



Creeping Gastric Cancer was Found after Gastrectomy: A Case Report

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Abstract

Gastric "Crawling" Adenocarcinoma (CRA) is a rare variant characterized by irregular glandular fusion and low-grade cell atypia, which tends to spread laterally in the mucosa and is difficult to diagnose early. This is a case report of a 58-year-old middle-aged man diagnosed with early-stage stomach cancer. The previous physical examination of the patient found that the gastric horn was scattered in the ulcer focus. Endoscopic ulcer sampling was performed on the gastric horn mucosa, and the result was adenocarcinoma. The patient underwent accompanying laparoscopic radical gastrectomy for distal gastric cancer. Superficial concave or superficial flat type was seen throughout the tumor area. This case study is about the diagnosis of reptile cancer, which has certain discussion for future research.

Keywords: Early cancer; Creeping type; Gastric cancer

Clinical Data

Patient is a 58-year-old male. Antrum space occupying lesion was found for 2 weeks. Two weeks ago, the patient went to the local hospital for gastroenteroscopy (Figure 1, 2 for the gastroenteroscopy results and disease examination results), indicating the gastric antrum space occupying lesions. Additional immunohistochemical results of the patient's disease examination in other hospitals: CKL+, P53+ 60%, ki-67+80%: HER-2: 1+, negative. MH1+, MSH2+, MSH6+, and PMS2+ indicate that the Microarray is Stable (MSS). Occasionally there is irregular pain in the upper abdomen, no diarrhea, vomiting, abdominal distension, palpitation, chest tightness, low back pain and other discomfort. Since the illness, mental diet can be, sleep well, bowel and stool normal, recent weight has not changed significantly. In the past, she was in good health and had allergic history of penicillin, amoxicillin, levofloxacin, ambroxol and other drugs, occasionally drank alcohol, and had no special medical history or family history.

Physical examination: System check no abnormality.

Abdominal examination: The abdomen was flat and symmetrical, without abdominal varicose veins, gastrointestinal type and peristaltic wave, and the abdomen was soft, without tenderness or rebound pain, and no abnormal mass was touched. The liver and spleen were untouched, and the hepatojugular reflux sign was negative. No positive signs.

Auxiliary examination: Total abdominal male CT spiral scan + enhanced CT indicated that the gastric wall of the gastric antrum was slightly thickened and strengthened, and further examination was recommended. All tumor markers (C12 protein chips) had no significant changes and were in the normal range.

The patient was initially diagnosed with gastric malignancy and underwent laparoscopic radical gastrectomy. The results of postoperative examination of the patient were: (stomach) hand-holding cancer/crawling cancer, Japanese convention type: Tub2; Nakamura type: Differentiated type, Lauren type: Intestinal type. WHO classification: Moderately differentiated adenocarcinoma; Cell mucous type: intestinal type; The tumor infiltrated into the submucosa, and there was no cancer involvement in the two broken ends. No cancer metastasis was observed in 4 lymph nodes in the adipose tissue around the greater curvature (0/4), no cancer metastasis was observed in 8 lymph nodes in the adipose tissue around the lesser curvature (0/8), and no cancer involvement was observed in the omentum tissue. Tumor stage: pT1bN0Mx (Figure 3). Immunohistochemical results: Postoperative hospital disease check its EHRs - 2 (-), Desmin (+), Ki - 67 (80%), CK (+) and

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Figure 1: A: Gastroscope: Arc at the corner of the stomach, rough mucosa, found a erosive lesion, biopsy 1 piece with disposable endoscopic biopsy forceps, Chronic non-atrophic gastritis with erosion. B and C: No suspicious, chronic non-atrophic gastritis was seen elsewhere in the gastric mucosa.

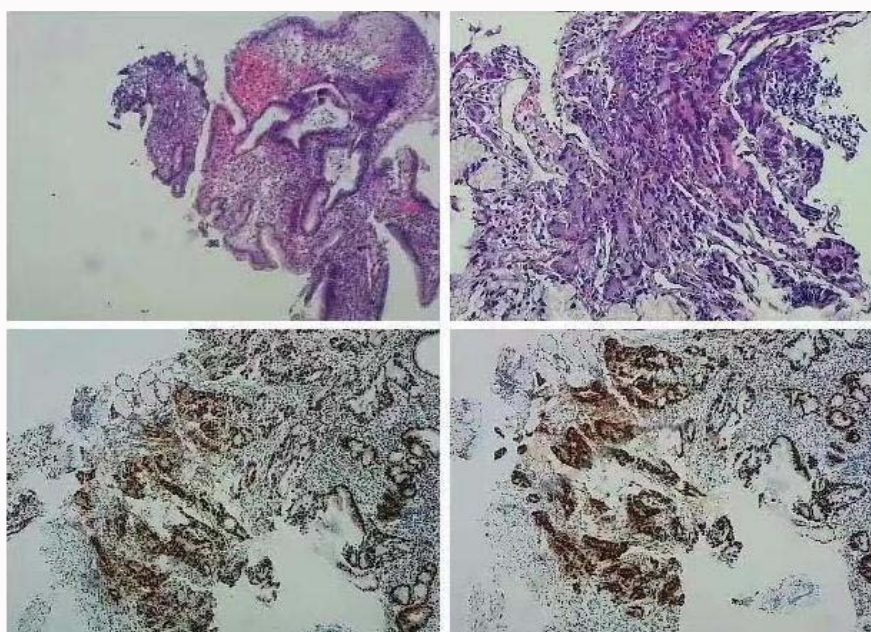


Figure 2: A and B: Mucosal biopsy of gastric horn: adenocarcinoma, HP+. C and D: Antral mucosa biopsy: moderate chronic gastritis, mild activity, intestinal metaplasia +. HE dye: x100.

