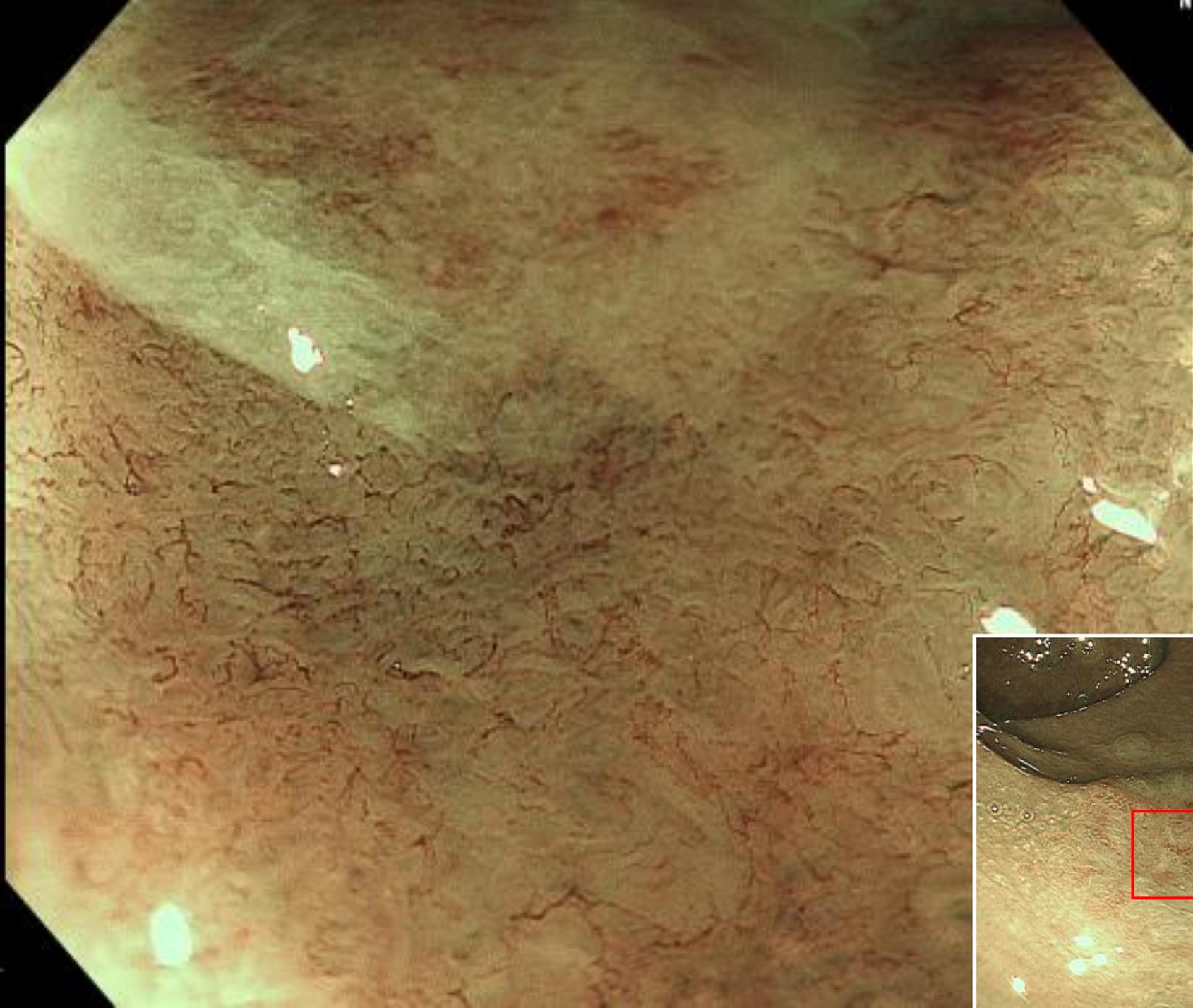


NBI観察(拡大含む)  
4枚

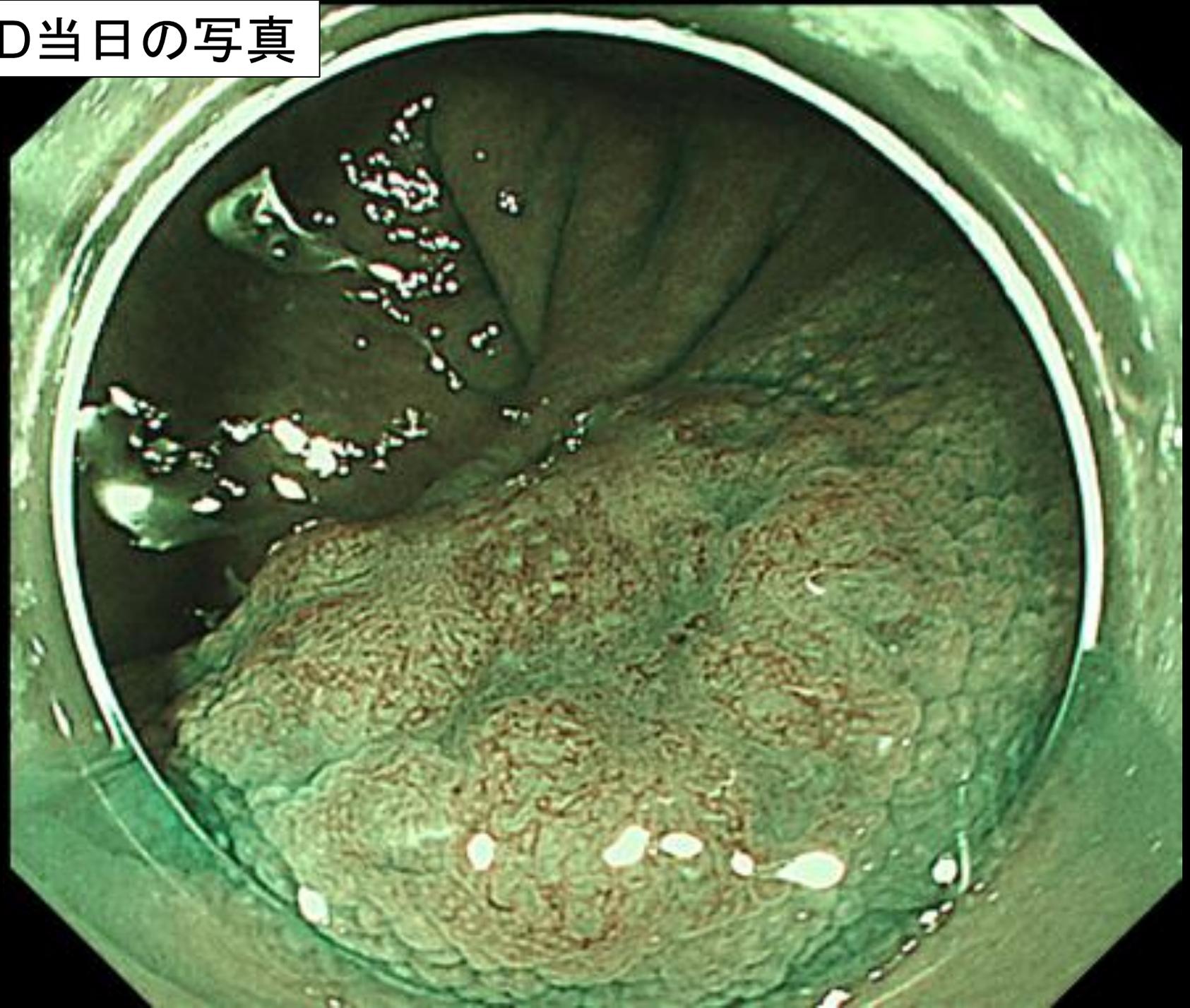






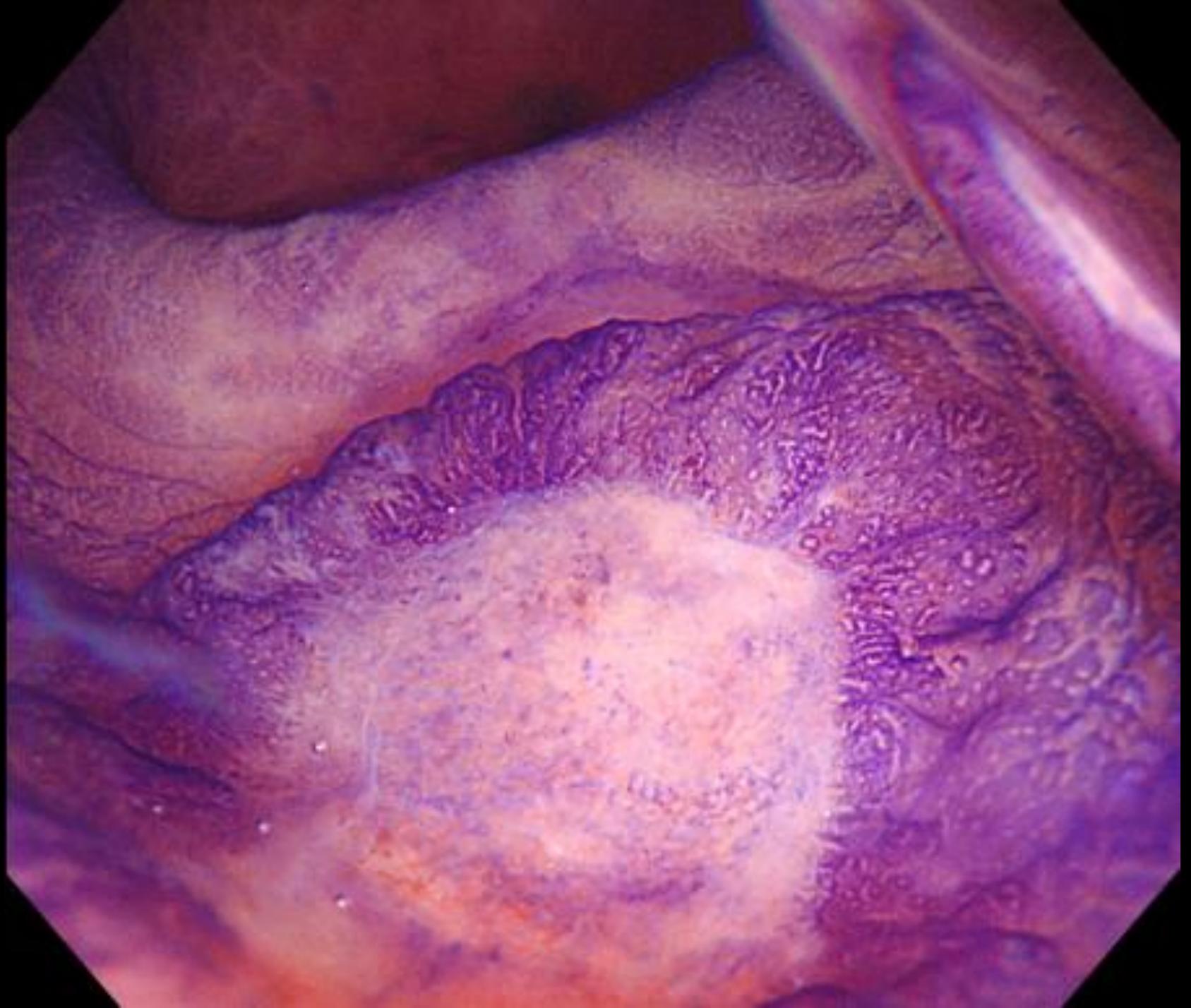


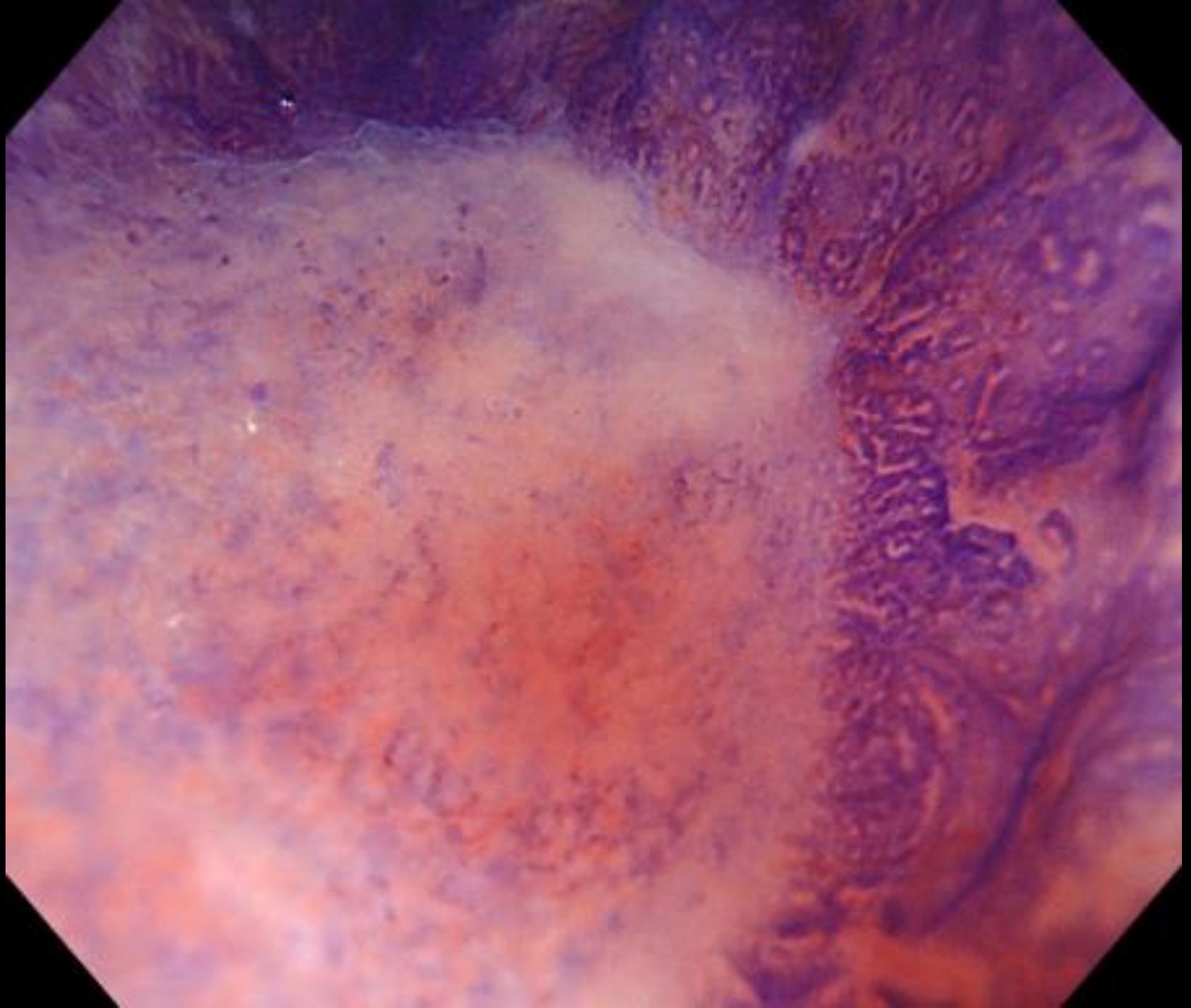
ESD当日の写真



ピオクタニン染色 3枚  
※粘液あり

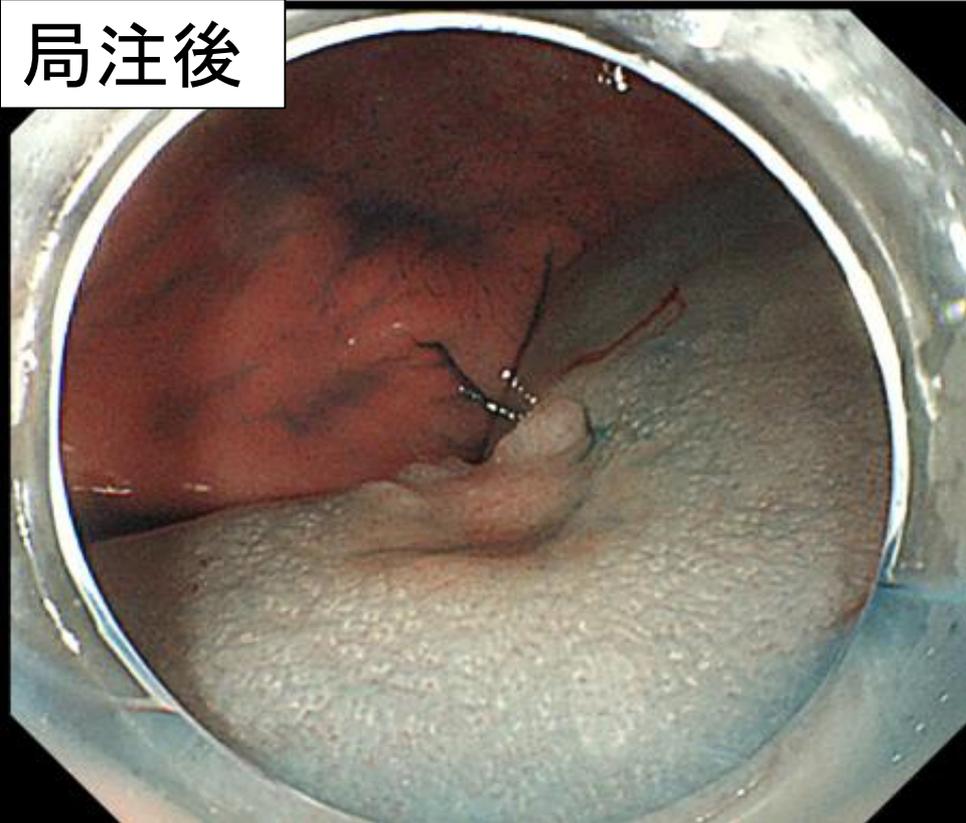
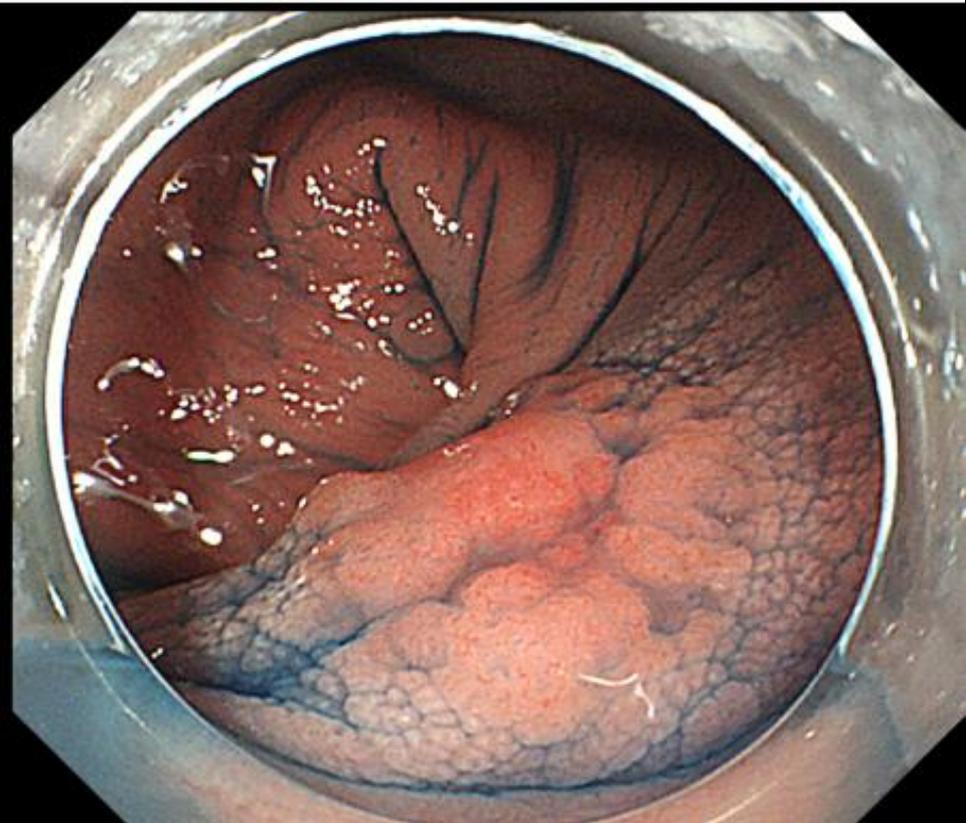


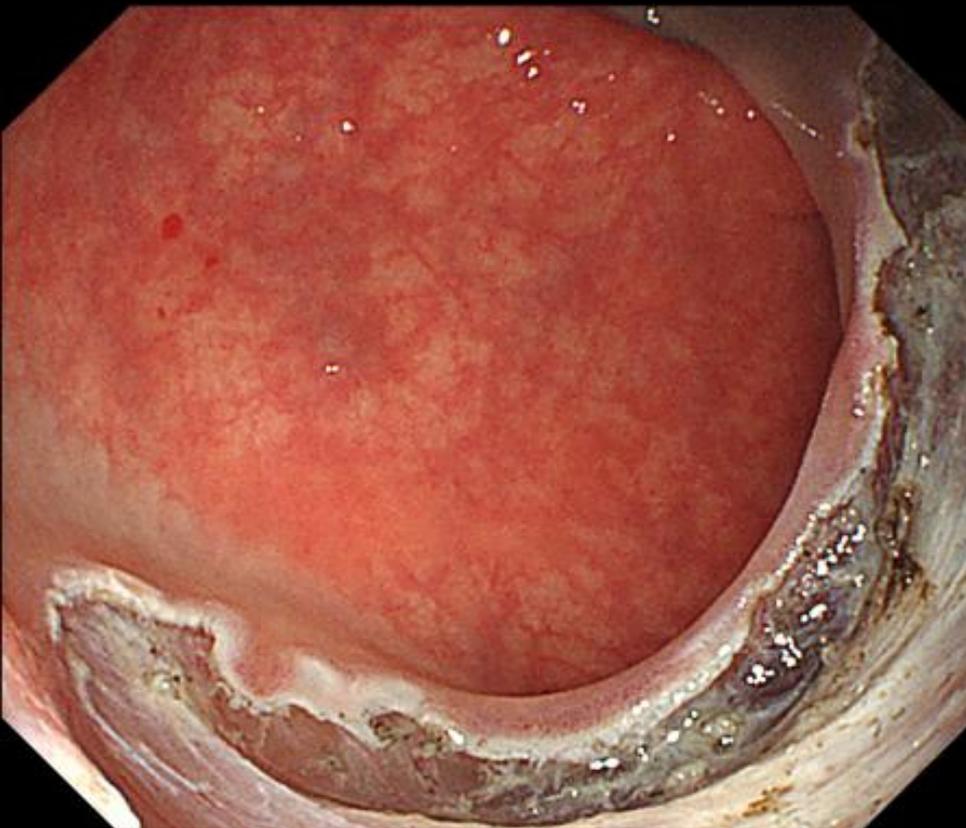
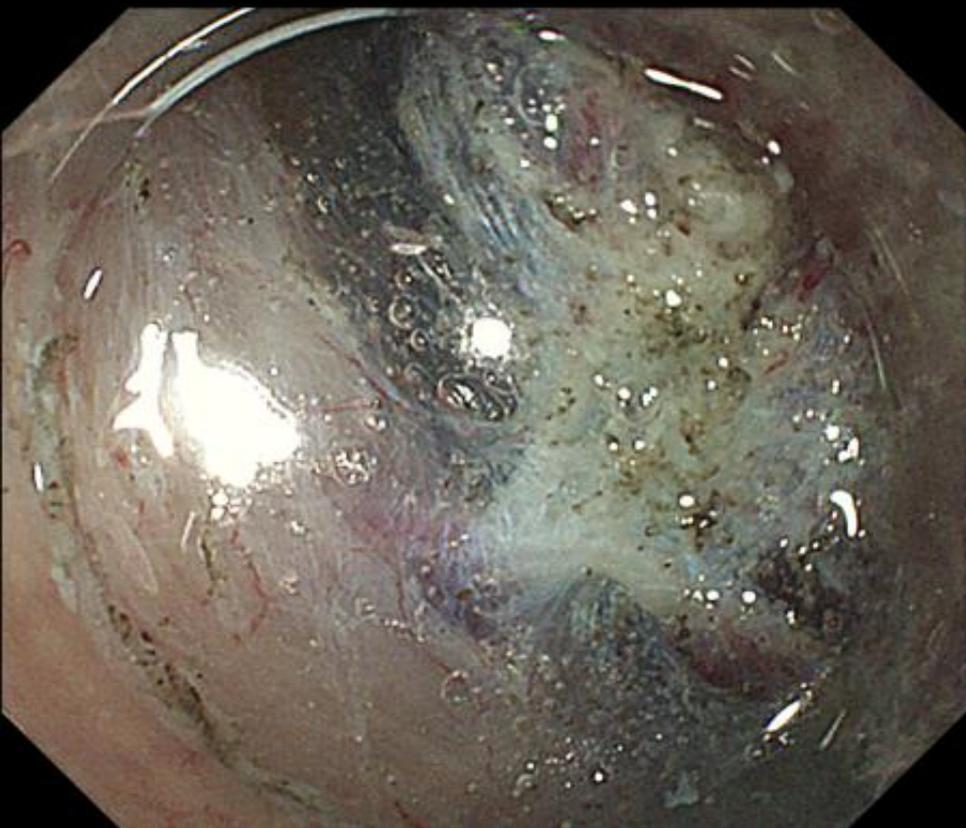




