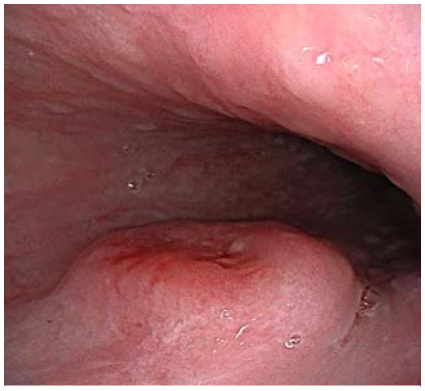
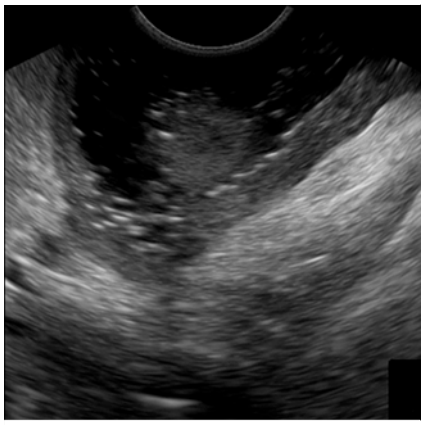
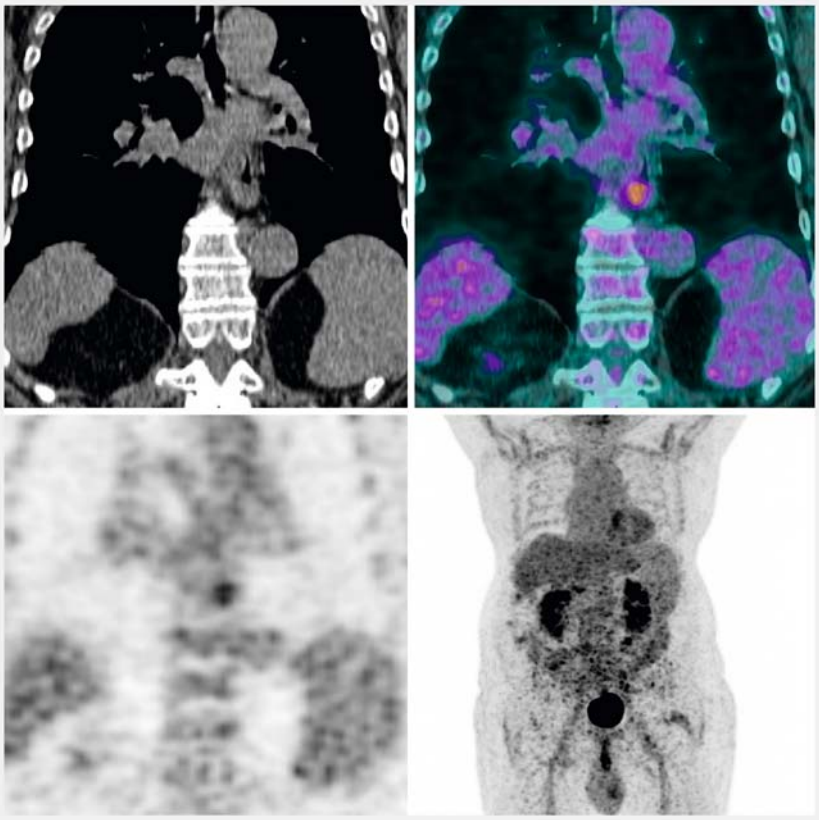
# Endoscopic submucosal dissection of poorly differentiated carcinoma mimicking adenoid-cystic carcinoma of the esophagus



▶ **Fig. 1** Esophagogastroduodenoscopy showed a flat elevated lesion of 15 mm with a mild central depression in the middle esophagus.



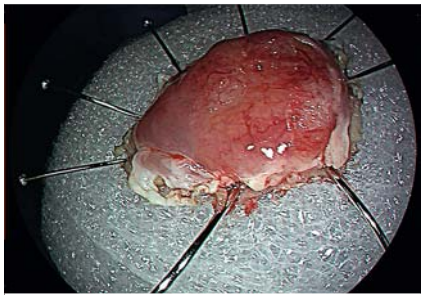
▶ **Fig. 2** Endoscopic ultrasound showed the lesion was limited to the mucosal layer.