SATB2 (-), CDX - 2 (+), MUC6 (-), P53 (weak +), Mucin 5Ac (-).

Discussion

Gastric Cancer (GC) is the fifth most common cancer worldwide and the third leading cause of cancer death [1]. According to the World Health Organization (WHO) classification [2], GC includes five main types of adenocarcinomas, including adenocarcinoma of the form, tubular adenocarcinoma of the kidney, mucinous adenocarcinoma, low viscosity and mixed adenocarcinoma, as well as other rare entities. The most common histopathological subtype is renal tubular adenocarcinoma, which can be divided into two grades of highly differentiated adenocarcinoma or moderately differentiated adenocarcinoma [2]. As an important subtype in moderately differentiated adenocarcinoma, CRA has received increasing attention as a specific histological GC subtype due to its unique clinicopathological and molecular manifestations [3-6]. According to Yasuko Fujita et al., immunohistochemical staining of GRA showed that TP53 mutation (especially c.529_546del mutation) and a variety of AI were closely related to CRA carcinogenesis in clinical cases and molecular analysis. In terms of clinicopathological and molecular findings, CRA was an independent entity of GC. Despite the characteristic histology of CRA, little is known about the molecular

characteristics of CRA [7,8]. It can be seen that immunohistochemistry has certain diagnostic significance, and MUC-2, MUC-5AC, and MUC-6 are usually mixed in immunohistochemistry, or can be expressed in intestinal type alone. The expression of P53 was usually stronger or negative than that of normal tissues. Ki67 showed a high proliferation index. The diagnosis of "crawling" gastric cancer is relatively difficult. According to Japanese researchers such as Haruta Y, it is necessary to take multiple endoscopic examinations to obtain sufficient evidence [6]. The problem lies in the fact that these lesions cannot be detected under endoscopy. The patient is indicated as adenocarcinoma by endoscopy for the first time, and biopsy is usually performed to diagnose enterosis or atypical hyperplasia after the discovery. The most common type of gastric cancer can only be followed up by endoscopists. Such cases are actually quite common, but the early diagnosis is too difficult, and most of them are developed to the later stage of mixed component cancer to be clear. "Creeping" gastric cancer is characterized by small cell atypia, which is easy to cause missed or underdiagnosis, especially in biopsies. In addition, although the "crawling" gastric cancer has a glandular tubular structure, which is equivalent to moderately differentiated adenocarcinoma, it is prone to low adhesion cancer regions, suggesting that this tumor may be more aggressive, although it is a

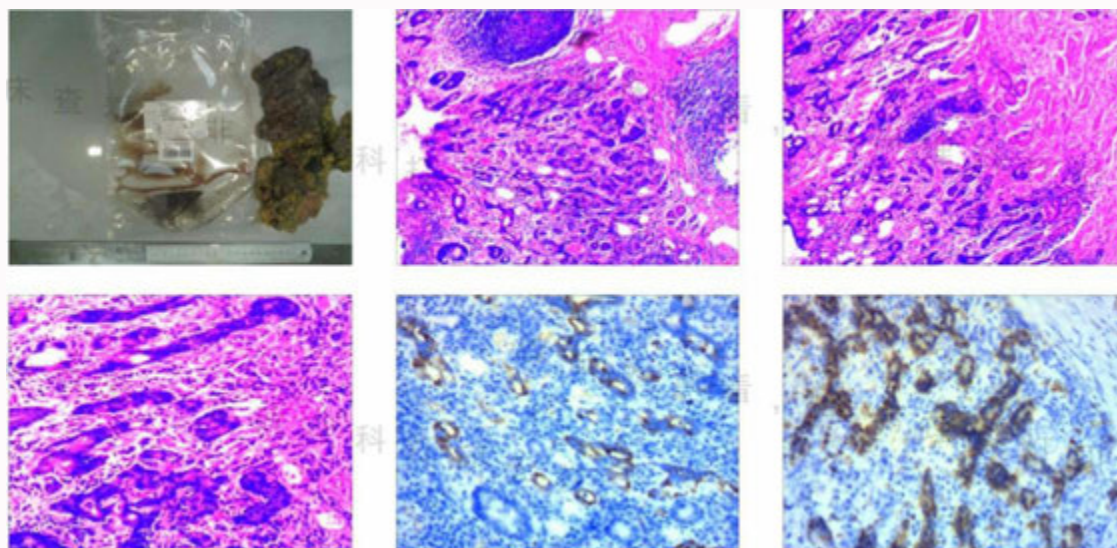


Figure 3: A: the postoperative specimen shows superficial concave or superficial flat patterns throughout the tumor area. B, C and D: The appearance of the glands is irregular, some glands are fused, some glands are branched, some glands are cystic dilated, the glands are sparse, but the horizontal "hand" is obvious, and the appearance of the glands is irregular. E and F: Some glands hold hands laterally, some glands are cystic dilated, single cell atypia is not obvious, the nucleus is located at the base of the cell, cystic dilated glands are covered by a flattened epithelium, cytoplasmic eosinophilic. HE dye: x100.

low-atypic adenocarcinoma. Therefore, we should pay more attention to the combination of structure and cell atypia, and strengthen the understanding of this kind of tumor. Pathology, molecular expression profile and related genes are of significance in diagnosing the disease [9-11], and effective treatment plans are specified based on corresponding gene and pathology analysis [11-13]. In this case, the patient was diagnosed with early-stage cancer, the tumor invaded the submucosa, stage T1, and the latest postoperative treatment plan was not found for crawling cancer. According to the latest guidelines and treatments, chemotherapy and radiation therapy were not required in the later stage, and follow-up review was conducted [14].

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