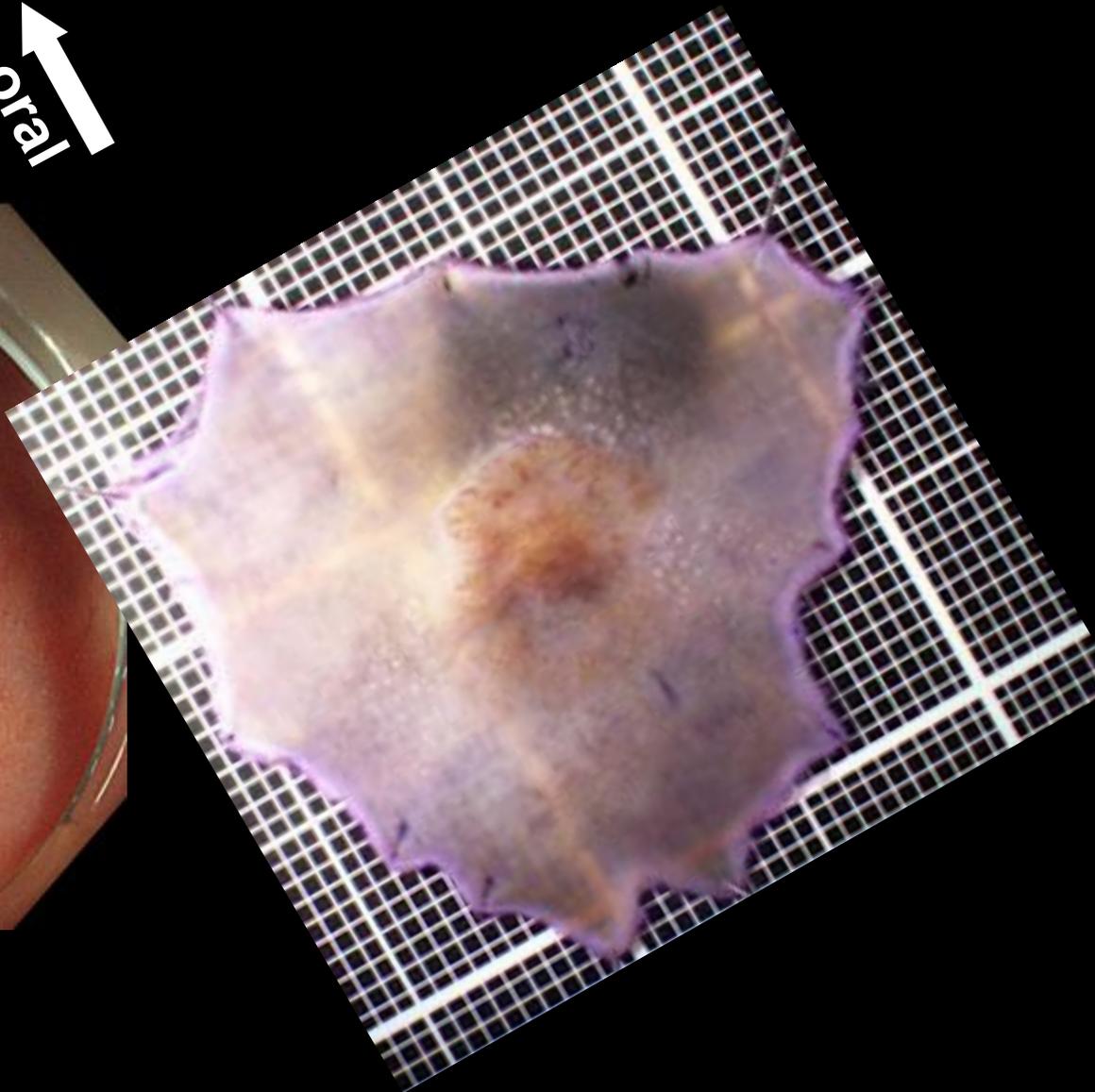
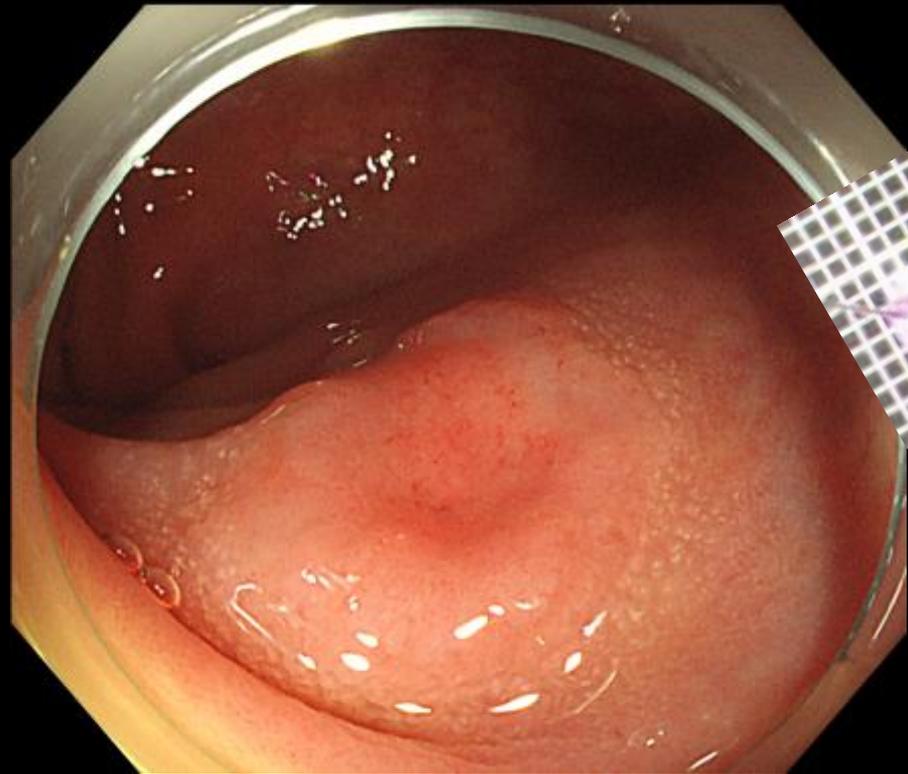
ESD当日

局注後





Oral

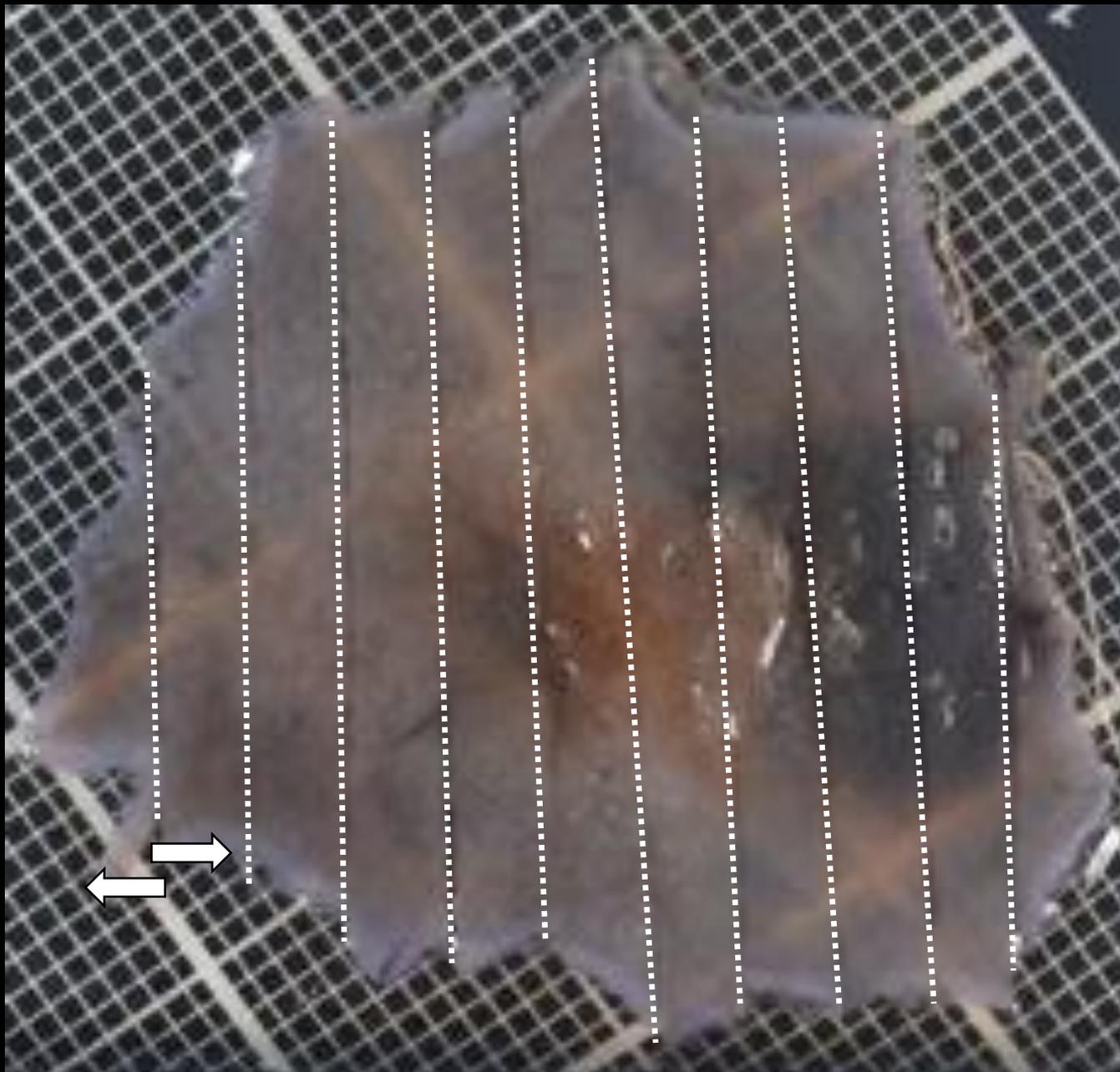


# 標本切り出し



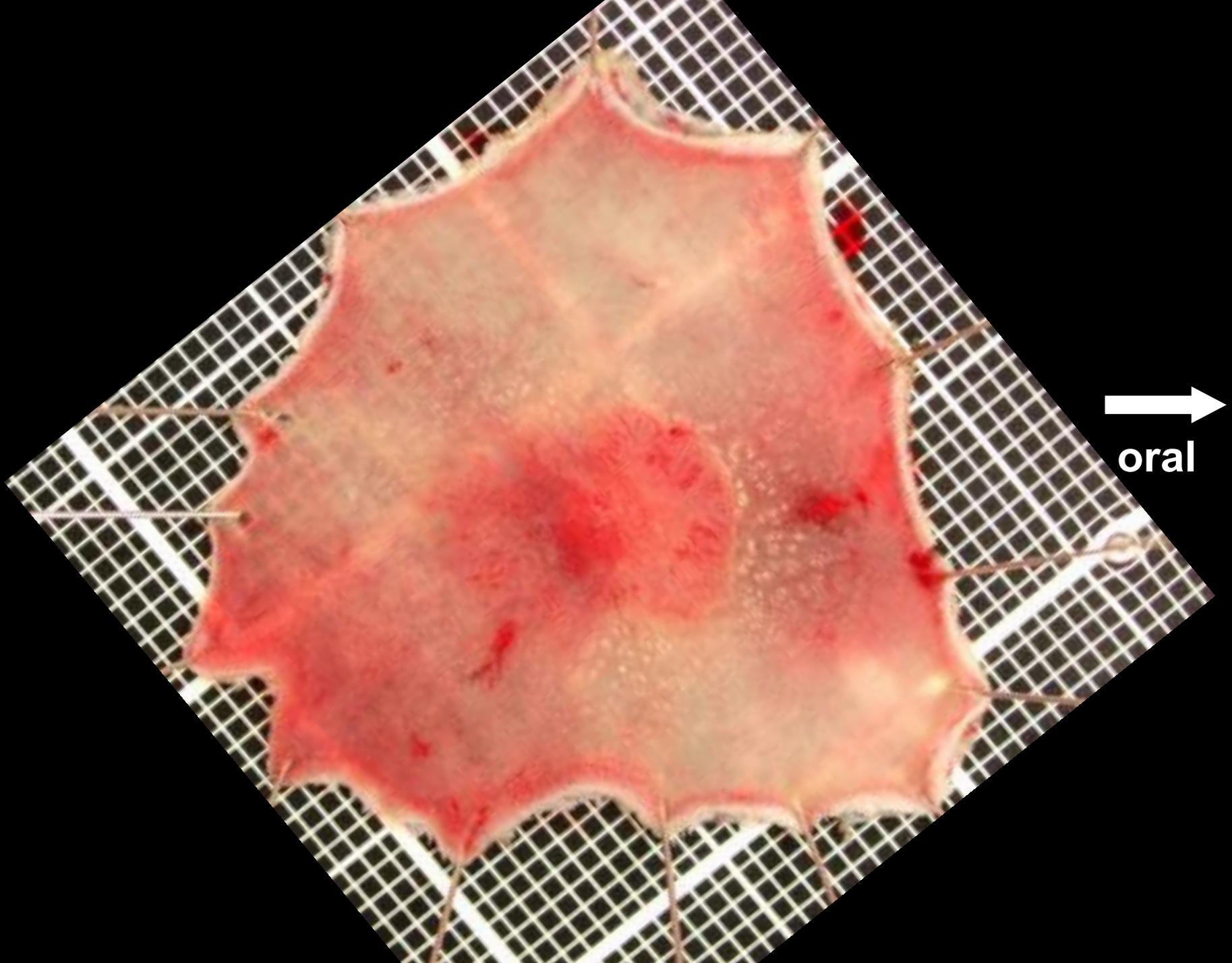
→  
oral

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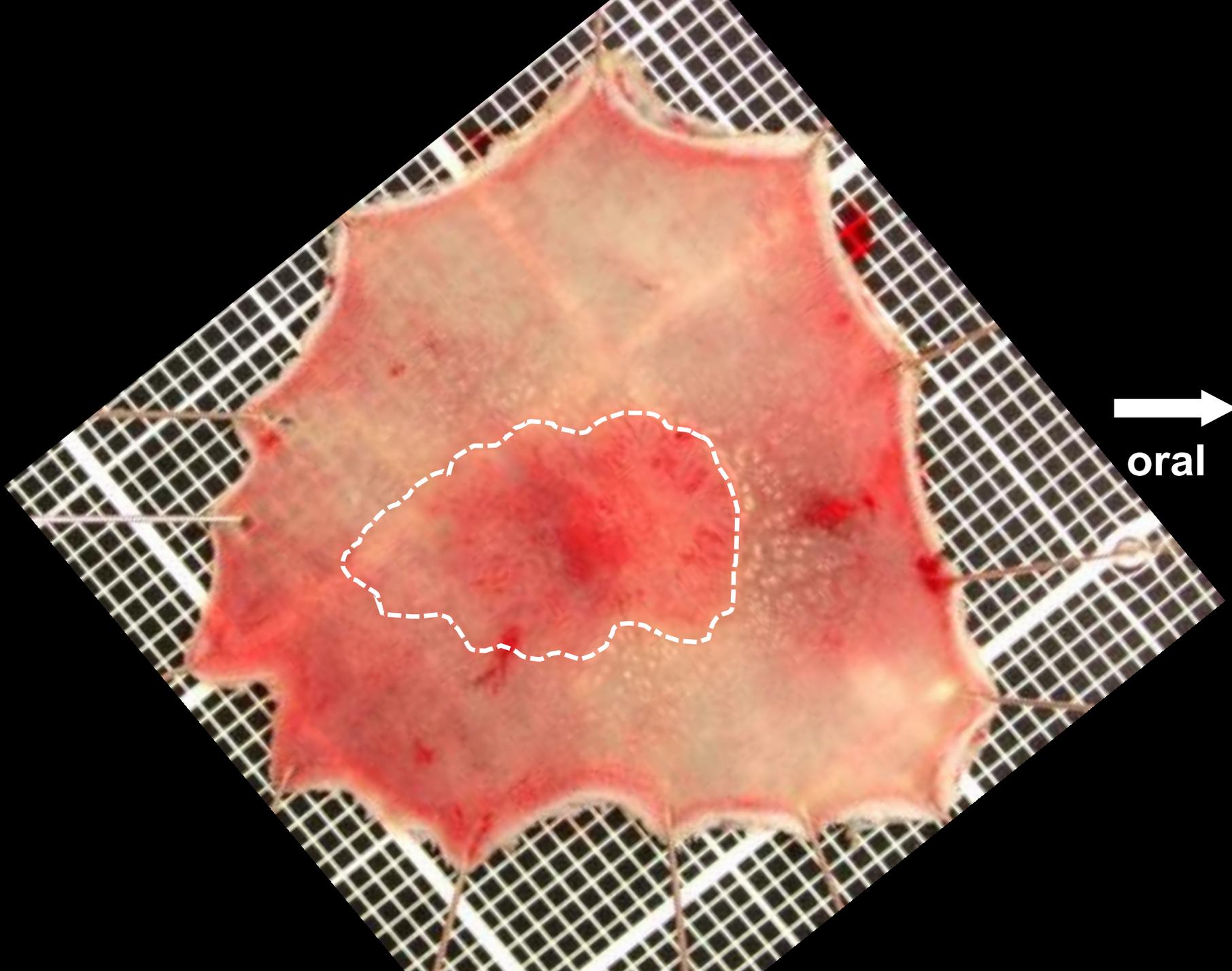


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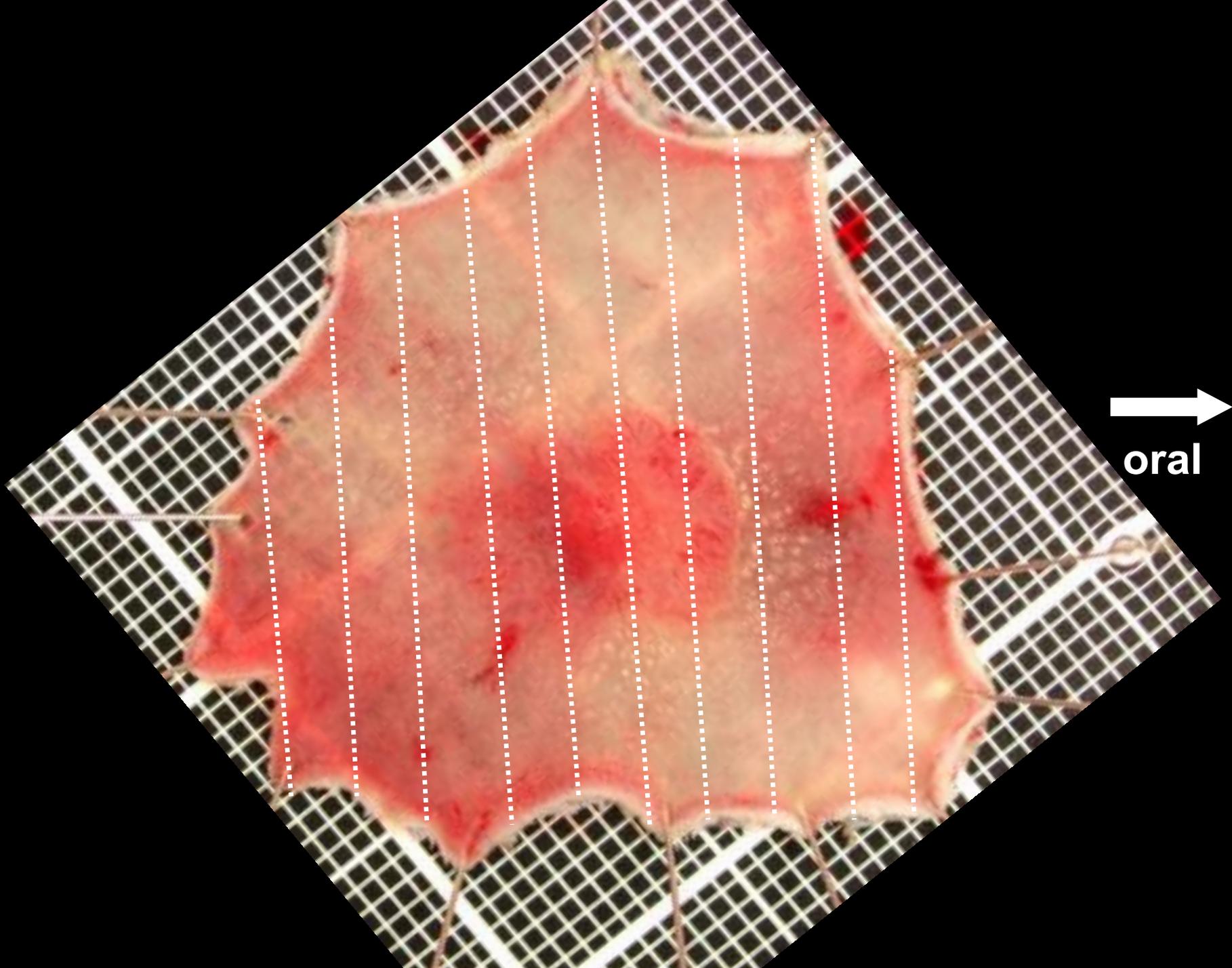
oral



