Introduction

Patients with end-stage renal disease require phosphate binders to trap dietary phosphate. Lanthanum carbonate, an orally administered phosphate binder, is used for treating renal failure. Some reports have described lanthanum carbonate deposition in the gastric mucosa [1, 2]. We reported a patient with early-stage gastric cancer accompanied with lanthanum phosphate deposition in the gastric mucosa.

Case report

A 78-year-old man with Helicobacter pylori infection was undergoing hemodialysis for chronic renal failure and was receiving lanthanum carbonate preparations for 3 years. Endoscopy revealed fine white granular discoloration throughout the stomach, a moderately reddish depression on the lesser curvature of the gastric angle, and white granular discoloration in the surrounding area. A magnified image using narrow-band imaging showed that the depressed part had irregular vascular and pit structures. We established a diagnosis of intramucosal gastric cancer and performed endoscopic submucosal dissection. Histopathological examination revealed a well-differentiated adenocarcinoma that was confined to the mucosa of the depressed area. Moreover, using an electron probe microanalyzer-equipped electron microscope, we found that the degree of lanthanum deposition was lower in the tumor region than in the non-tumor region. Thus, the current case can help in understanding the relationship between lanthanum deposition and early-stage gastric cancer. Because gastric cancers can occur in lanthanum deposit-containing mucosa, esophagogastroduodenoscopy should be used carefully after understanding the characteristics of early-stage gastric cancer in such cases.
degree of lanthanum deposition was observed in the non-tumor region than in the tumor tissue (Fig. 2c). Immunohistochemical staining showed CD68-positive cells in the non-tumor region, indicating presence of macrophages that had phagocytosed lanthanum (Fig. 3).

Discussion

Endoscopic findings of lanthanum deposition in the gastric mucosa are reportedly described as numerous small and irregular white spots and annular white thickening [1, 2], consistent with the findings in the current case.

We identified a well-differentiated tubular adenocarcinoma presenting as a depressed area in the lanthanum deposit-containing mucosa. Tabuchi et al reported that early gastric cancer (papillary adenocarcinoma) with lanthanum deposition was observed as a depressed area on endoscopy [3]. Our case showed findings similar to the findings of this report.

We found a lower degree of lanthanum deposition in the tumor area than in the non-tumor area. Whether lanthanum deposition is a result of mucosal damage by H. pylori infection remains controversial [4–6], but some reports have suggested an association between mucosal distribution of lanthanum deposition and intestinal metaplasia [2, 7]. In gastric intestinal metaplasia, expression of claudin, a major protein of tight junctions in the epithelium that play an important role in fence function, is reported to differ from that in gastric cancer [8]. We hypothesized that this difference could lead to a difference in lanthanum deposition or absorption in the gastric mucosa. This may be why distribution of lanthanum deposits is different between tumor and non-tumor regions. Our case is very rare, and this report would add to the literature because lanthanum-induced differences between the tumor and non-tumor areas were clearly distinguishable in our patient.

Conclusion

The current case is of interest, as it can help in understanding the relationship between lanthanum deposition and early-stage gastric cancer. It is important to accumulate reports from a number of similar cases and to examine the endoscopic
imaging findings of early-stage gastric cancer in the gastric mucosa with lanthanum deposition.

**Competing interests**

None

**References**