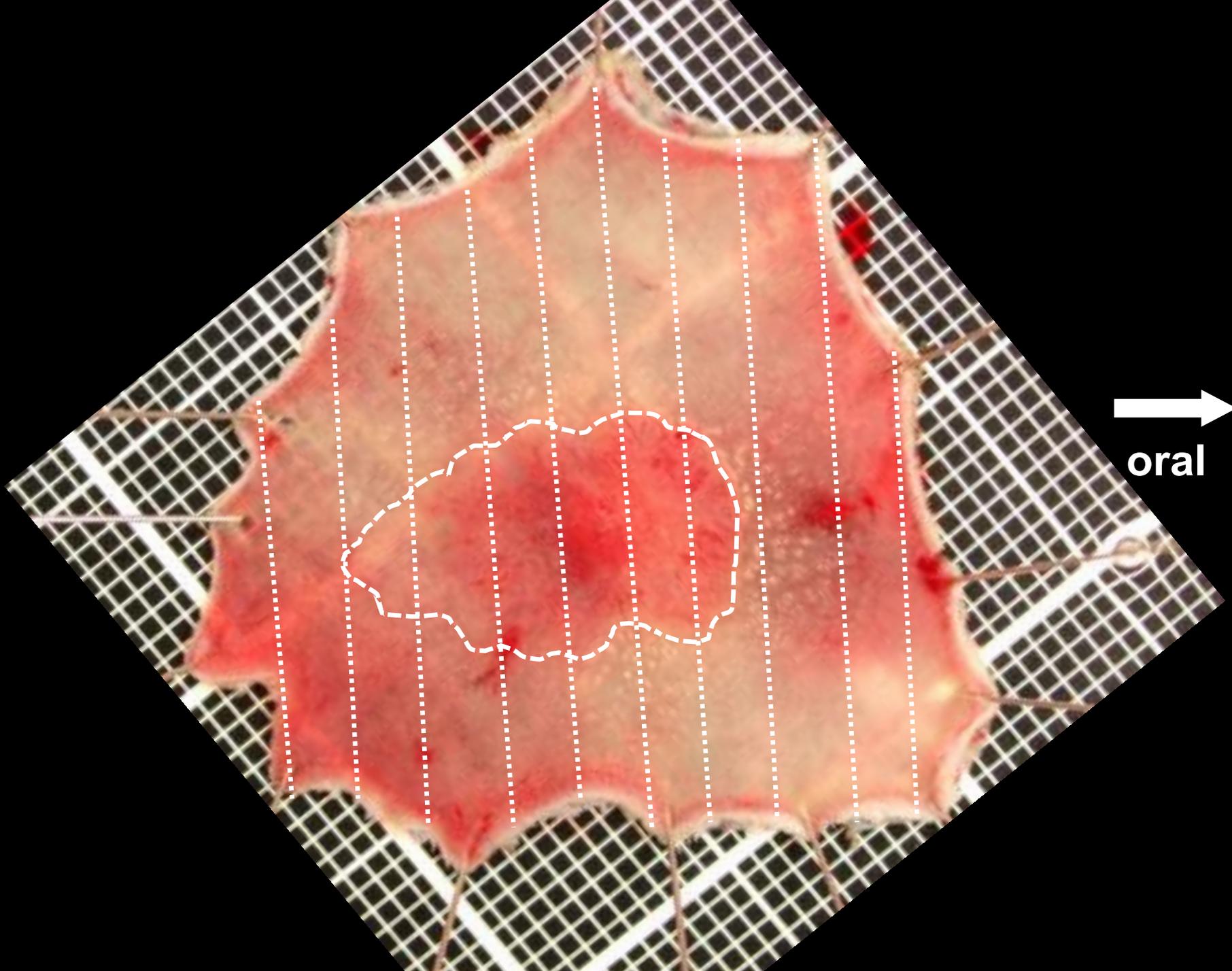
oral



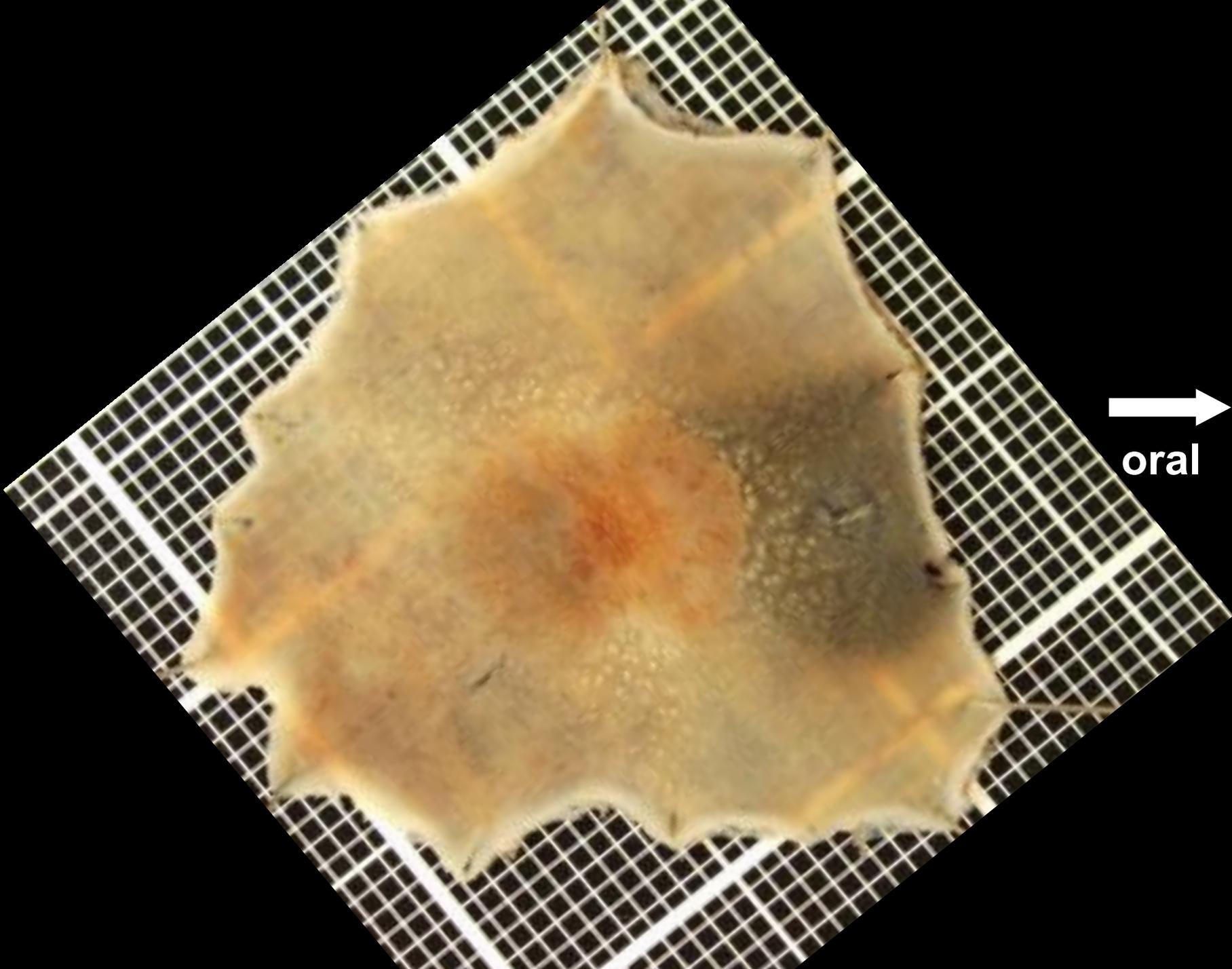
oral



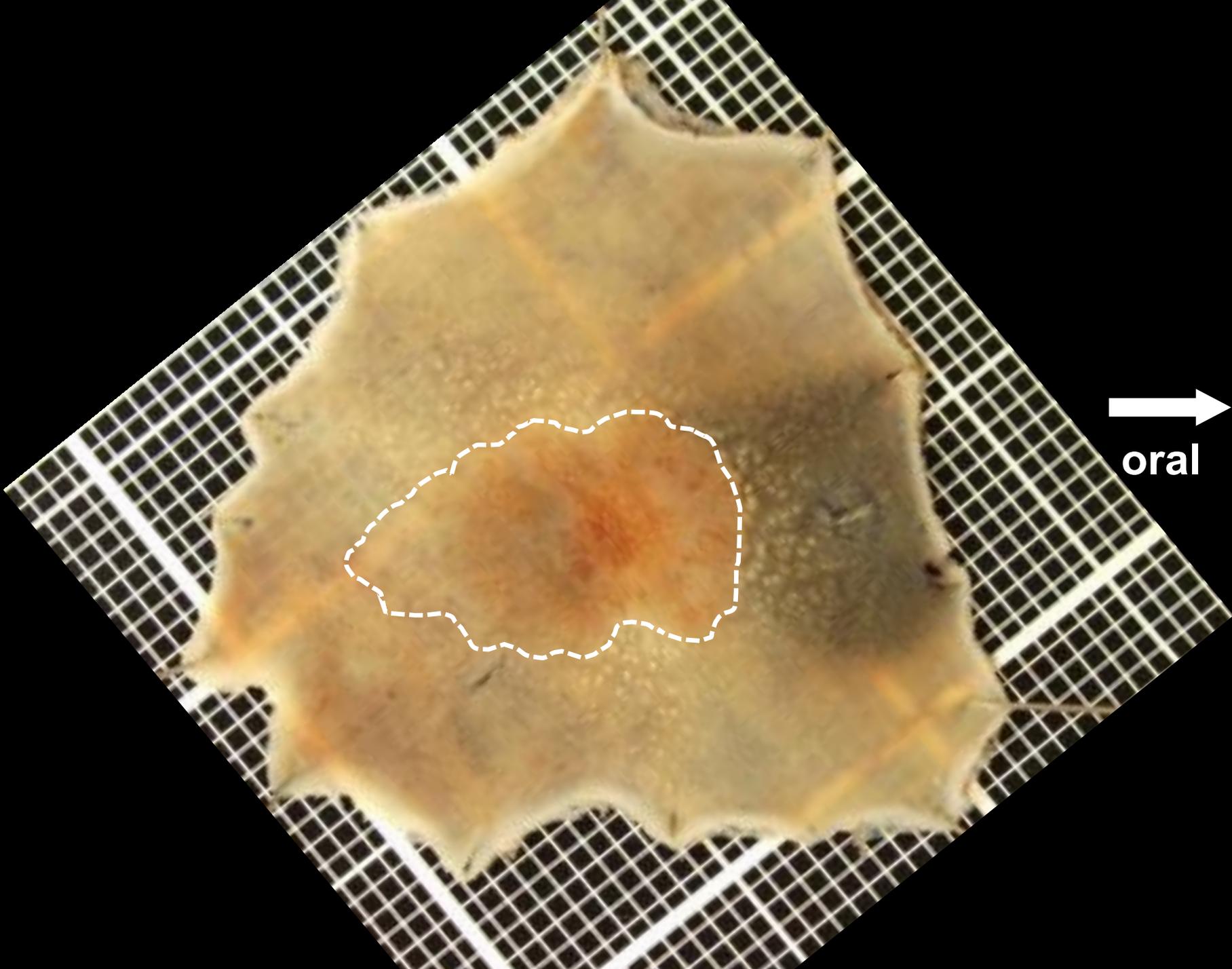
oral



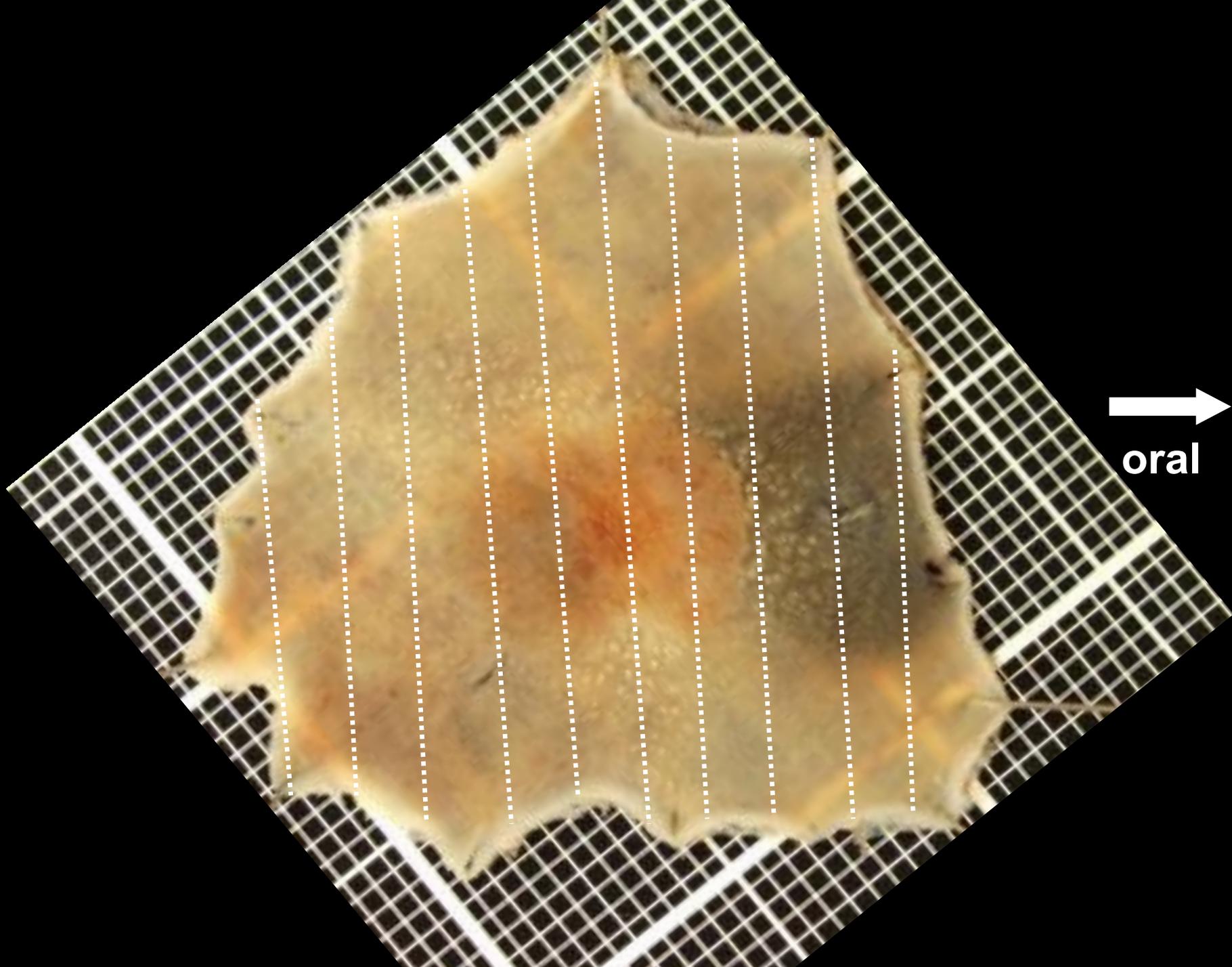
oral



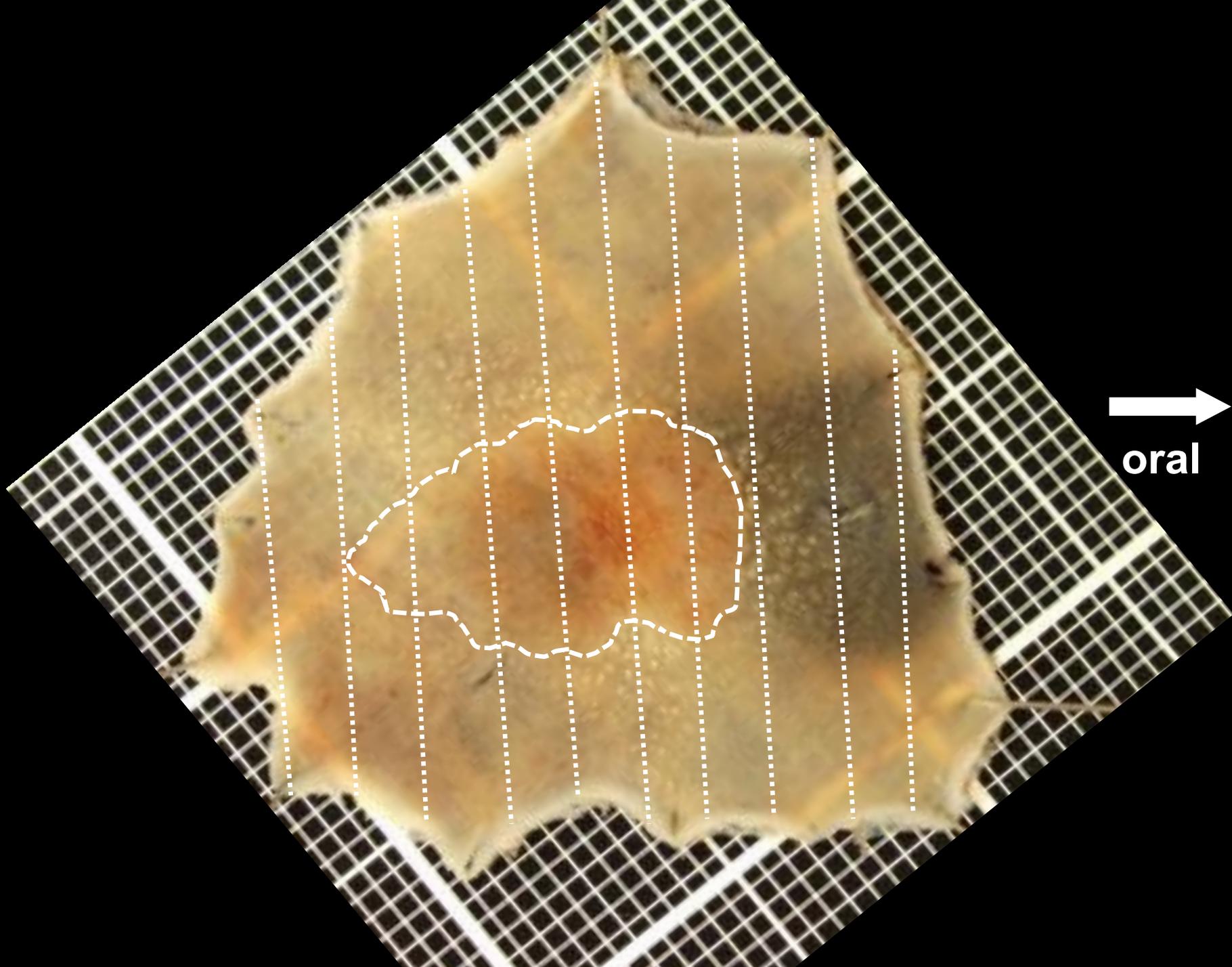
oral

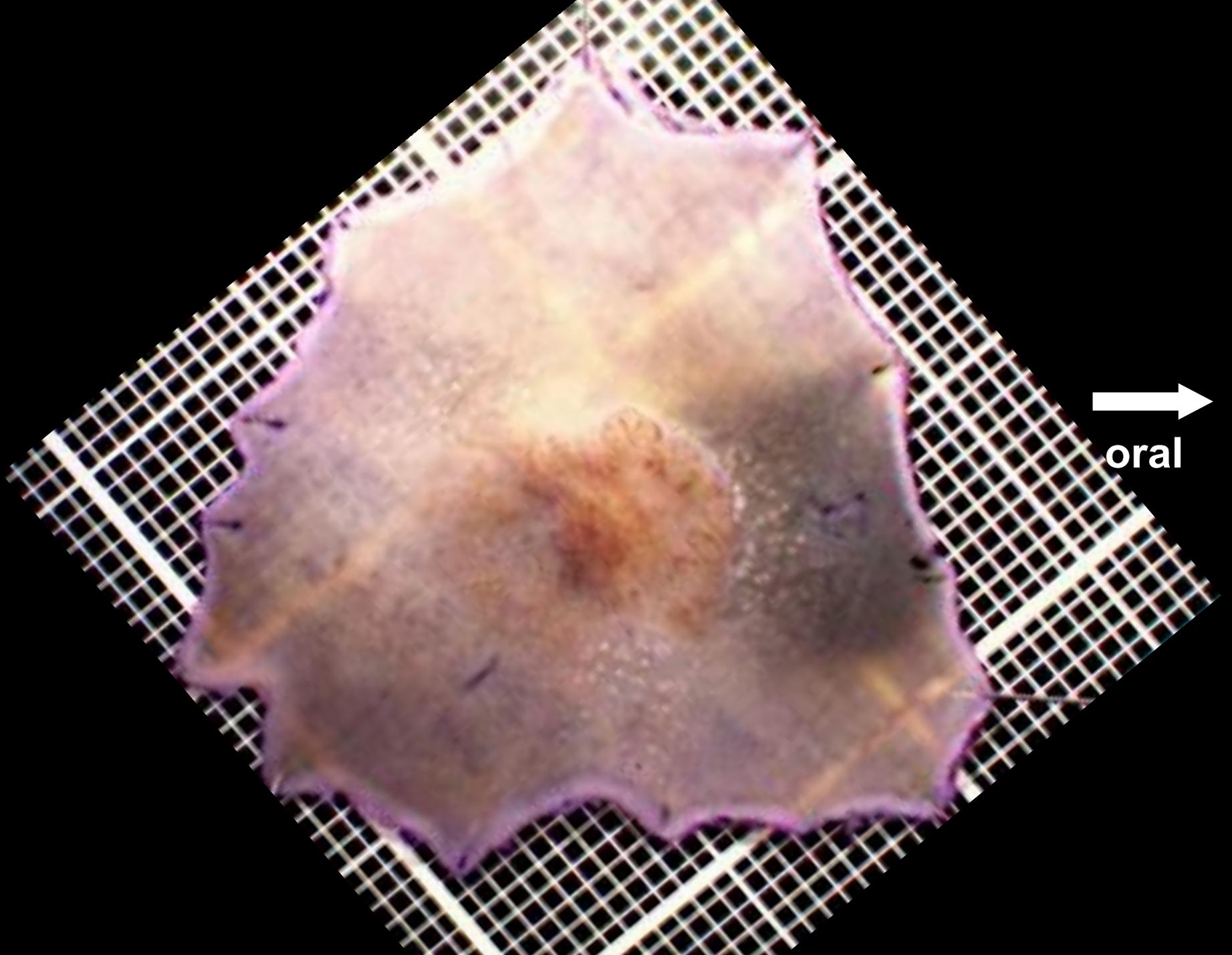


oral

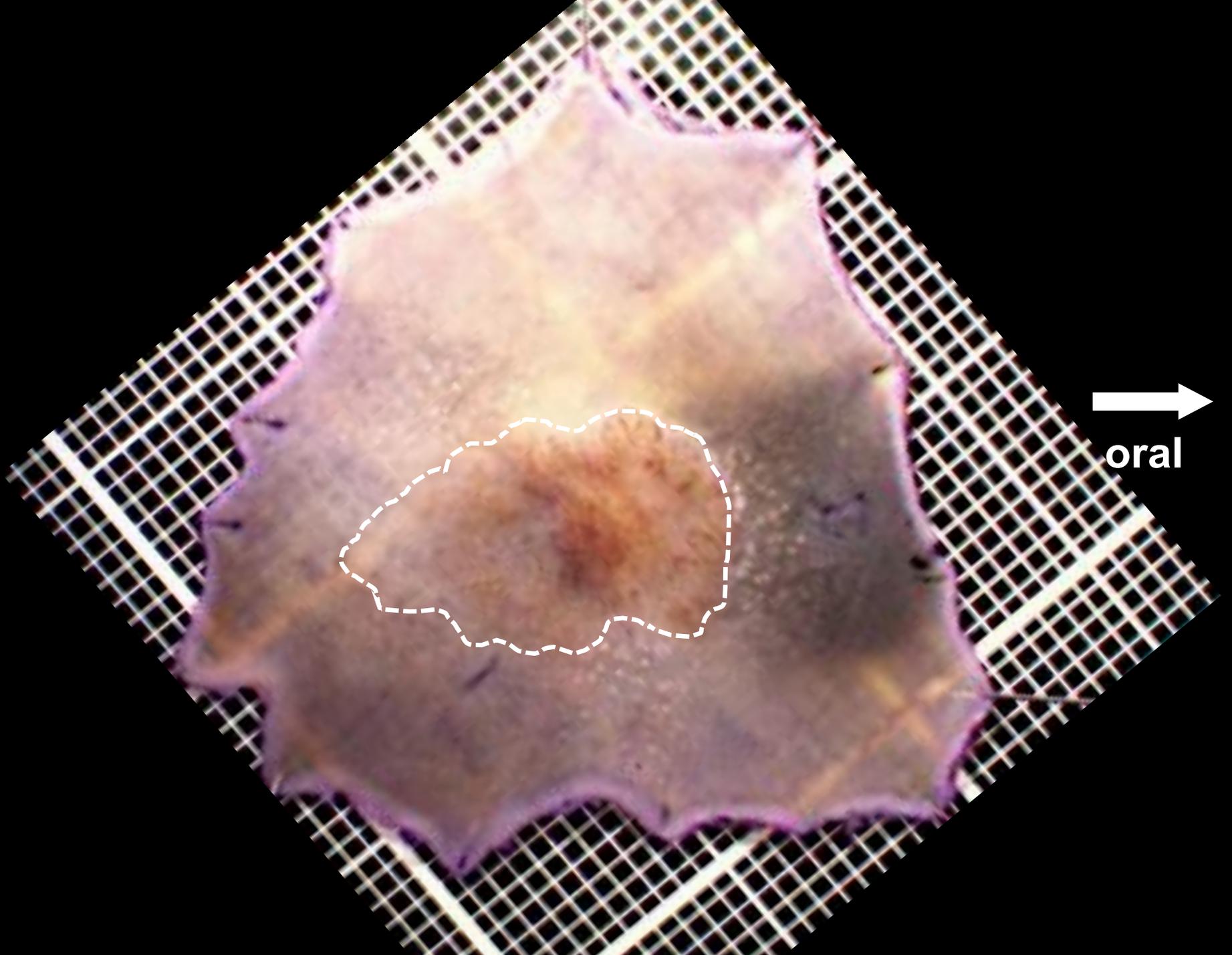


oral

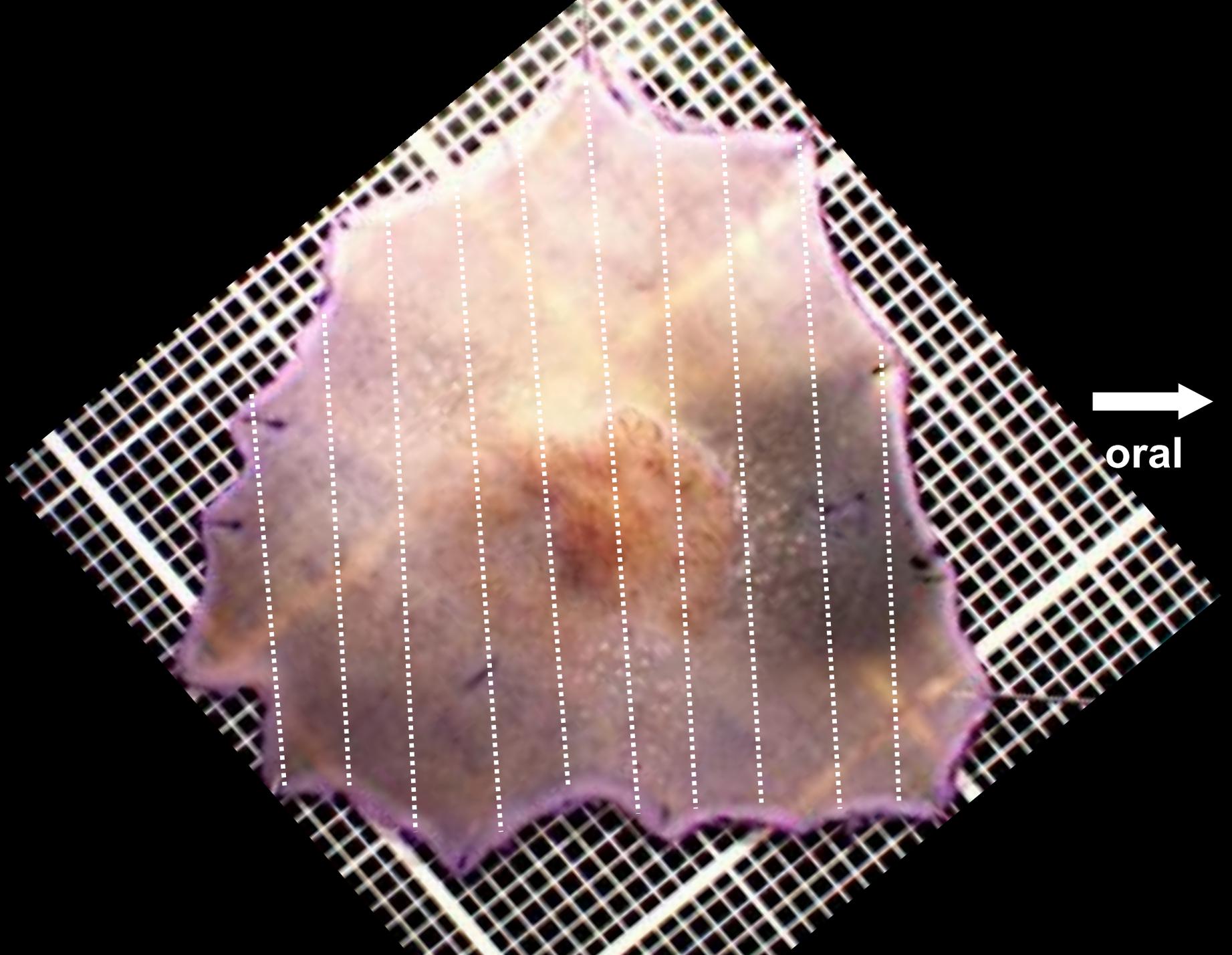




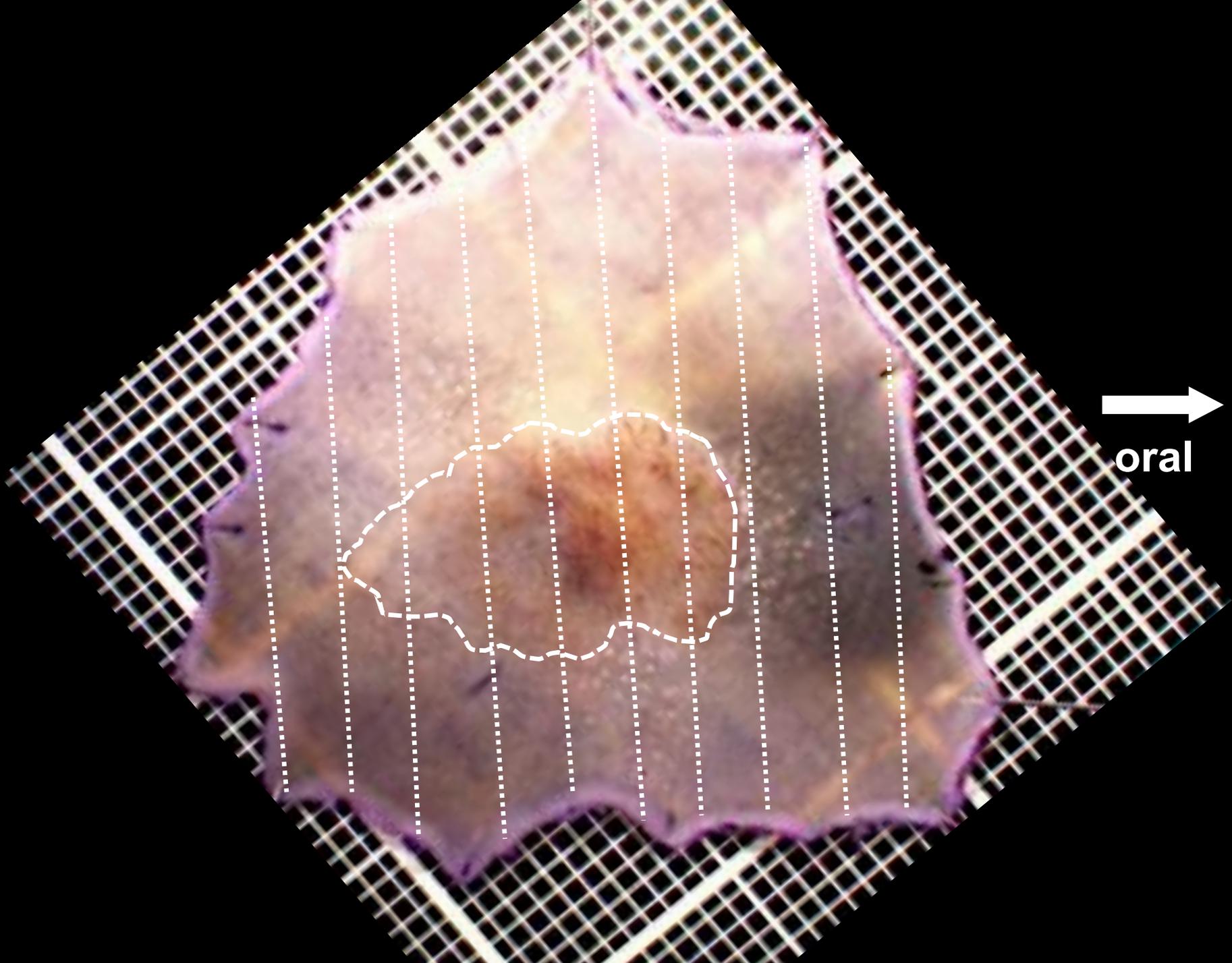
oral



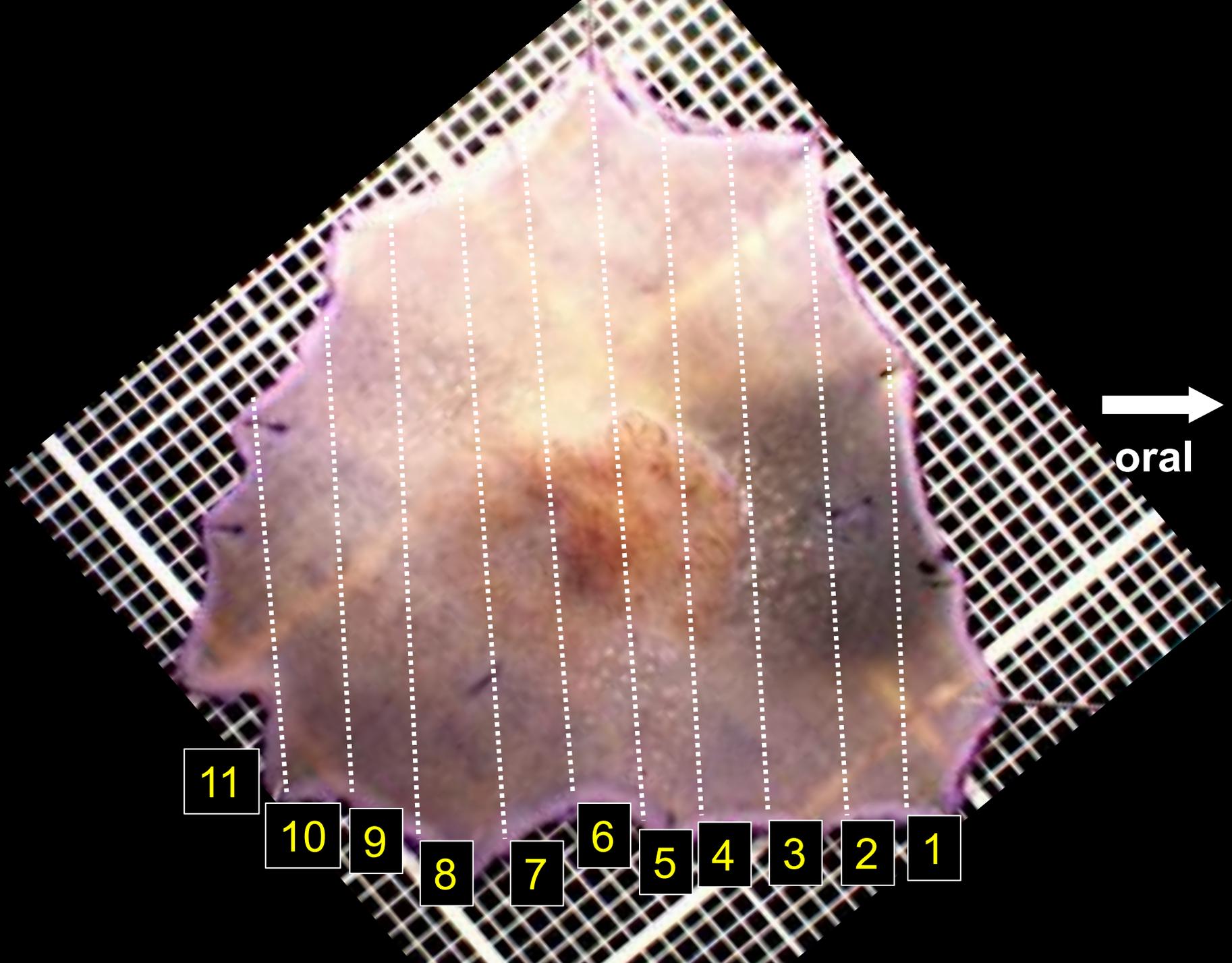
oral



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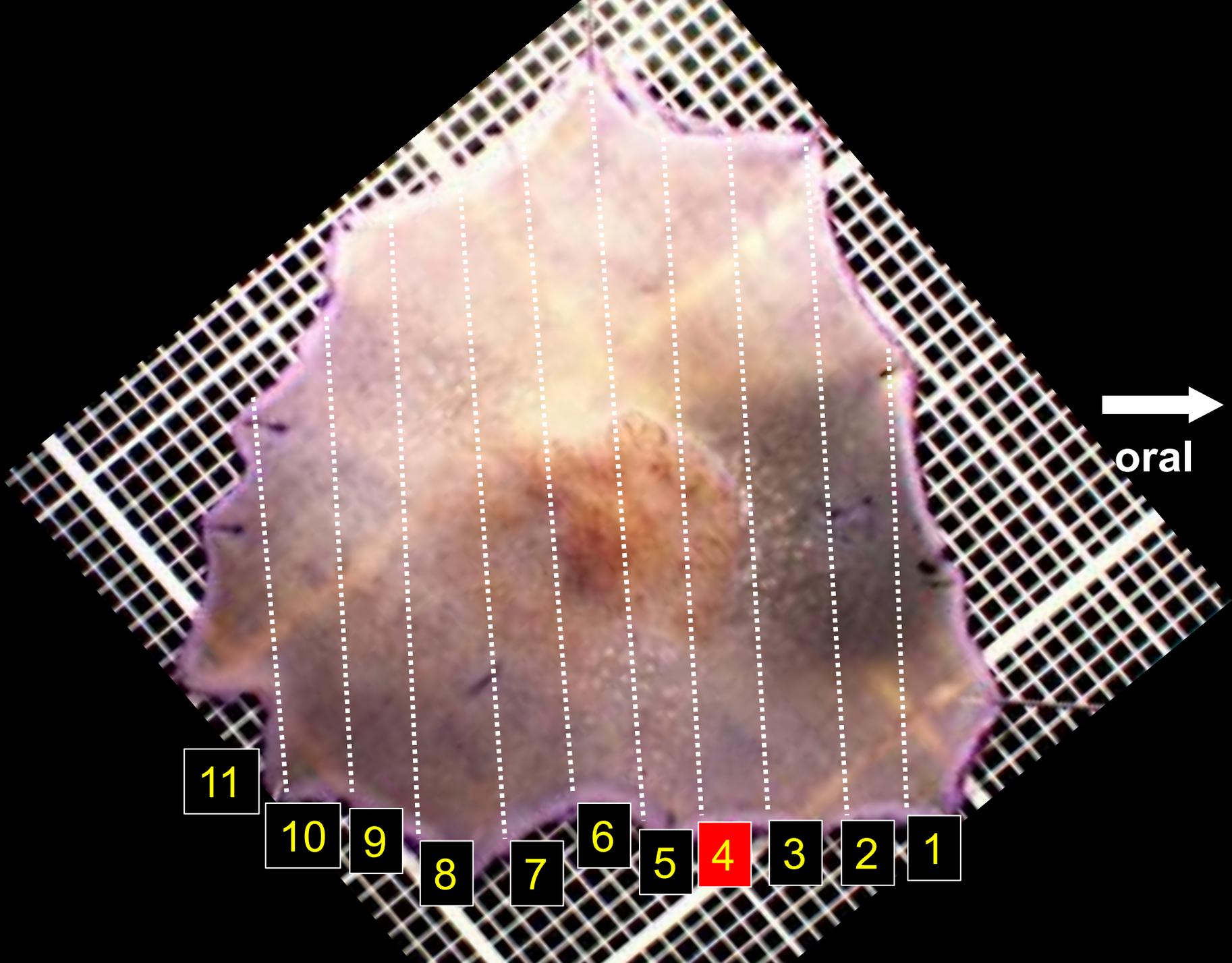
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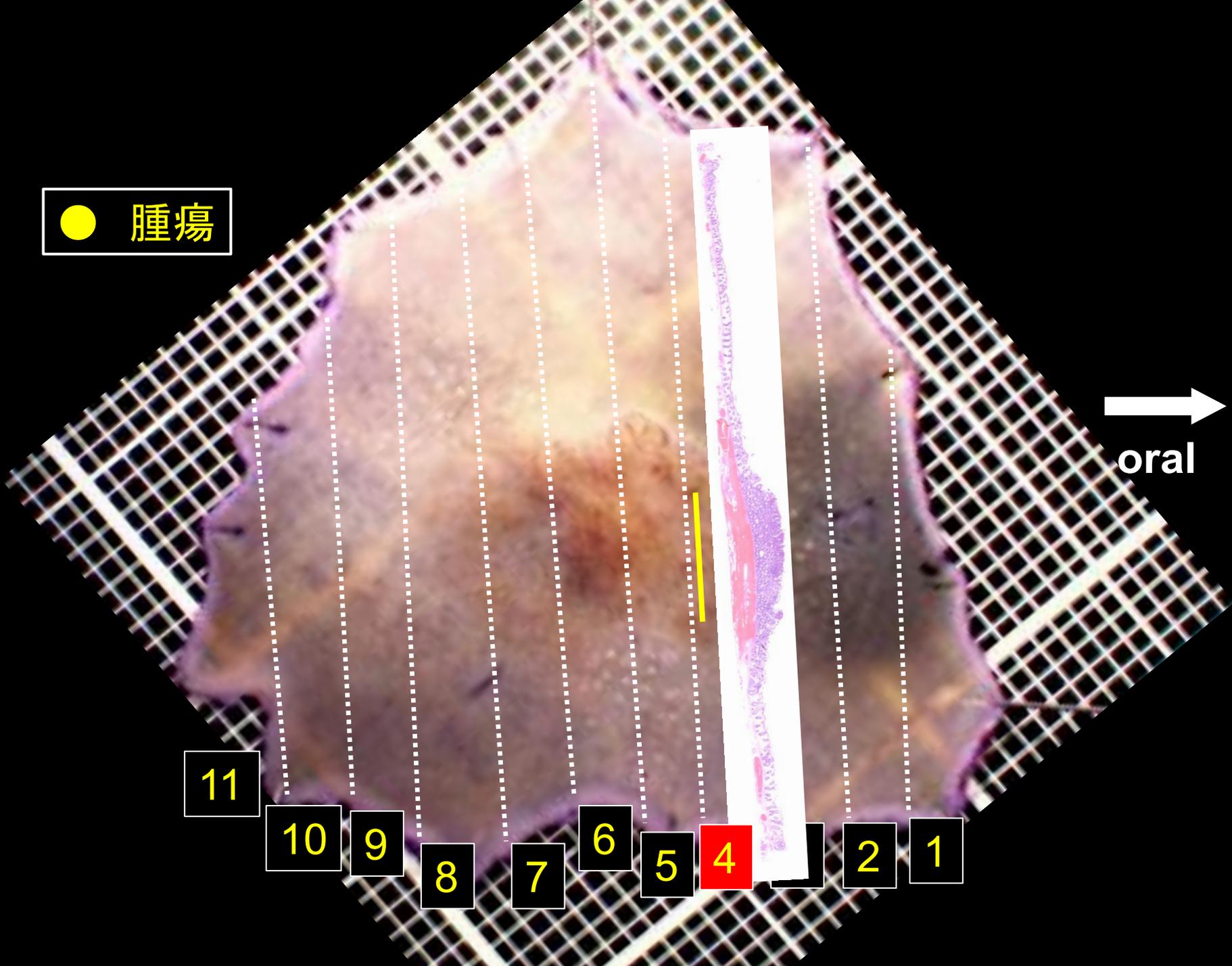
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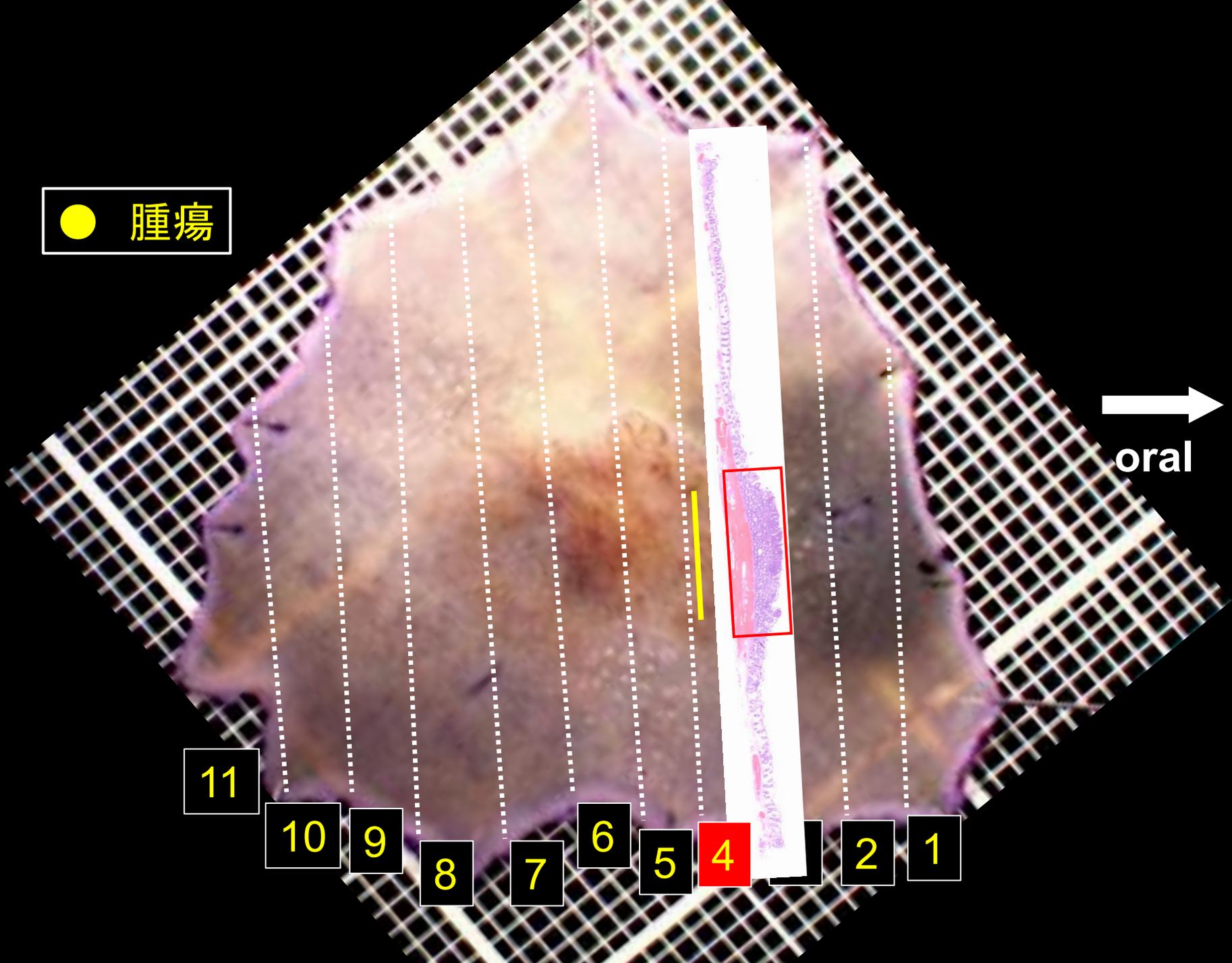
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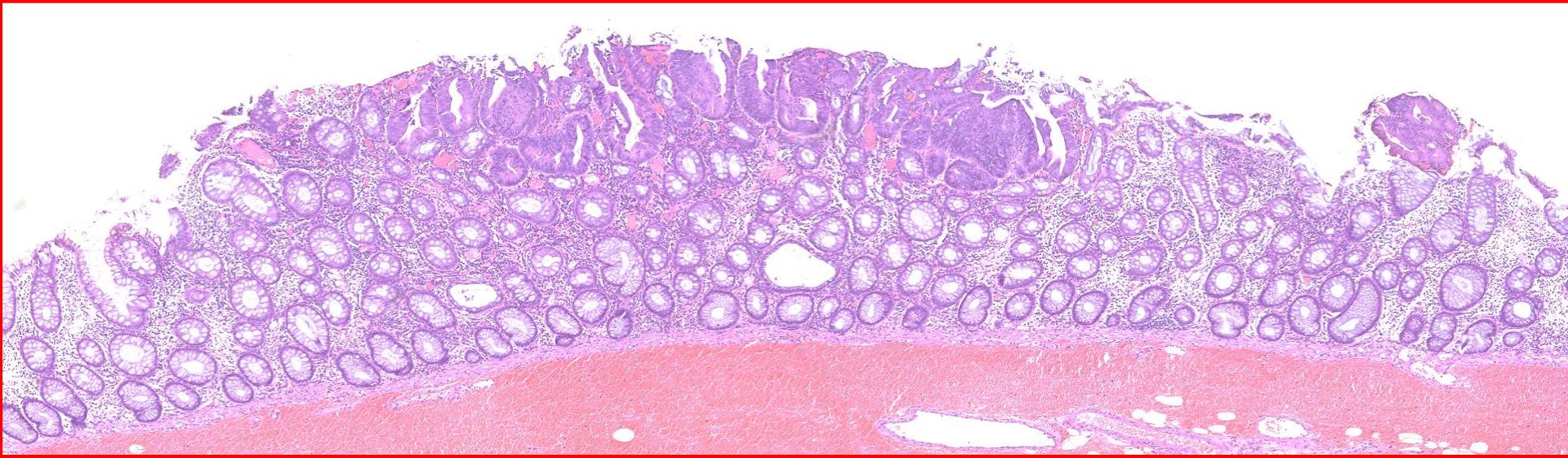
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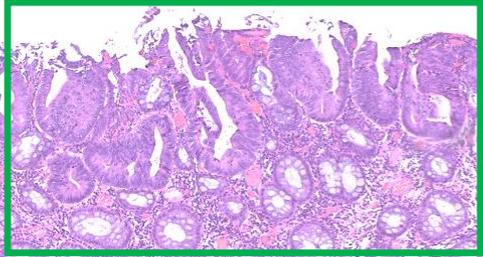
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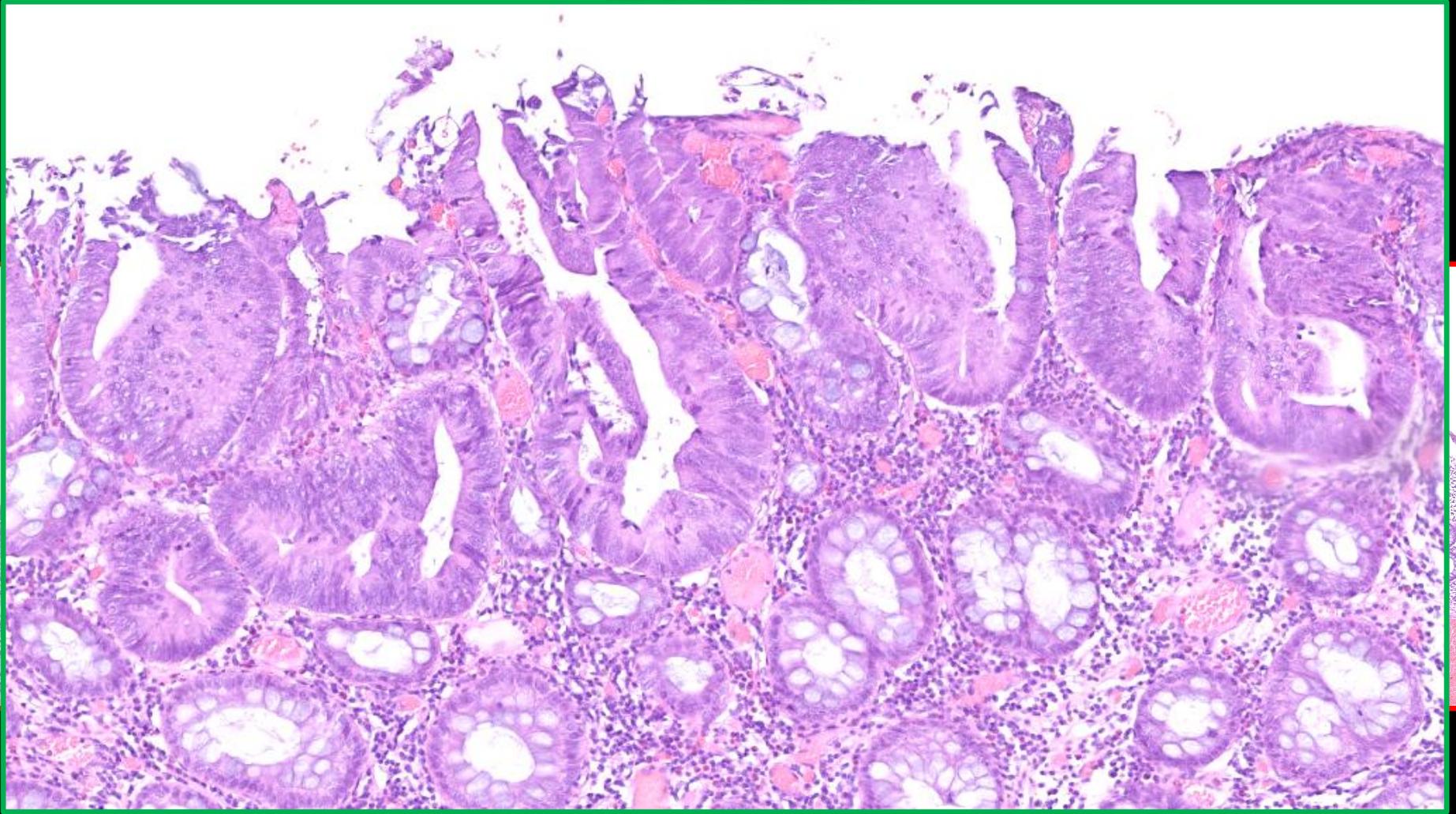
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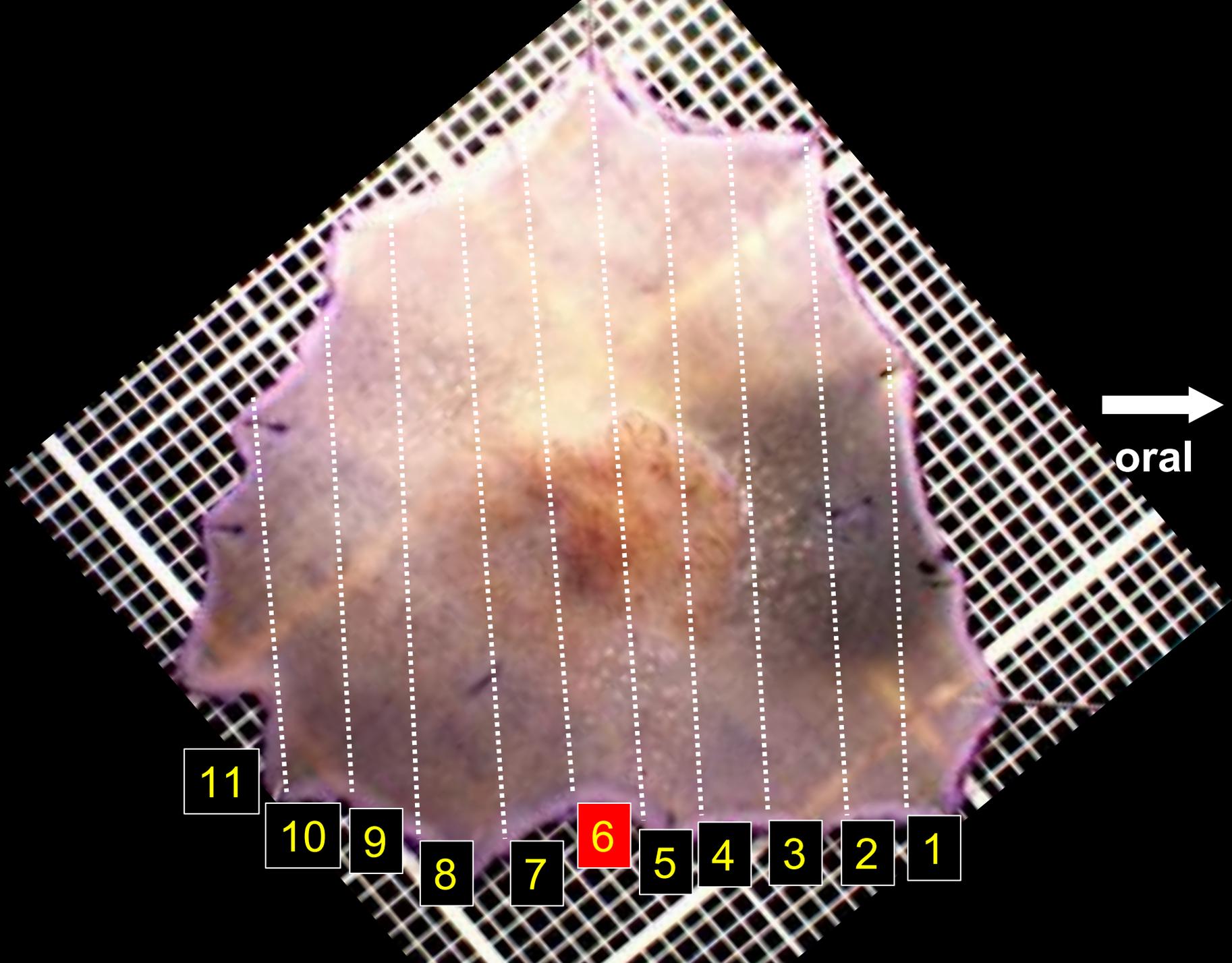
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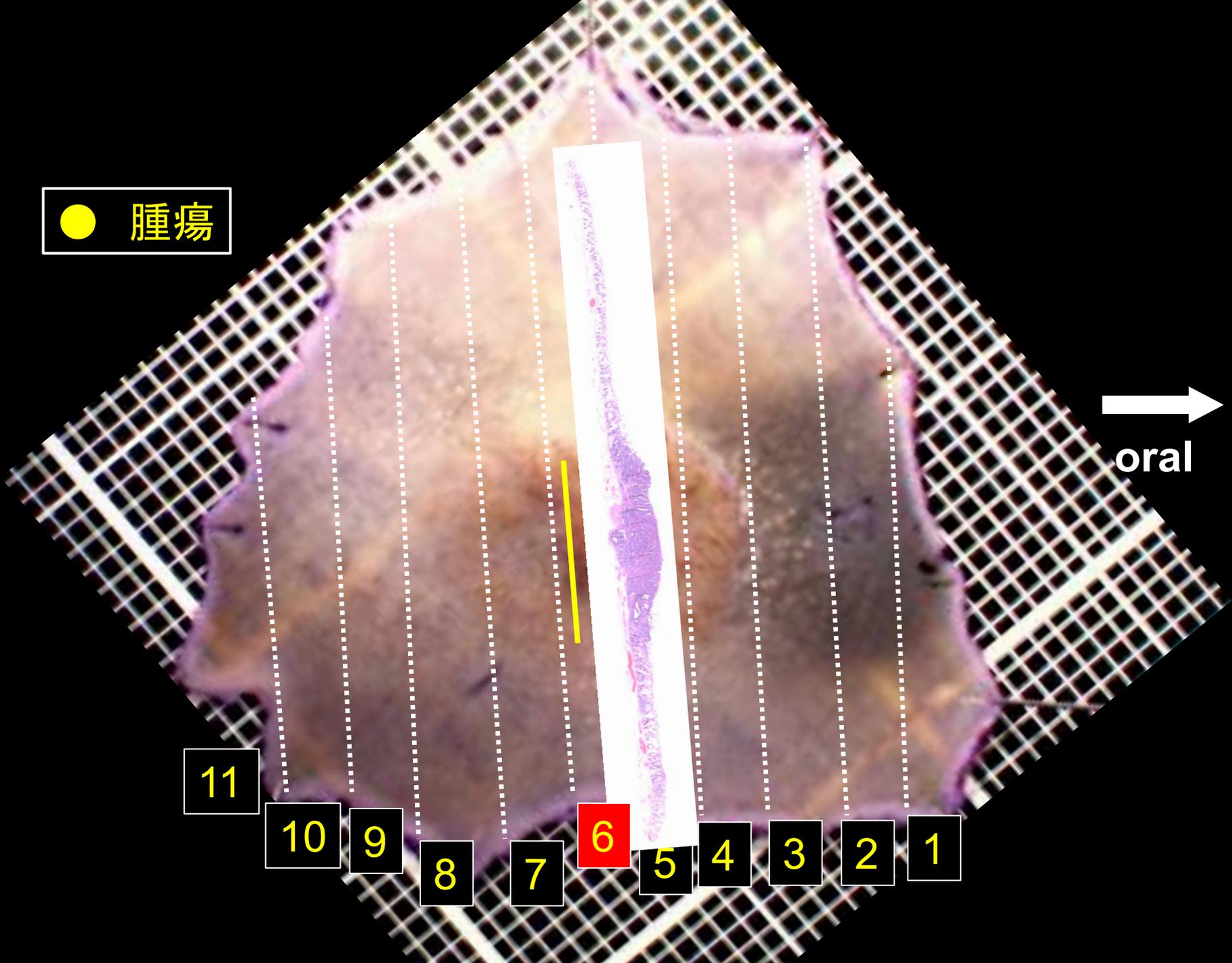
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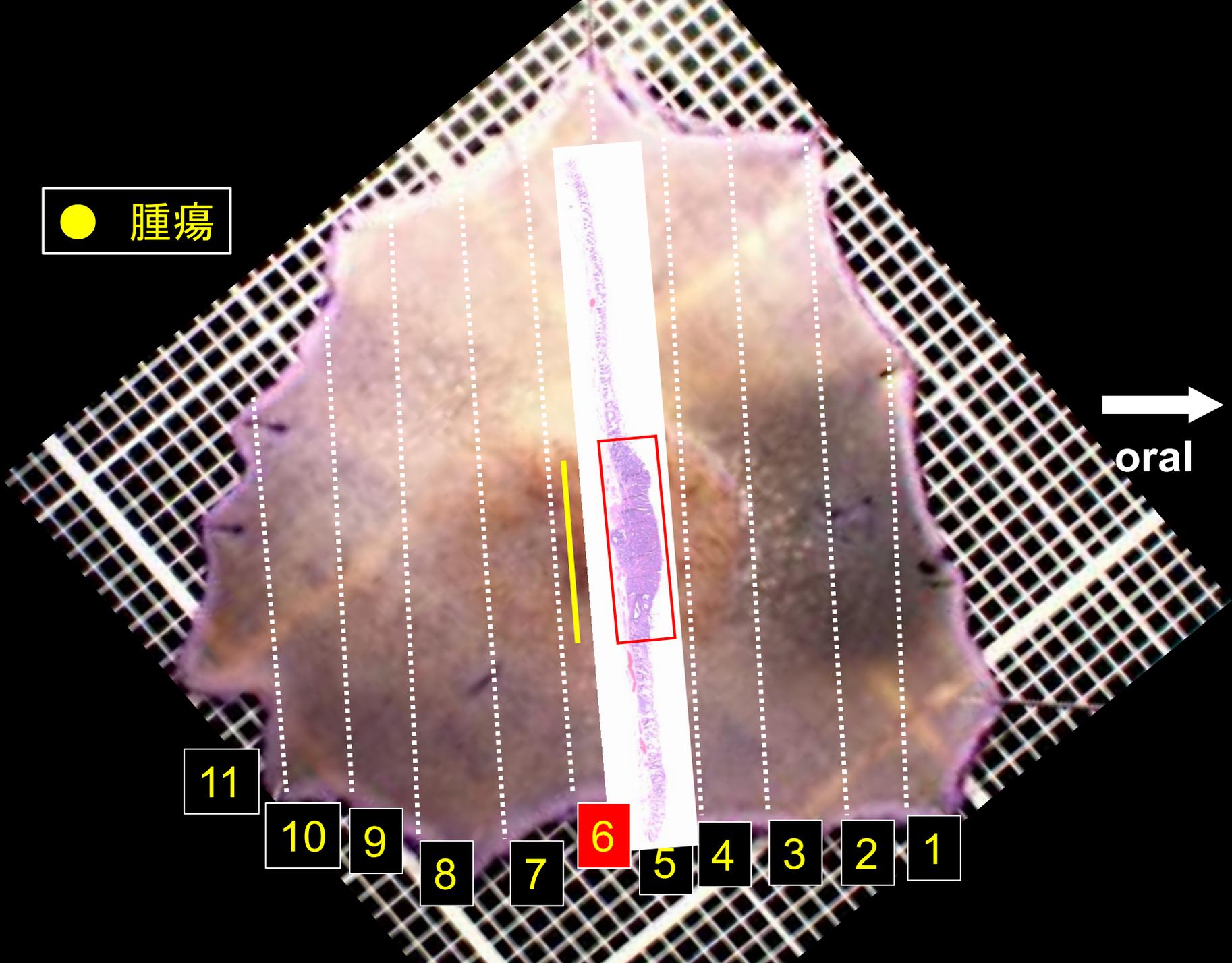
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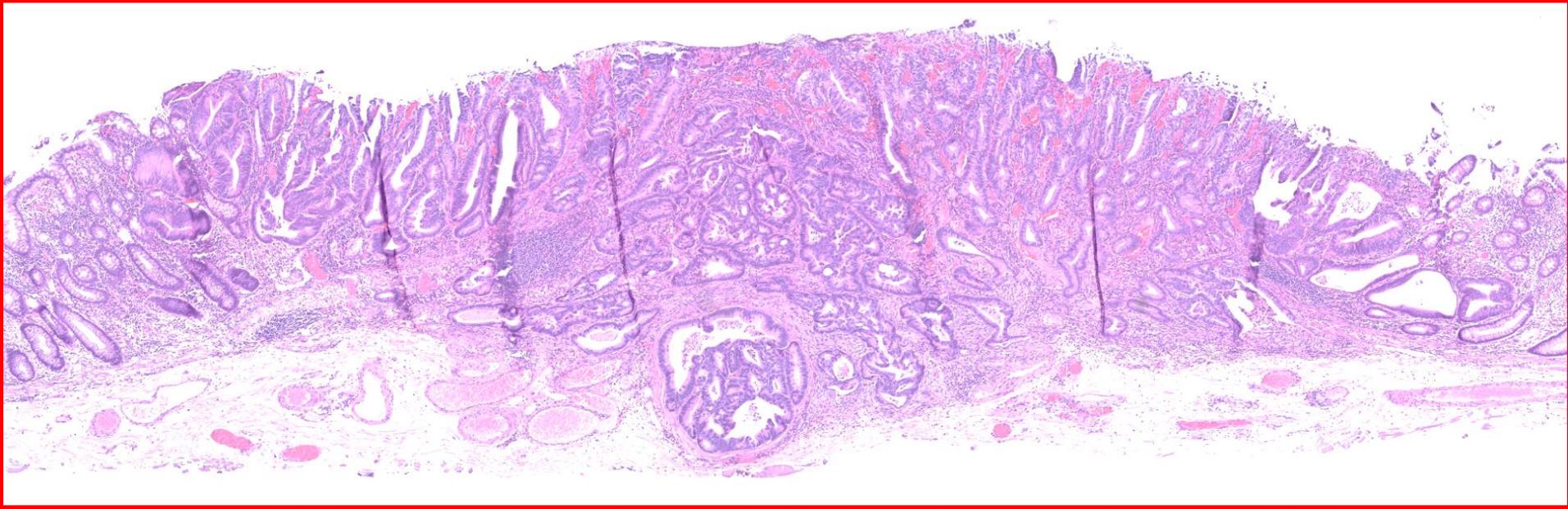
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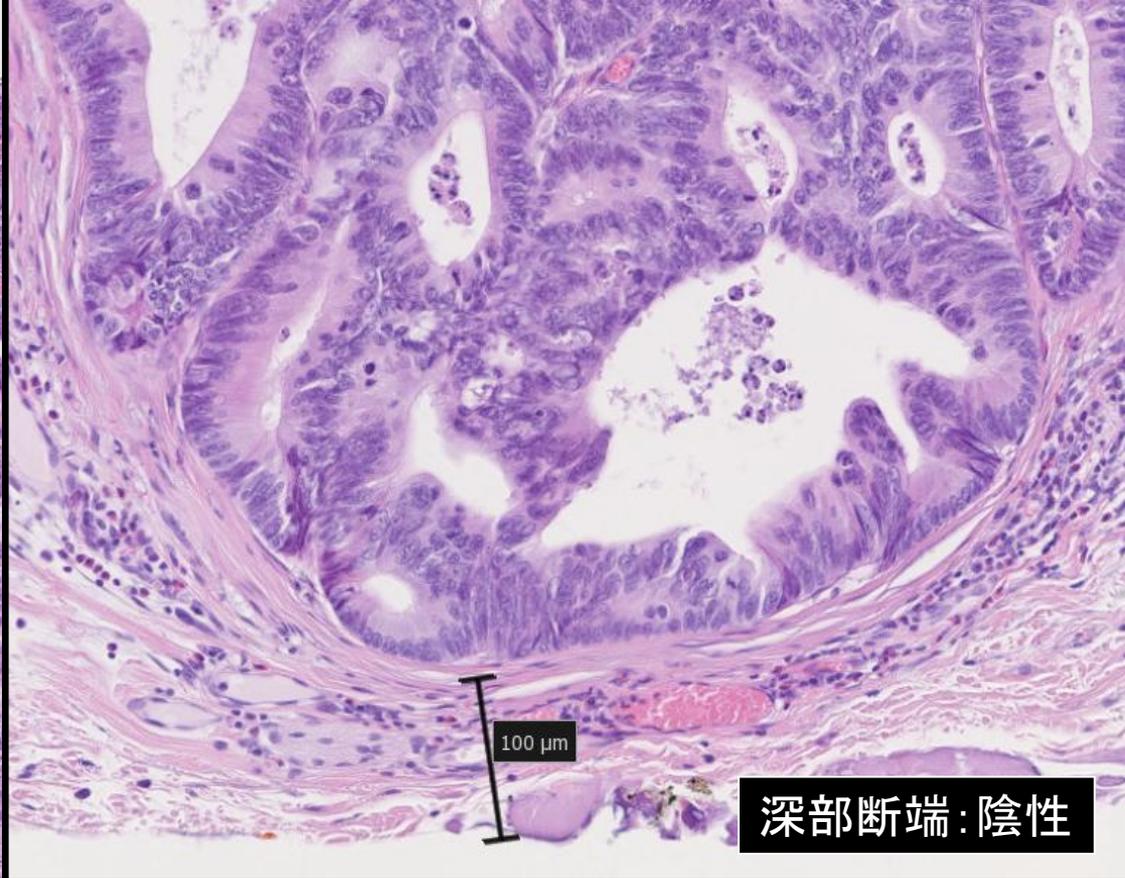
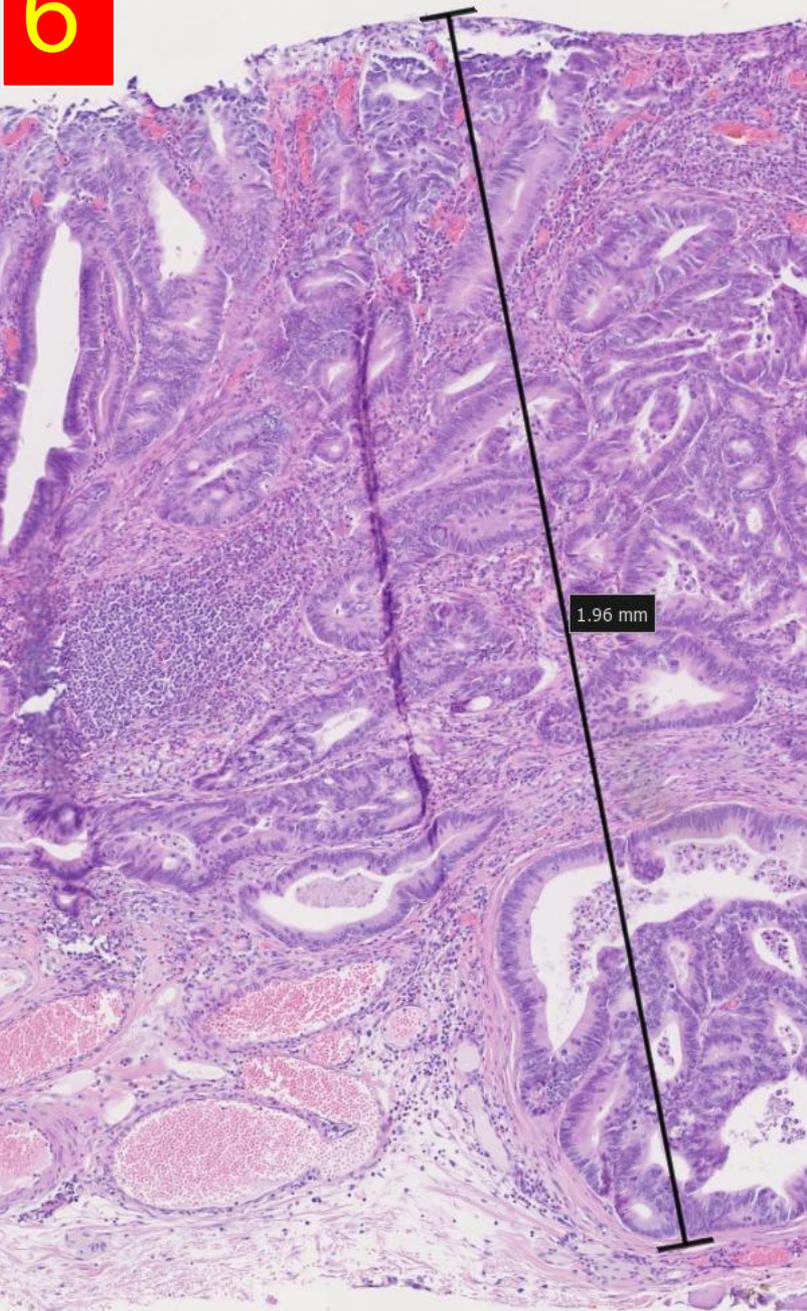
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深部断端：陰性

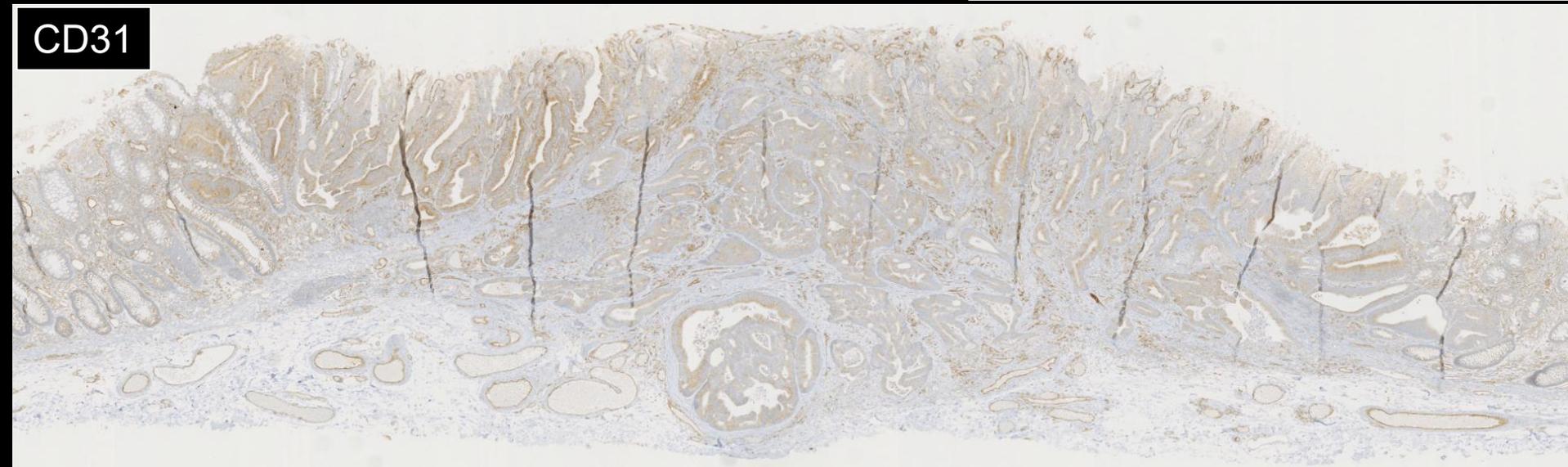
腫瘍表層から浸潤最深部まで  
: 約2000μm → SM2

D2-40

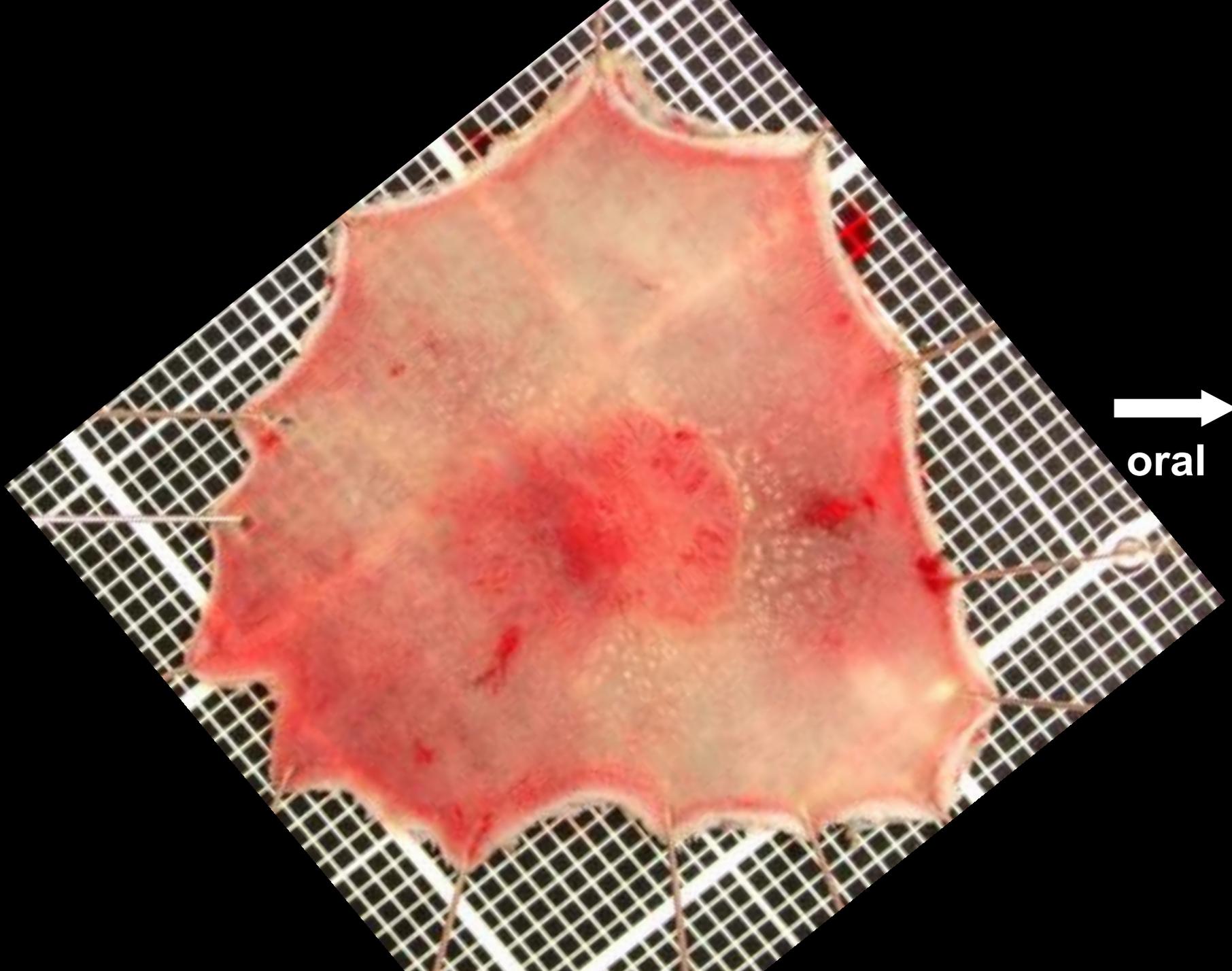


リンパ管侵襲：陰性 (Ly0)

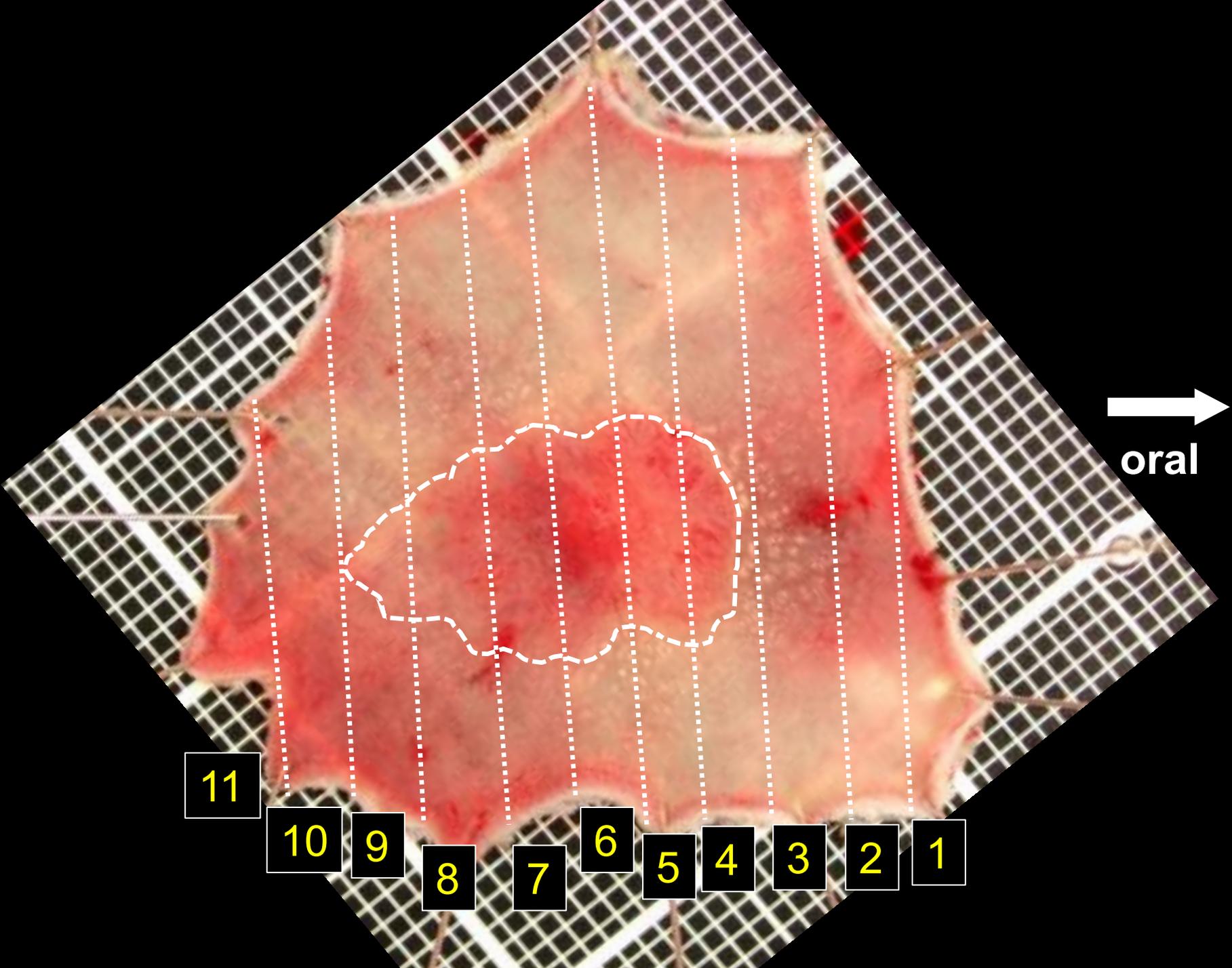
CD31



血管侵襲：陰性 (v0)



oral



oral

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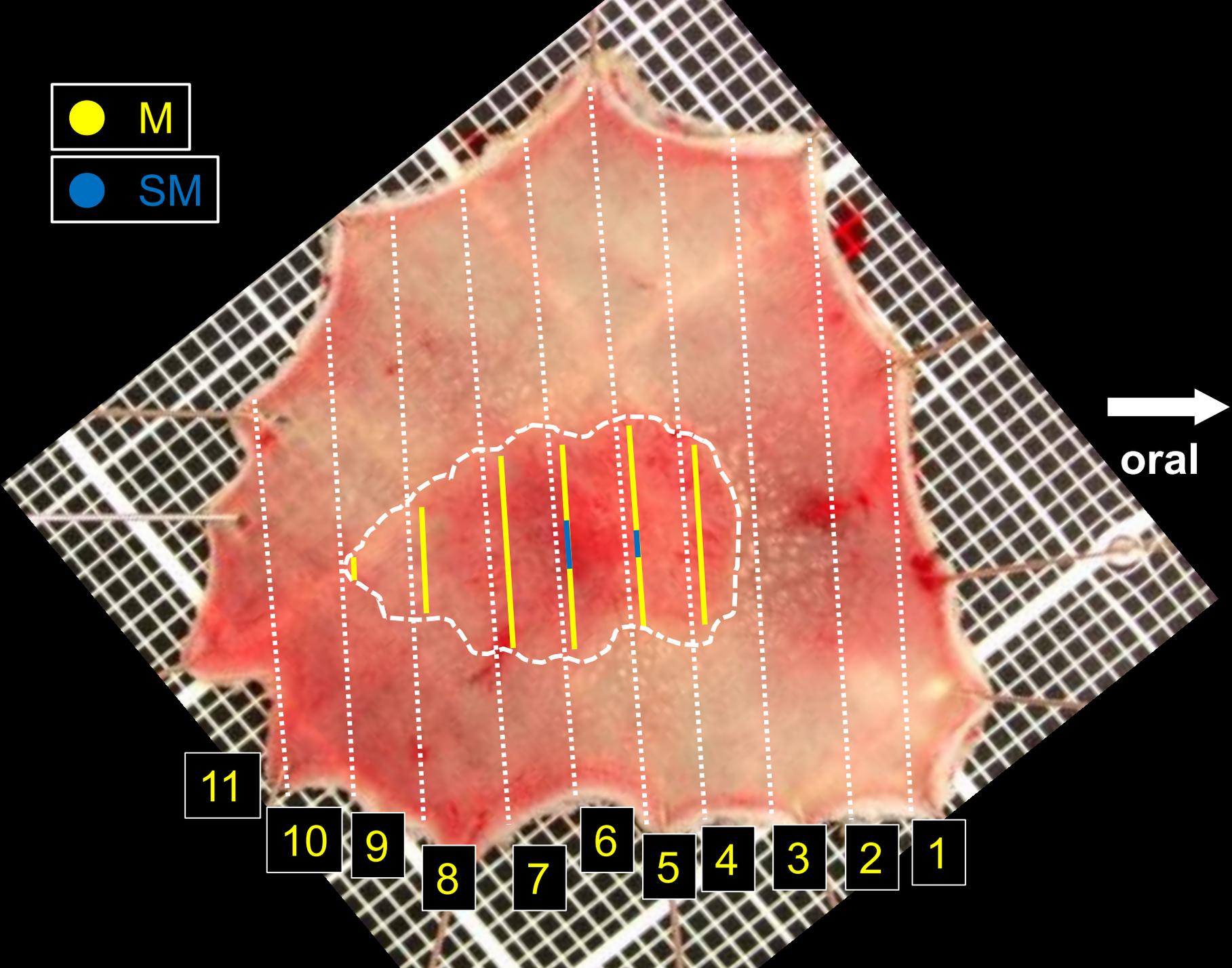
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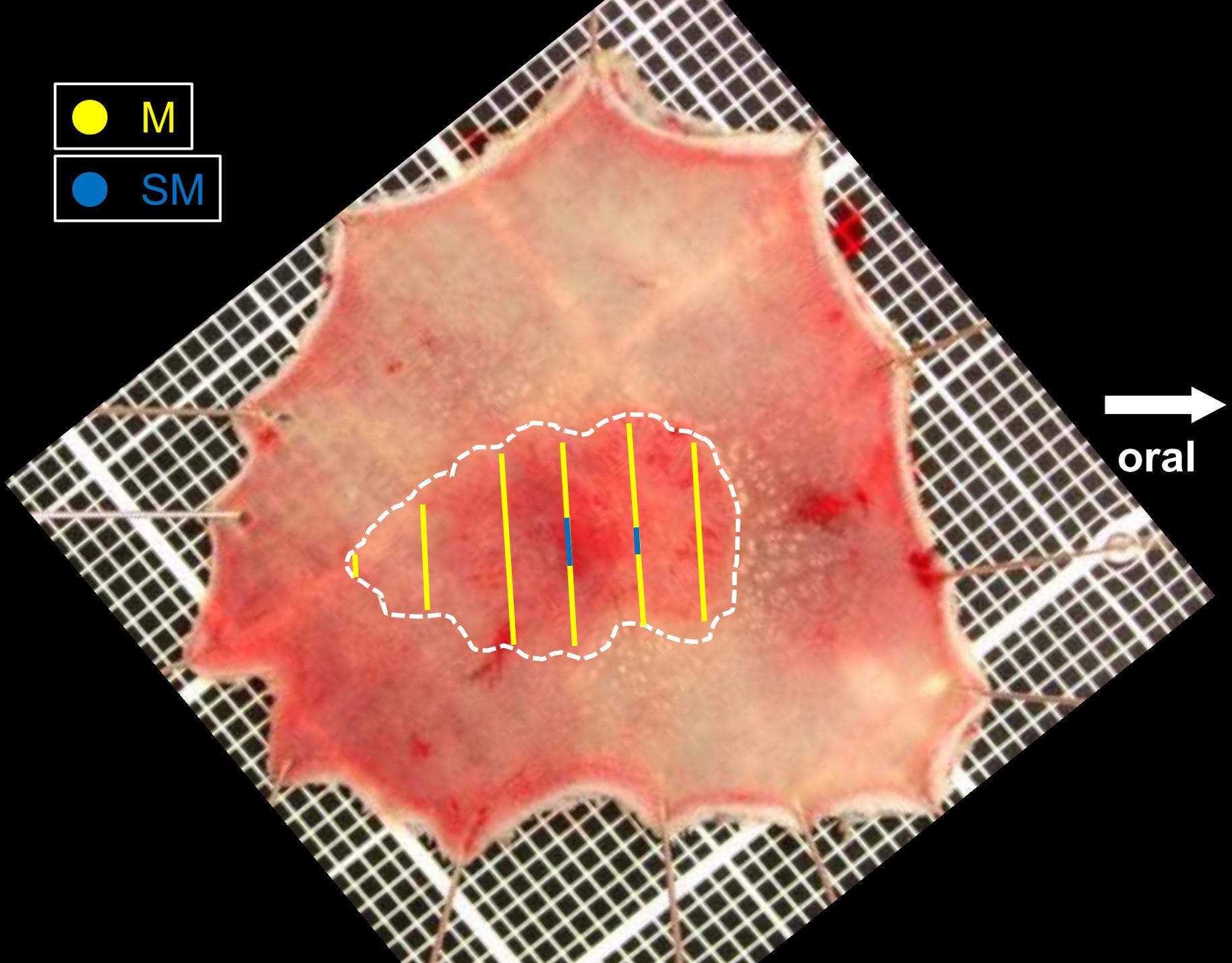
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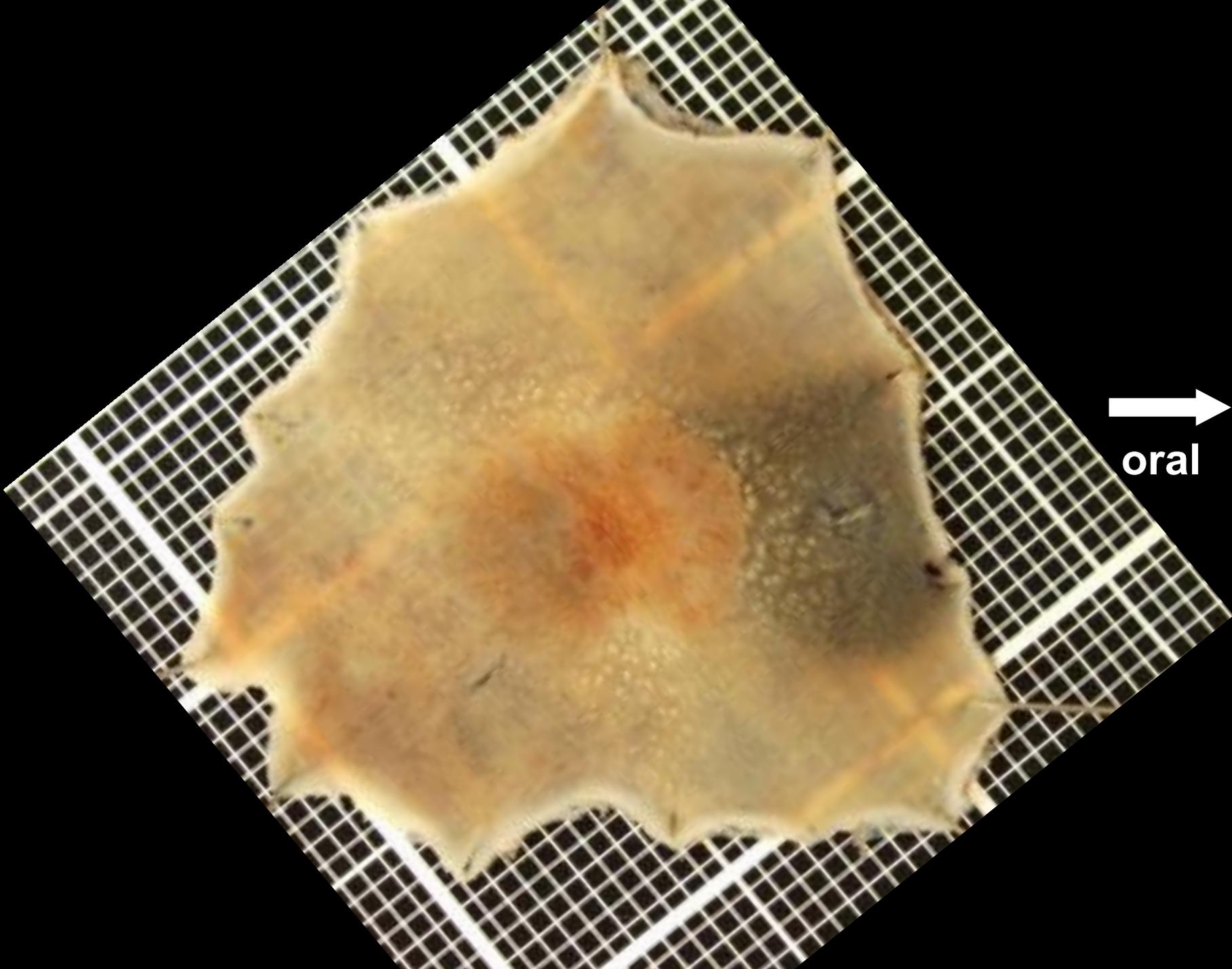
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oral

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● SM

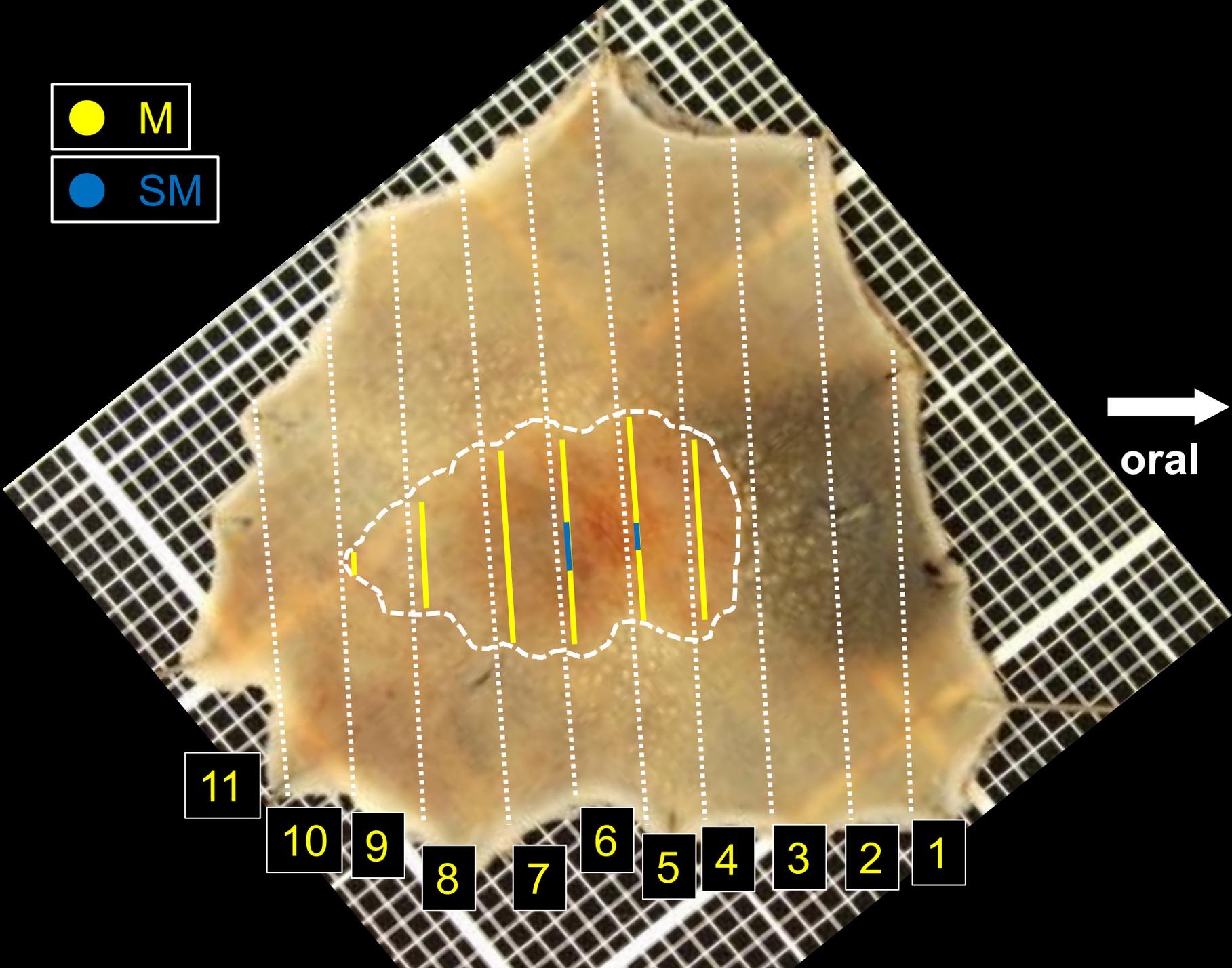




oral

● M

● SM



oral

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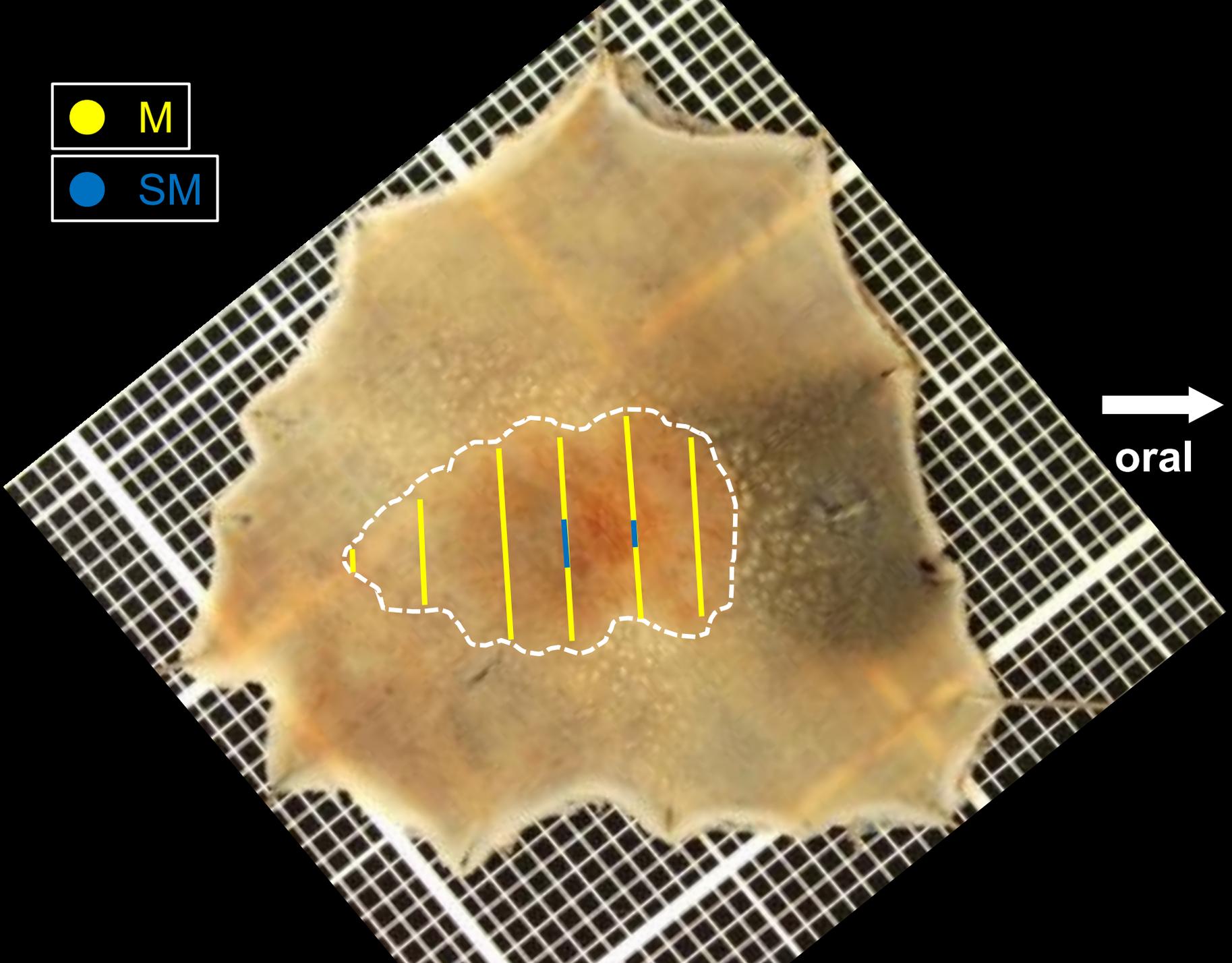
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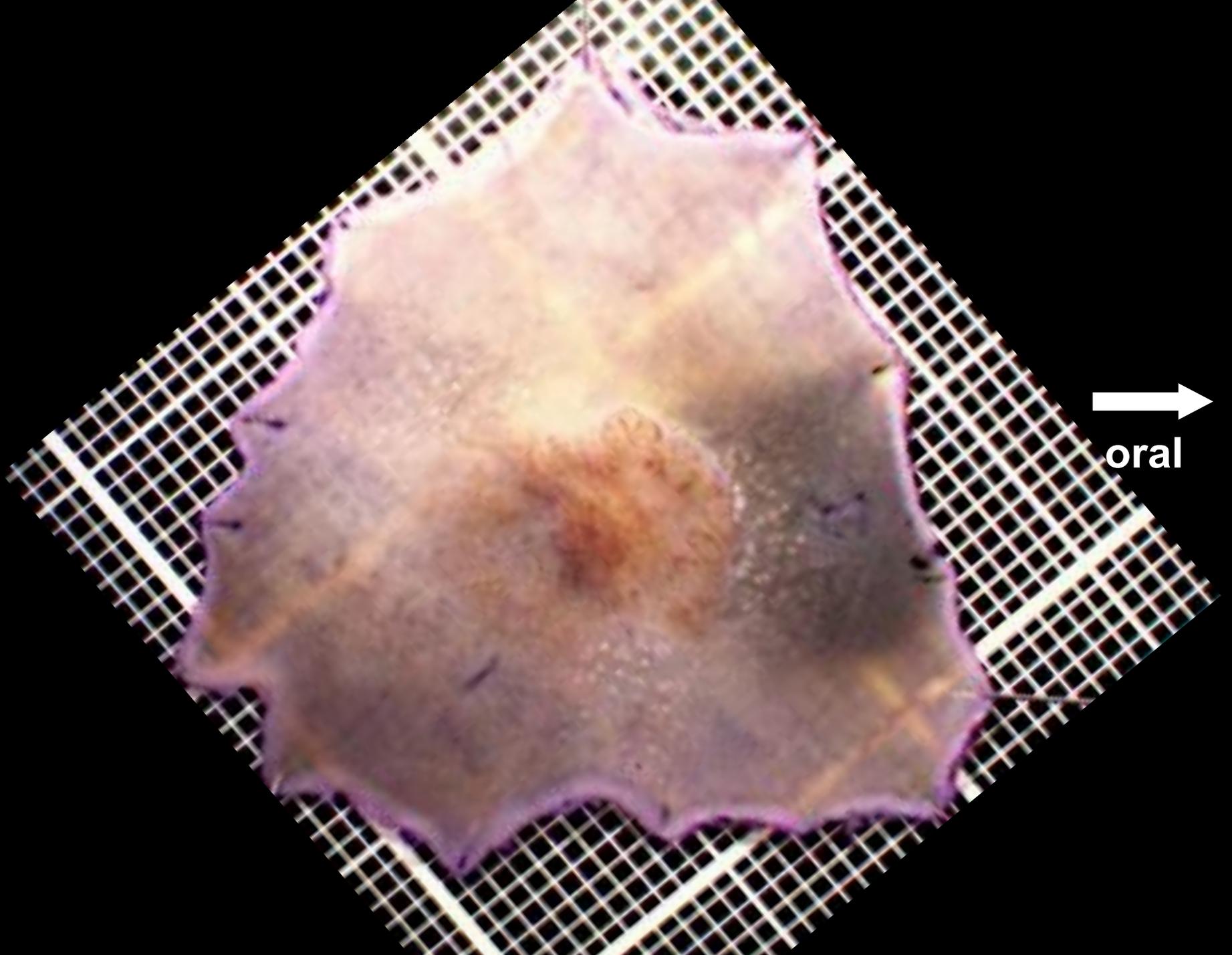
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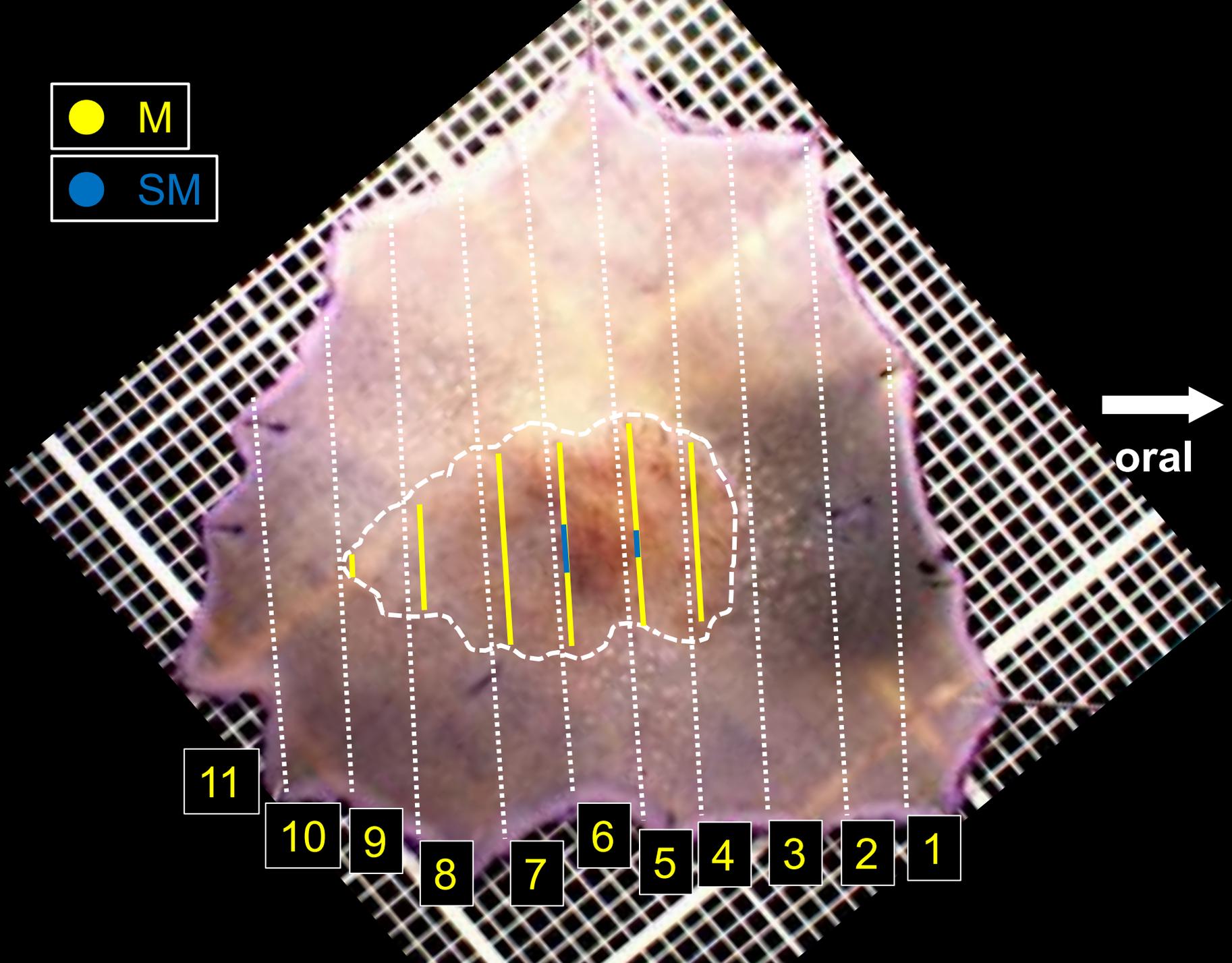




oral

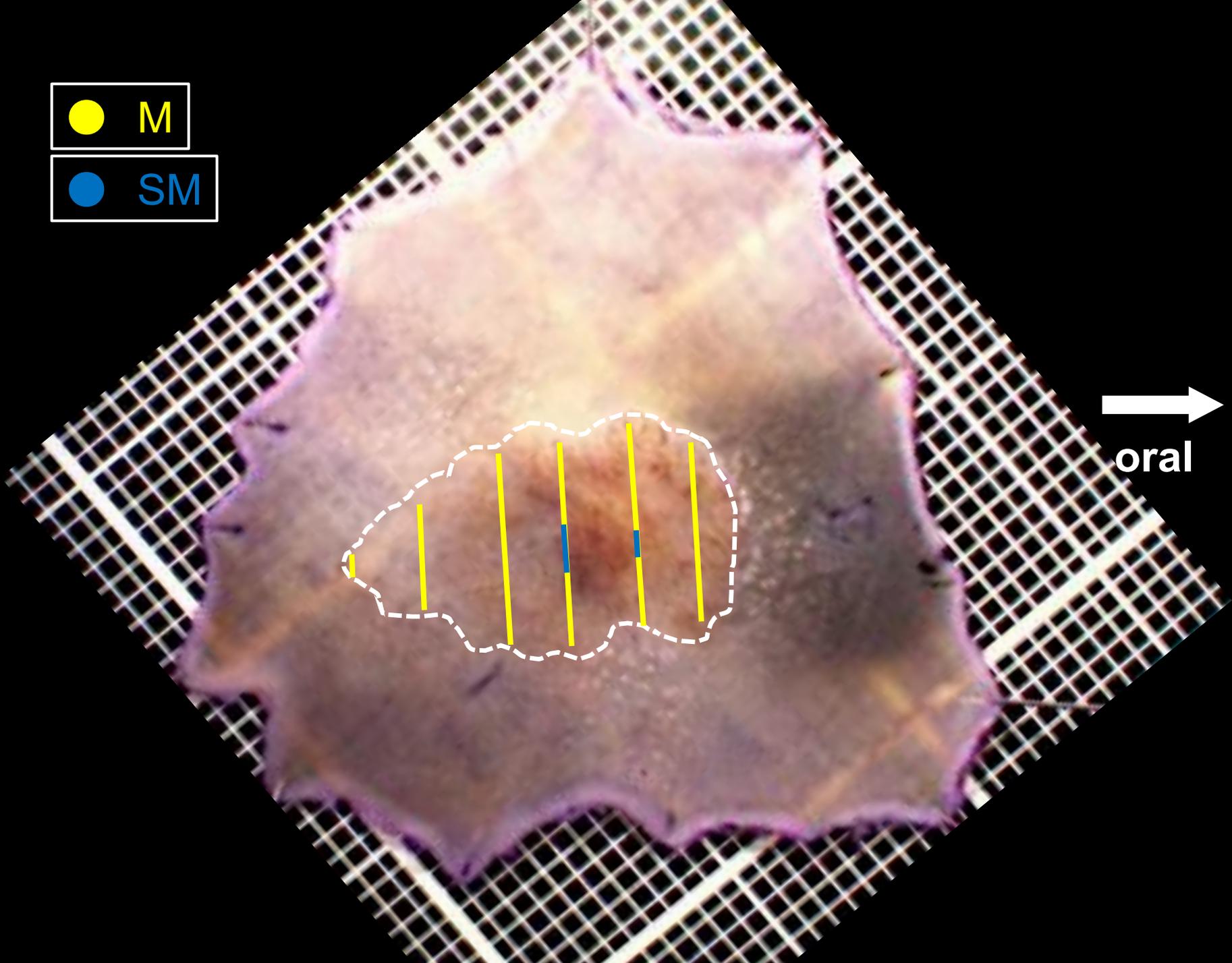
● M

● SM



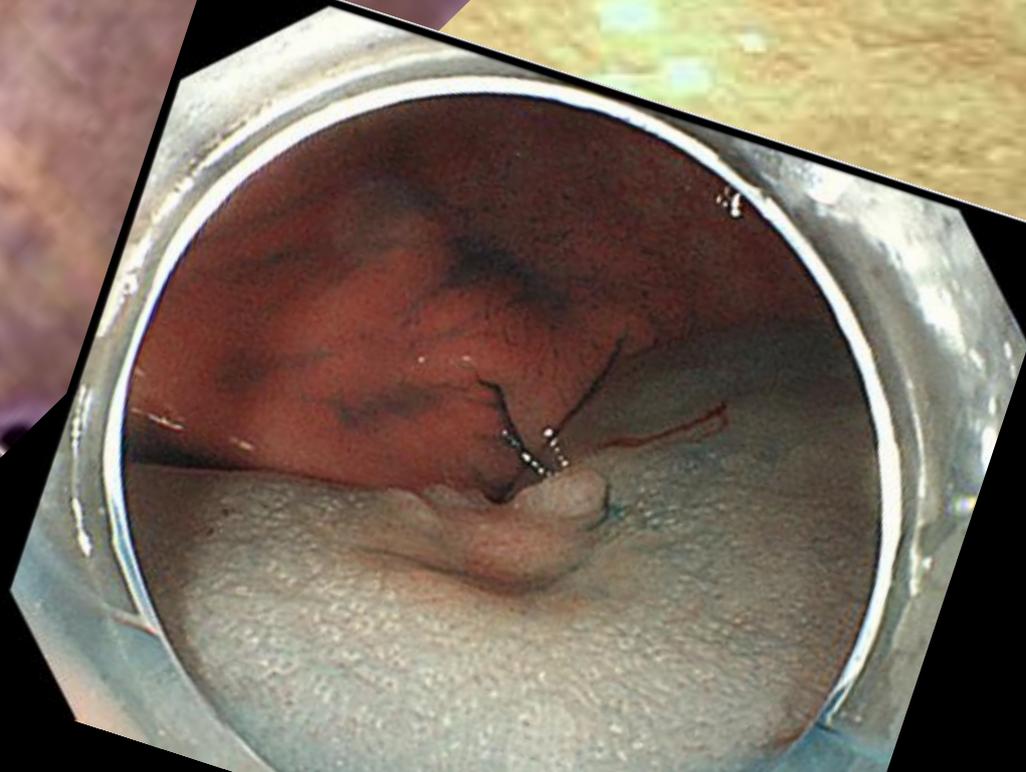
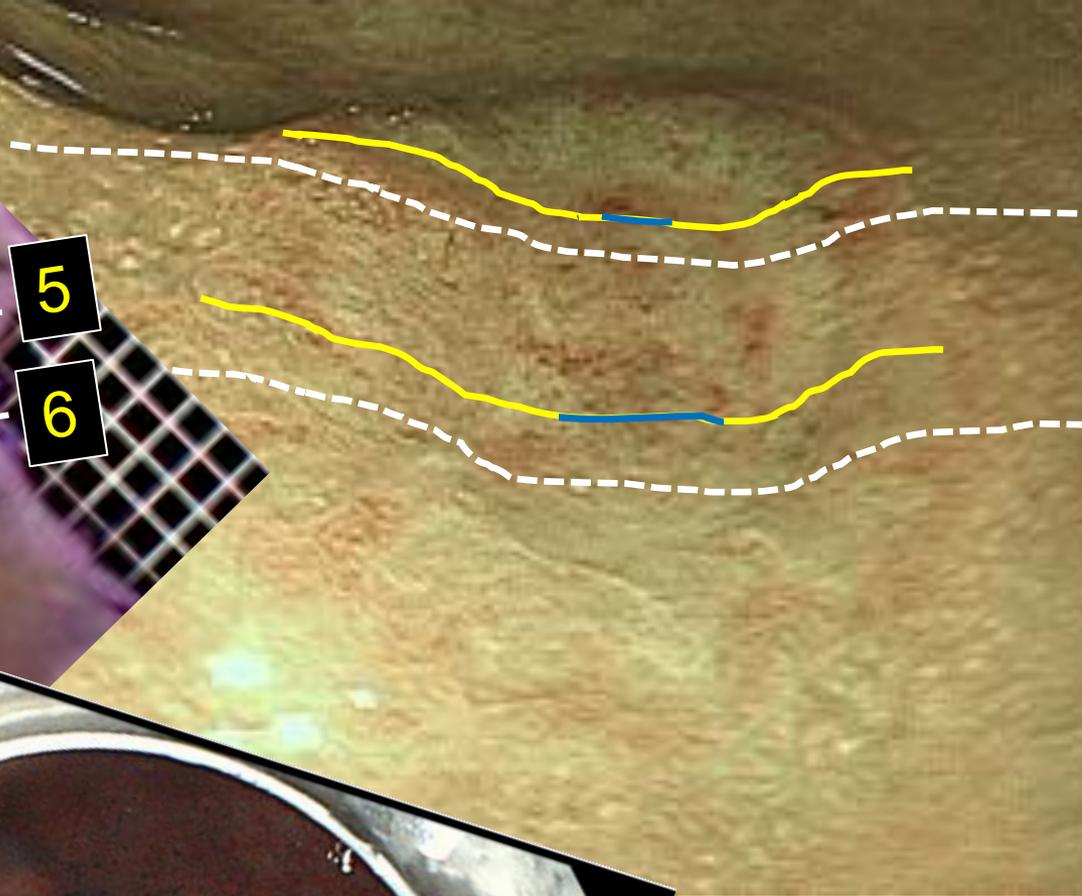
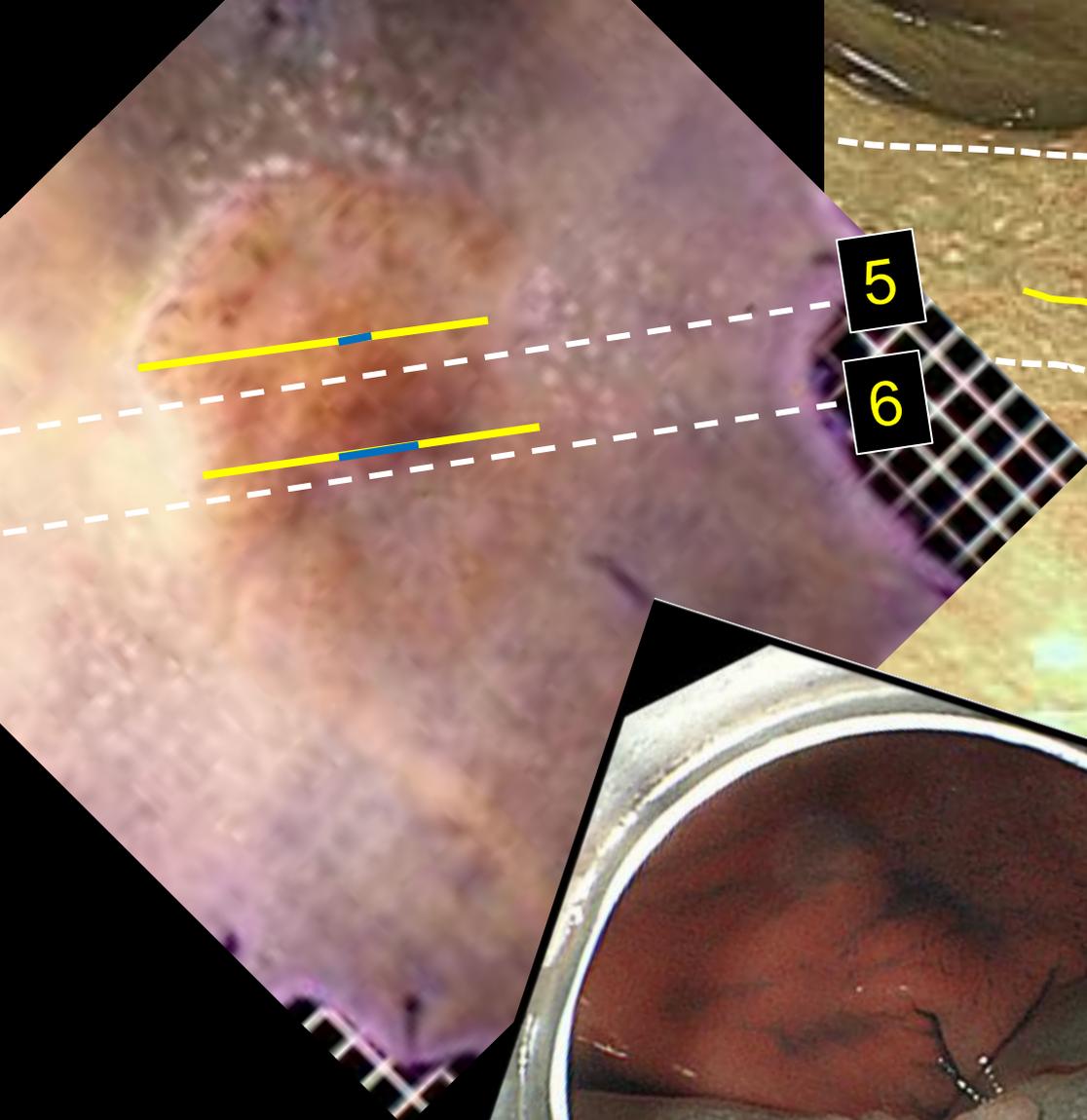
● M

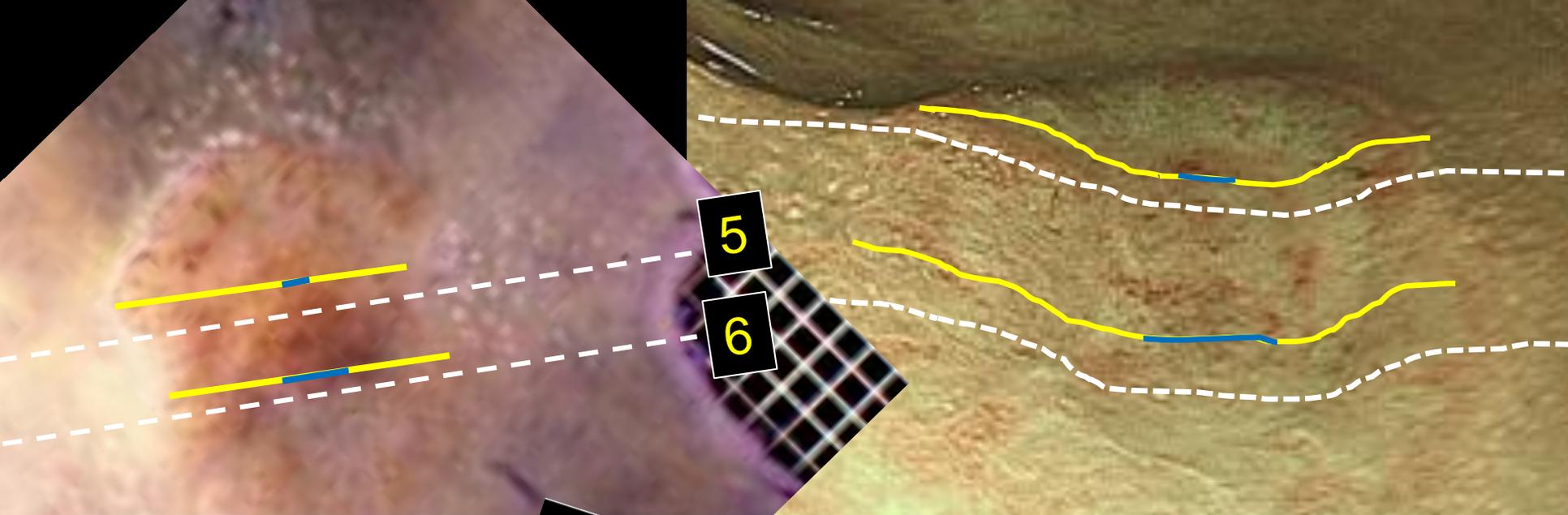
● SM



oral

# Mapping





SM浸潤部は、局注で浮きにくかった部分と一致



# 病理組織診断

Rectum, ESD: 15 × 10mm(35 × 35mm)  
tubular adenocarcinoma, well differentiated,  
carcinoma with adenoma component,  
pT1b(SM2, 2000 $\mu$ m), int, INFb, Ly0, V0,  
Grade1, EX negative, PN0, HM0, VM0.

→ 内視鏡的完全切除は可能であったが、pT1b(SM2)の診断

# SM深部浸潤癌の治療方針

〔内視鏡的切除後の pT1 癌の治療方針〕



# SM深部浸潤癌の治療方針

- ✓ SM浸潤距離のみが根治基準を満たさない場合、T1b癌のリンパ節転移の頻度は1~2%程度。

*Nakadoi K et al. CGH 2012; 27: 1057-62*

*Yoshii S et al. CGH 2014; 12: 292-302*

- ✓ 一方、最初からリンパ節郭清を伴う外科的手術を施行しても、結腸で1.5%、直腸で4.2%転移再発の報告あり。

*Kobayashi H et al. JG 2011; 46:203-11*

本人希望で追加切除は施行せず、  
慎重経過観察の方針に。

ESD後3.5年

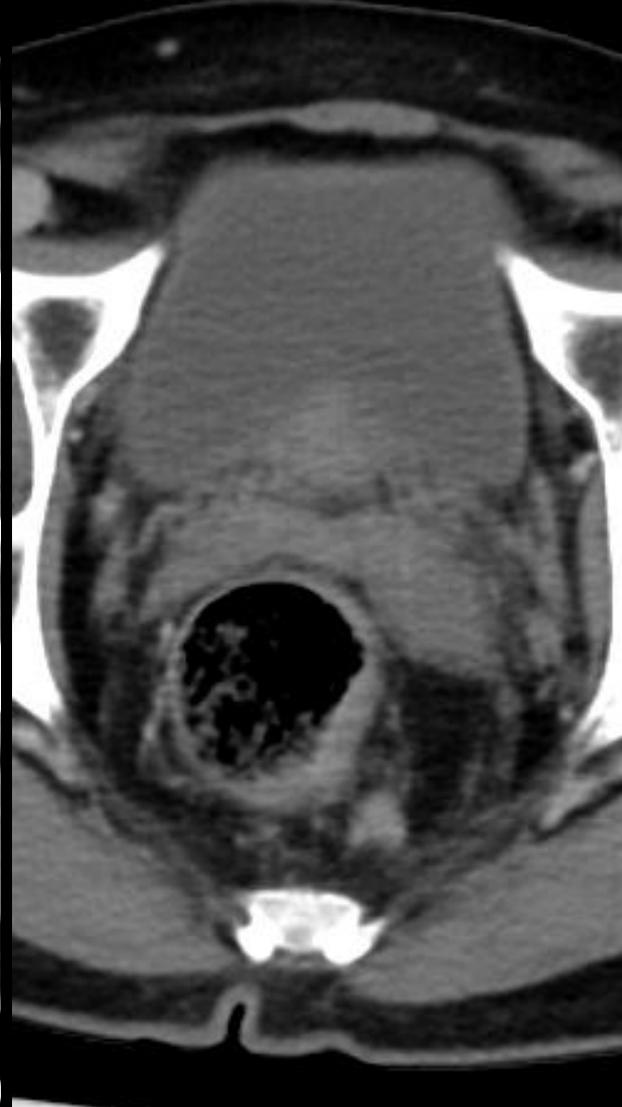
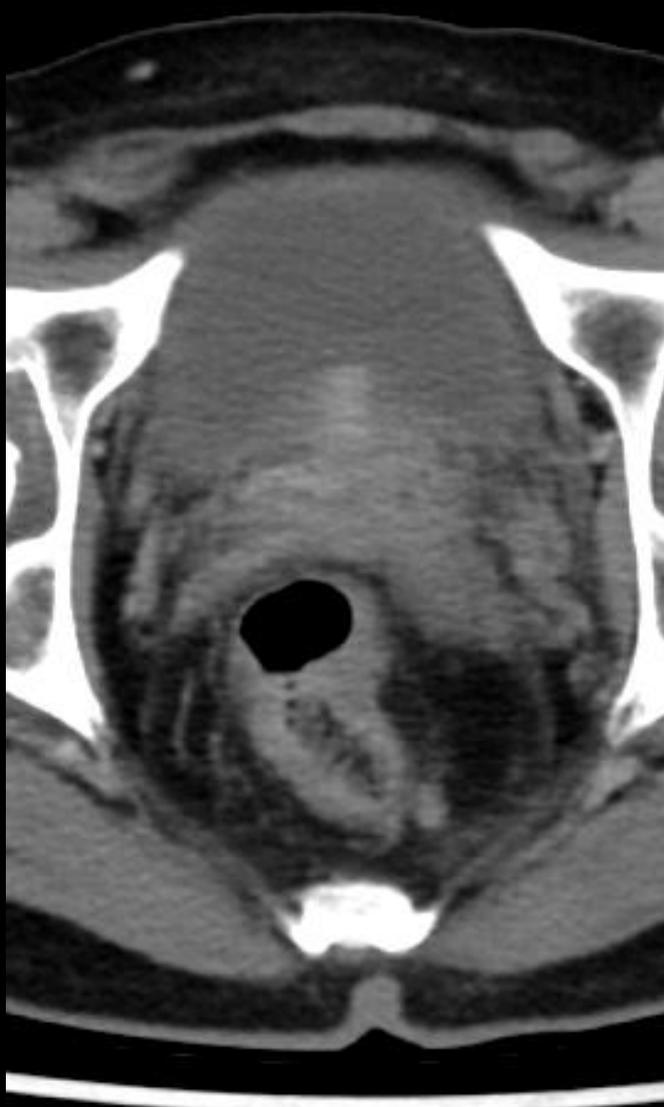
ESD後4年

ESD後4.5年

2021/10/5

2022/4/12

2022/10/4



ESD後3.5年

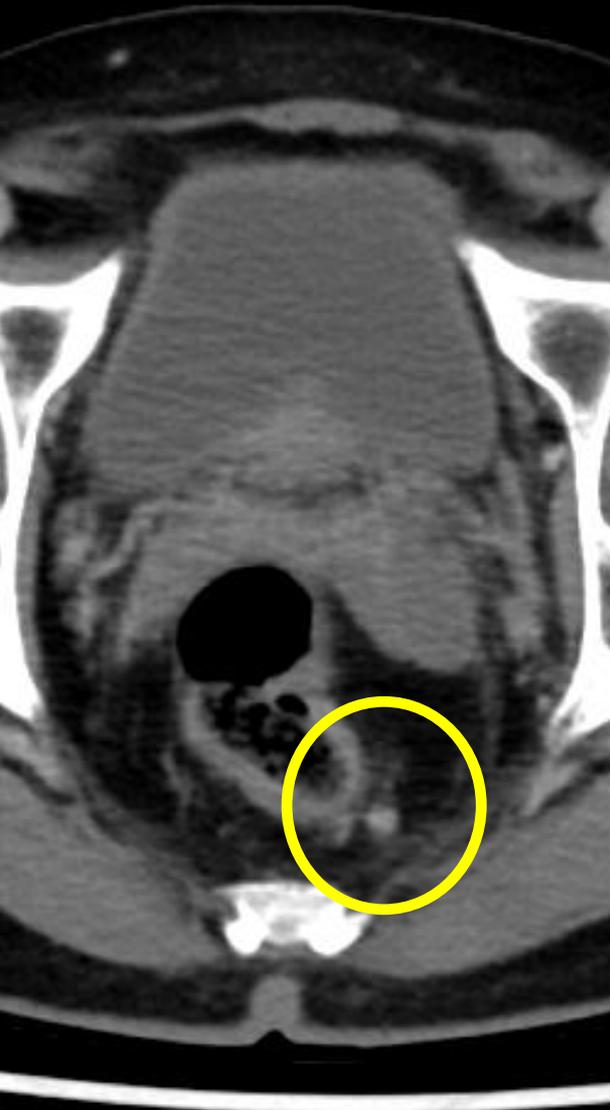
ESD後4年

ESD後4.5年

2021/10/5

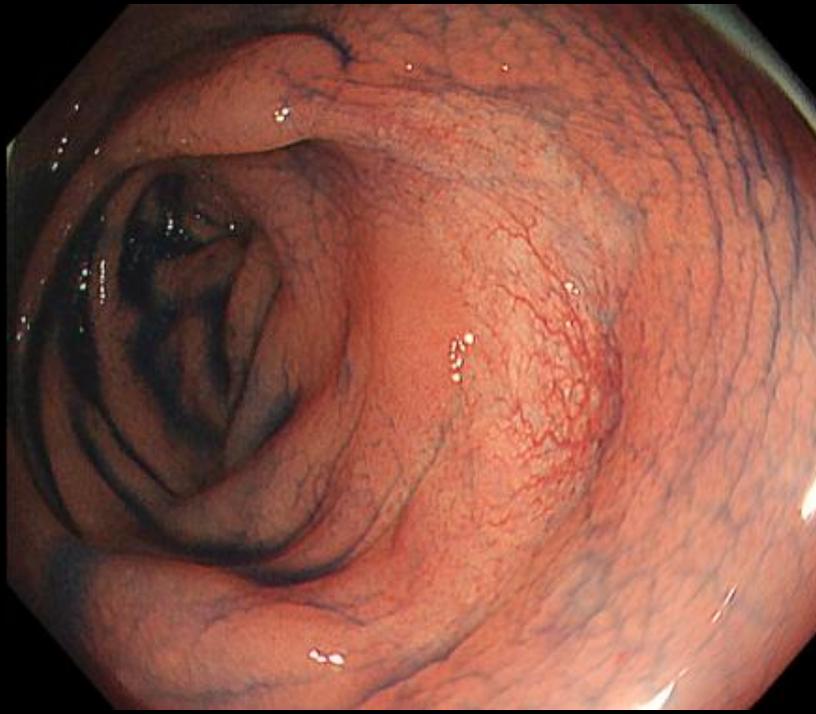
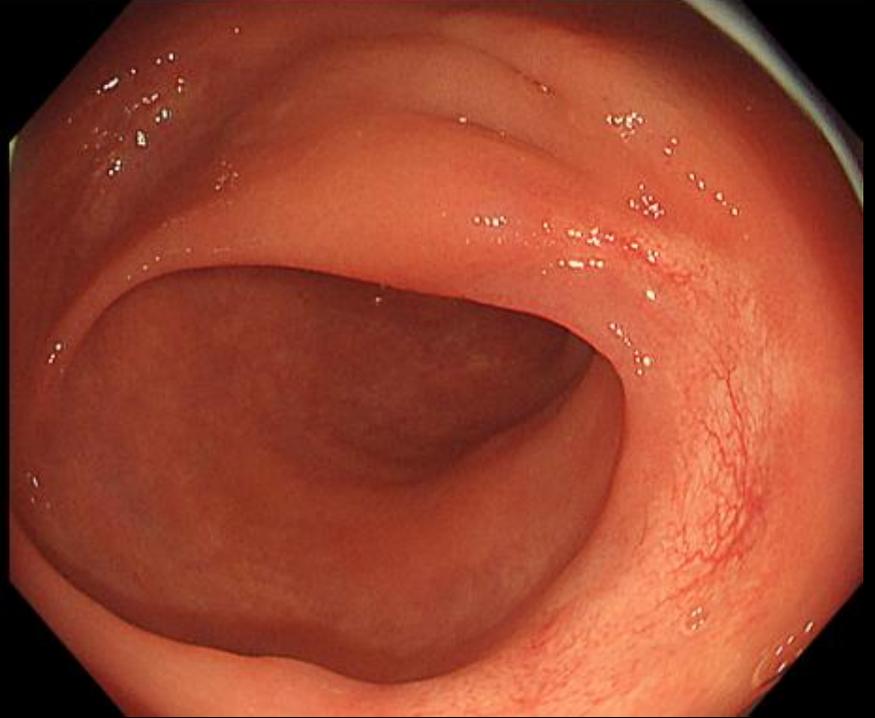
2022/4/12

2022/10/4



【ESD後4.5年 TCS】

ESD後癒痕上に明らかな  
遺残・再発所見なし。



CECTで増大傾向の結節影があり、  
内視鏡検査で局所再発を疑う所見はなかったが、リンパ節再発  
を疑い、ESD施行から5年で追加切除術を施行した。

→ 直腸低位前方切除術



oral





増大傾向であった結節部

ESD後瘢痕





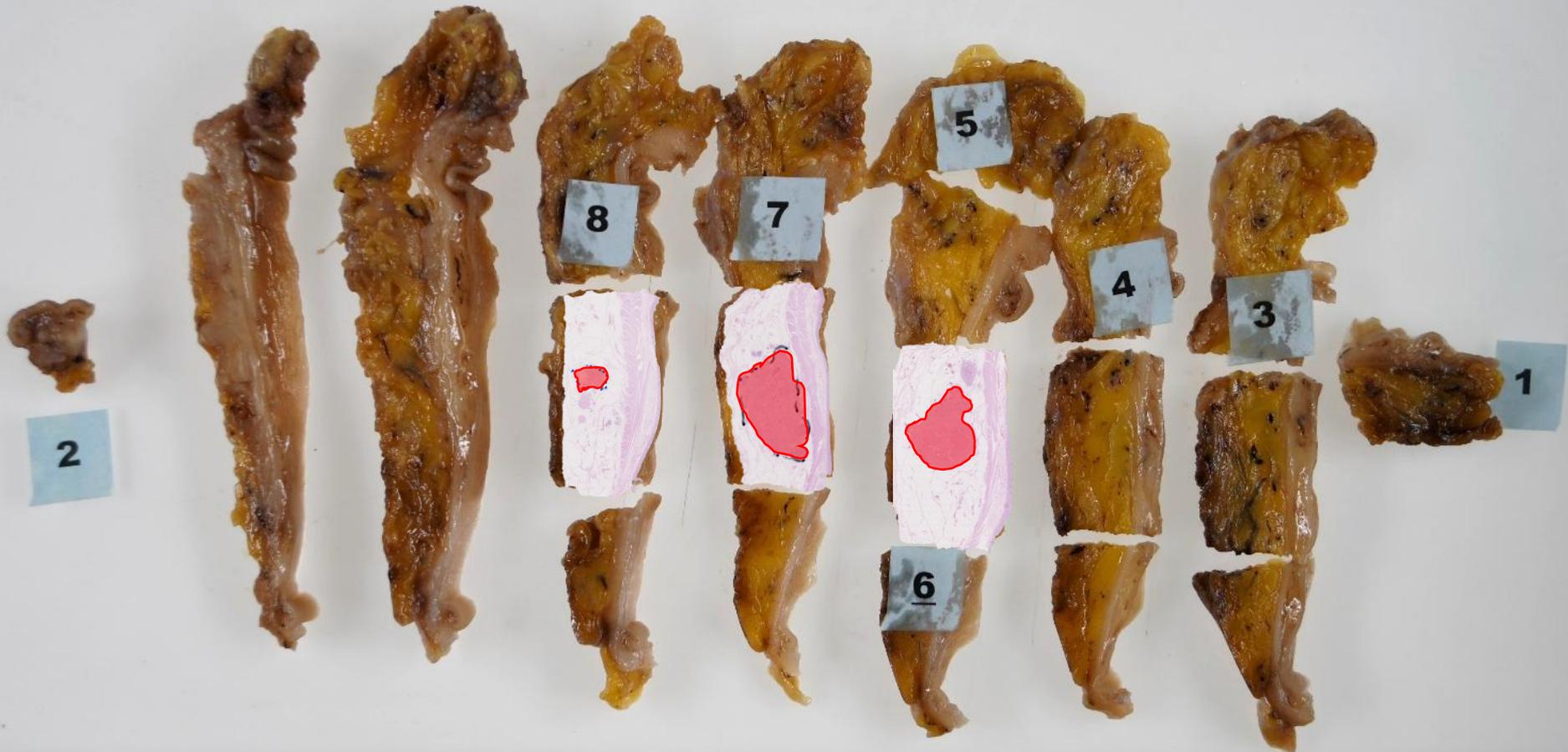
oral →



→  
oral



oral

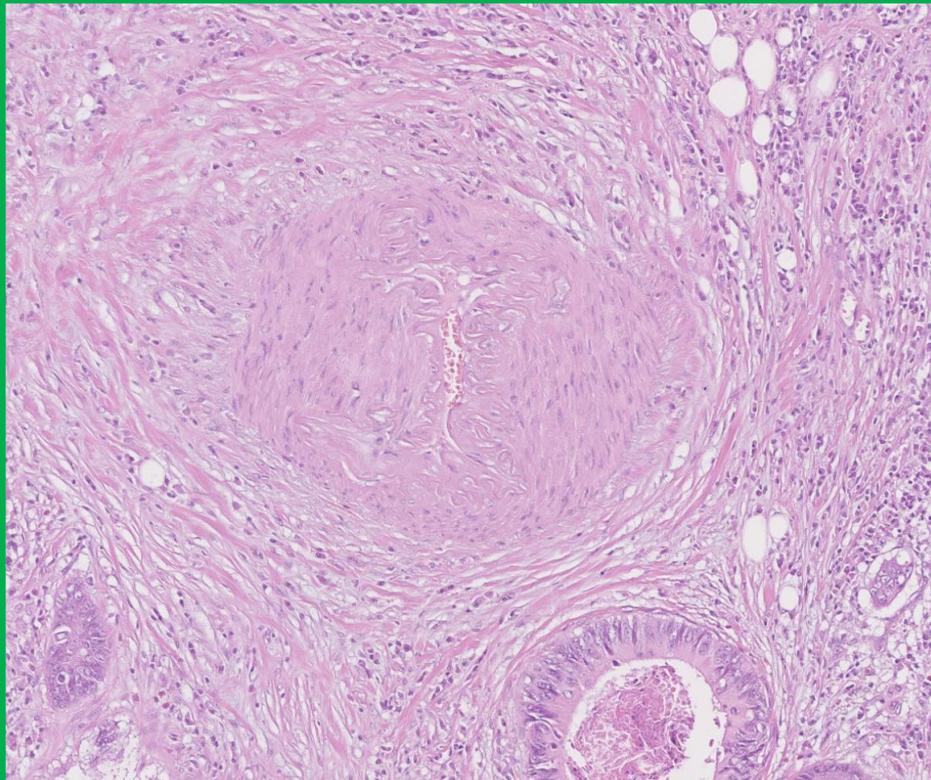
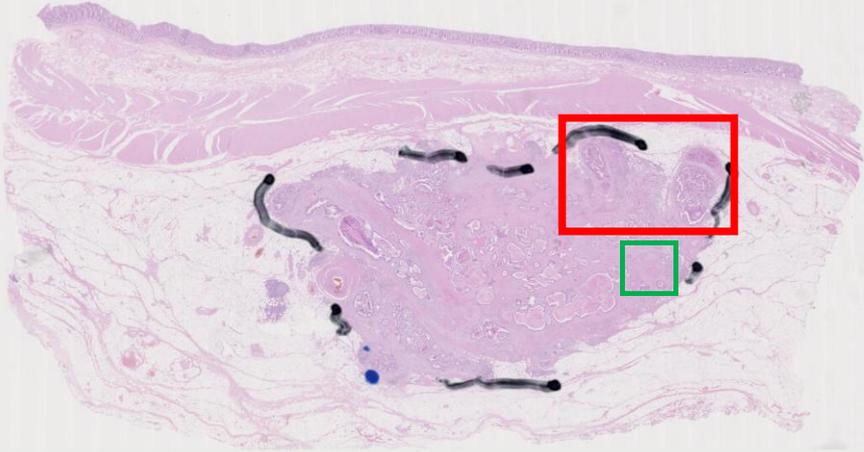


oral →



oral

# 代表切片 (7)



静脈・神経周囲侵襲あり

# 病理診断

Rectum, excision : recurrence of rectal adenocarcinoma, status post ESD.

- ・漿膜下層に高～中分化のtubular adenocarcinoma  
(ESD検体の組織型と一致)
- ・静脈侵襲・神経周囲侵襲あり。

→ 漿膜下層内への再発

Lymph nodes, dissection : no evidence of malignancy.

※ 郭清した領域リンパ節には明らかな転移なし。

# 局所再発？ 転移性再発？

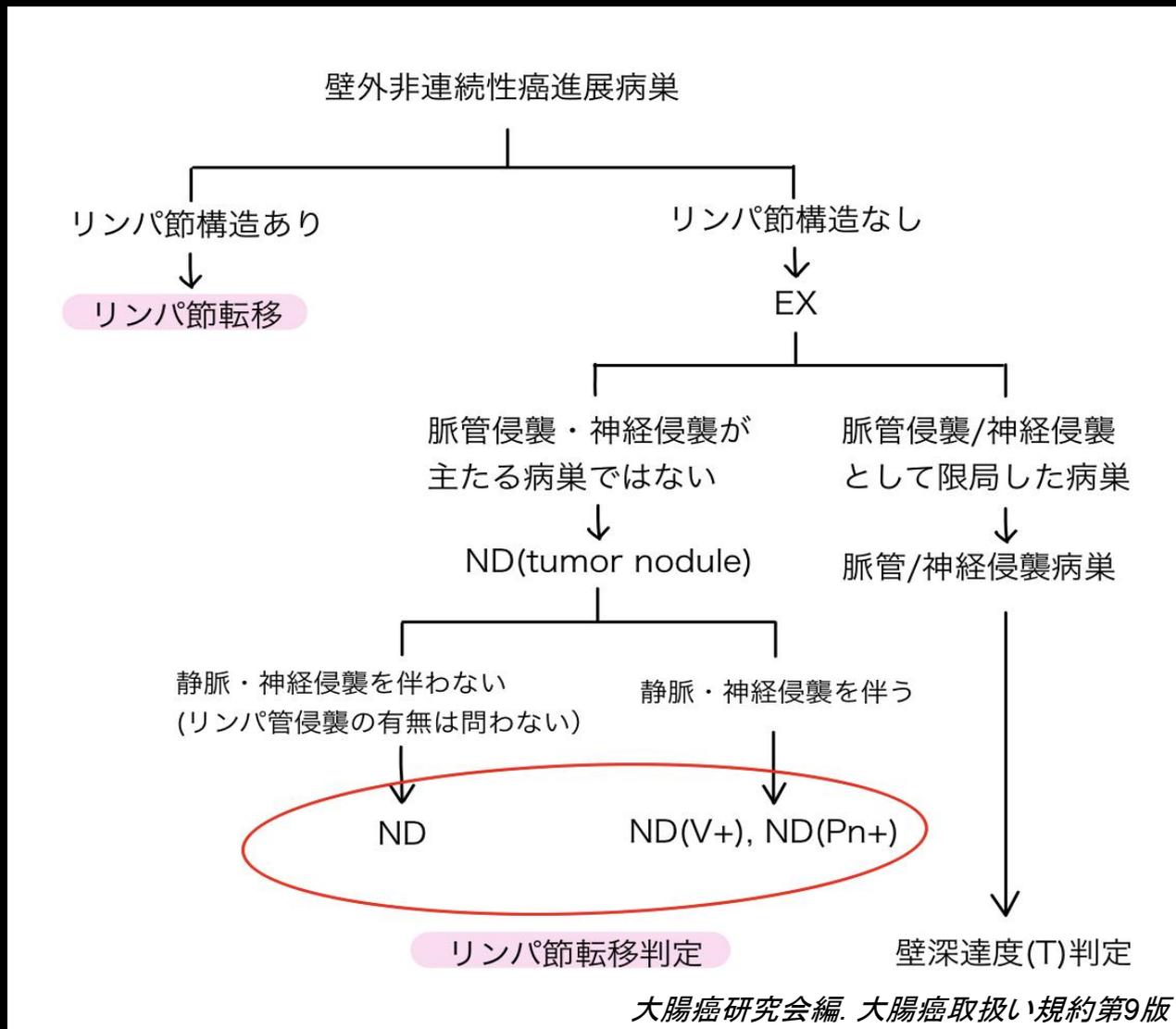
- ESDの深部断端が100 $\mu$ mと近いが、ESD後癒痕と再発部位は離れている。
- 領域リンパ節には転移所見なし。
- 再発部位直上の粘膜層・固有筋層には腫瘍細胞は含まれておらず、直接浸潤を示唆する所見はない。



壁外非連続性癌進展病巣

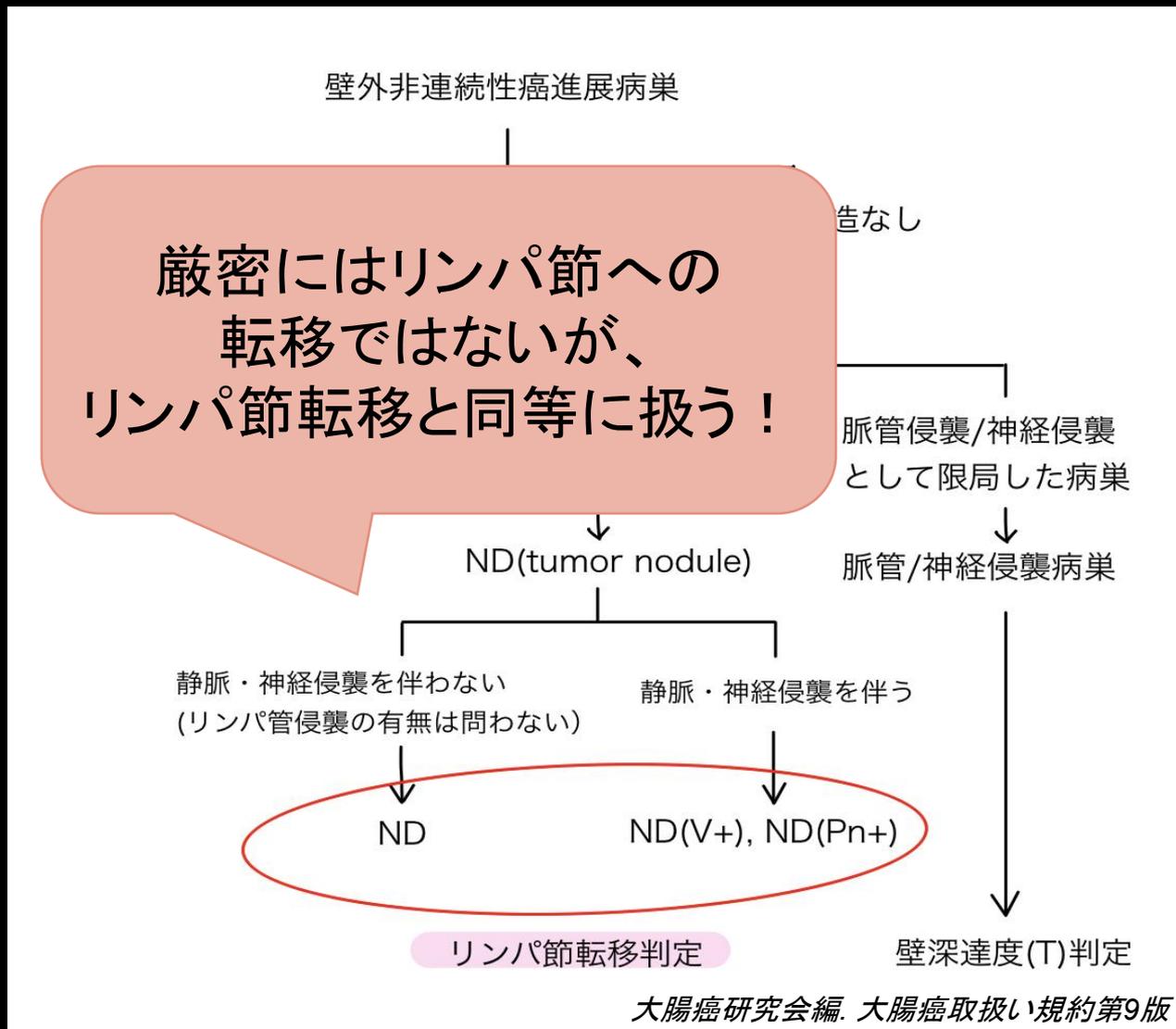
→ 病理学的には、  
「漿膜下層内の結節としての転移性再発」が正しい。

# 壁外非連続性癌進展病巣とは？



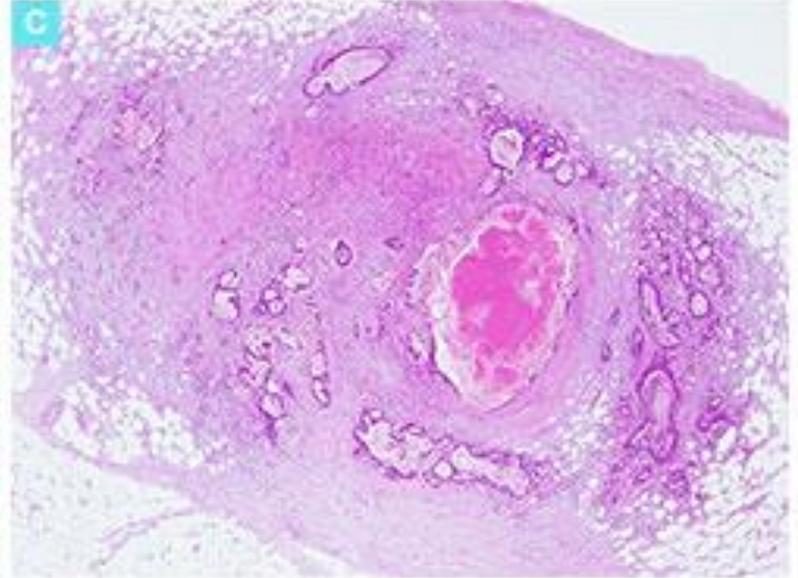
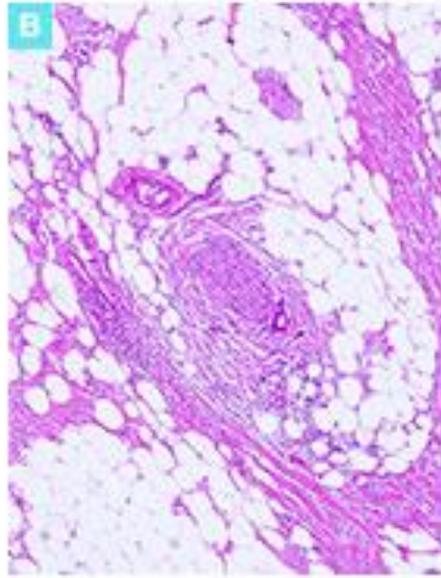
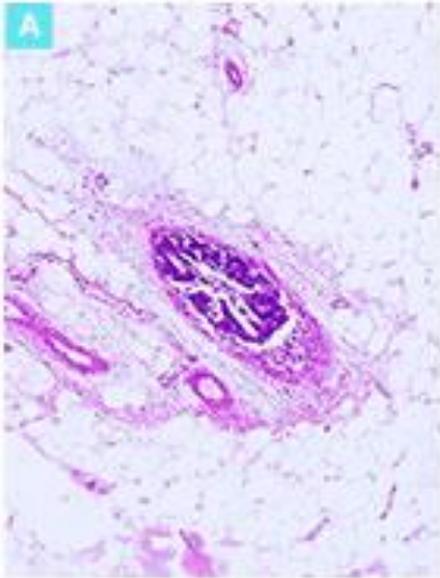
EX: extramural tumor deposits without lymph node structure

# 壁外非連続性癌進展病巣とは？



EX: extramural tumor deposits without lymph node structure

# 静脈侵襲・神経侵襲とND

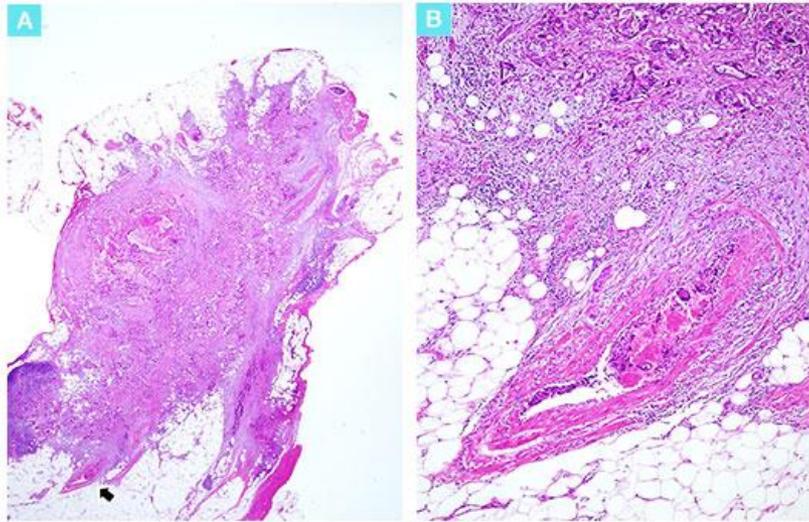


静脈侵襲

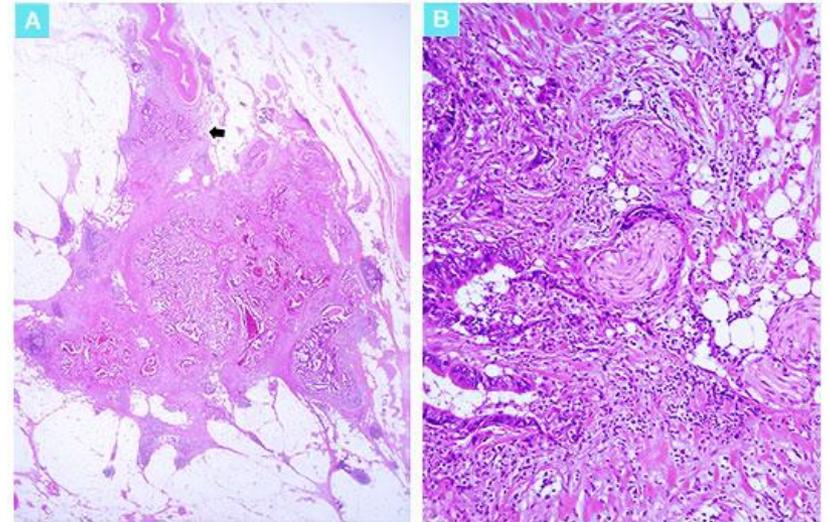
神経侵襲

それ以外のEX:ND

# 静脈・神経侵襲を伴うND



静脈侵襲を伴うND(V+)



神経侵襲を伴うND(Pn+)

- ✓ 静脈・神経侵襲を伴うNDは、リンパ節転移や他のEXを伴う症例よりも予後が悪く、5年生存率は40%台と不良。

# まとめ

- ESDで完全切除可能であったSM2直腸癌で、ESD後5年で再発し追加切除を行なった症例。
- ESDの根治度判定から推定されるリンパ節再発リスクは1-2%程度。
- 本例はリンパ節転移の中でもEX(リンパ節組織を伴わない壁外非連続性癌進展病変)としての再発例。
- さらにEXの中でも脈管・神経侵襲を伴うNDであり、予後不良の可能性あり。