▶ **Fig. 3** Staging of the tumor performed with an 18F-fluorodeoxyglucose positron emission tomography/computed tomography: uptake only in the middle tract of the esophagus (standardized uptake value 3.3)

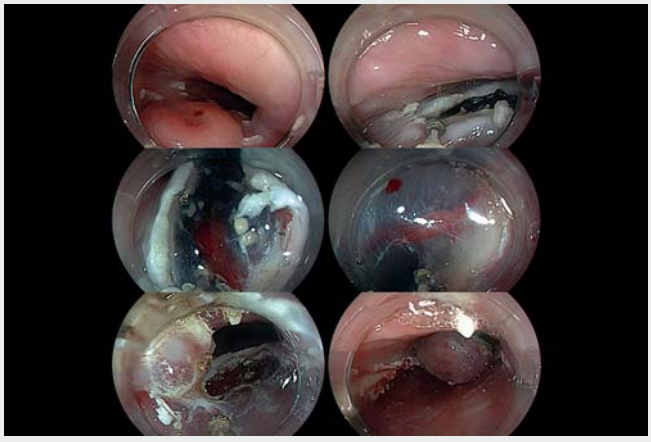
A 71-year-old man with a history of cryptogenic cirrhosis and hepatocellular carcinoma treated with radiofrequency ablation therapy underwent esophagogastroduodenoscopy (EGD) to evaluate portal hypertension. EGD showed a flat elevated lesion of 15 mm with a mild central depression (▶ **Fig. 1**) and hard consistency on biopsy sampling in the middle esophagus. No esophageal varices were found. The initial histological examination was compatible with adenoid cystic carcinoma with a solid pattern.

Adenoid cystic carcinoma is a malignant epithelial tumor arising in the submucosal glands, commonly in the salivary glands and upper respiratory tract. It occurs extremely rarely in the esophagus, where its behavior is biologically aggressive [1]. However, endoscopic ultrasound (EUS) showed a lesion limited to the mucosal layer (▶ **Fig. 2**). Staging was performed with an 18F-fluorodeoxyglucose positron emission tomography/computed tomography (18F-FDG PET/CT) scan (▶ **Fig. 3**), which showed only uptake in the middle tract of the esophagus.

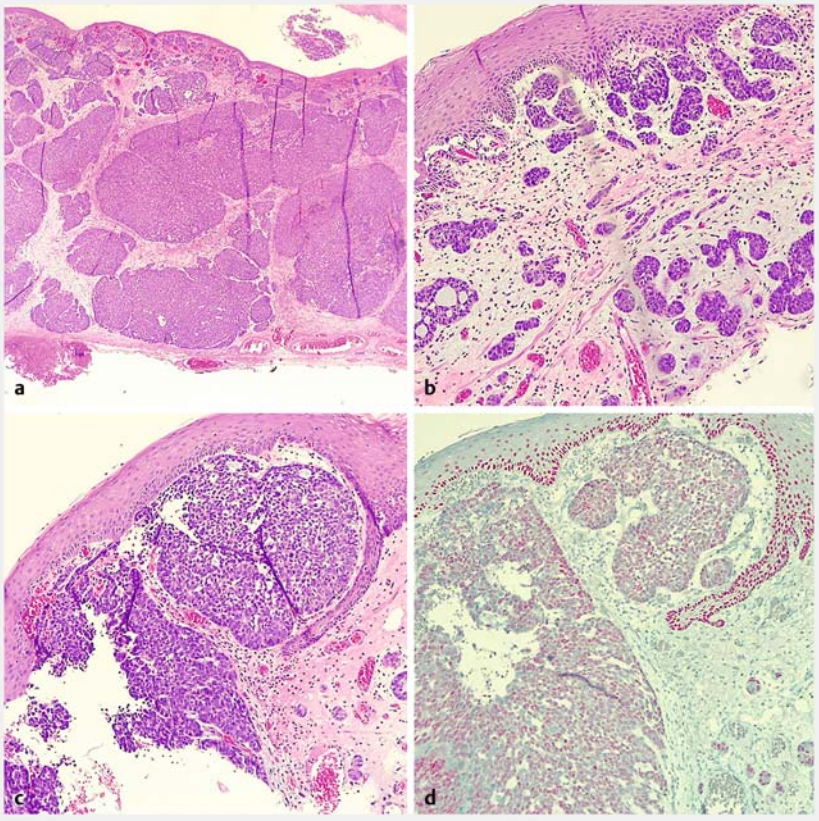


▶ **Fig. 4** En bloc resection was performed by endoscopic submucosal dissection.

Owing to the comorbidities, the patient was judged unsuitable for surgery. Therefore, an en bloc resection (▶ **Fig. 4**)



**Video 1** Esophageal endoscopic submucosal dissection. The lesion, initially typified as adenoid-cystic carcinoma, was in fact a poorly differentiated carcinoma.




▶ **Fig. 5** Esophageal mucosa with poorly differentiated carcinoma with high proliferative activity (mitotic index: 36 × 10 high-power fields), solid pattern with multiple nodular areas separated by fibrous stroma, with glandular aspects, focal necrosis and areas of stromal hyalinization. **a** 2 × magnification. **b** 10 × magnification. **c** 20 × magnification. **d** Immunohistochemistry: p40+.

was performed by endoscopic submucosal dissection (ESD) (▶ **Video 1**). The definitive histological evaluation showed a poorly differentiated carcinoma with prevalent adenoid-cystic and focal basaloid features (▶ **Fig. 5**). The subsequent multidisciplinary evaluation of the case considered only close radiological and endoscopic follow-up indicated. Endoscopic control at 6 months showed the presence of a regular scar at the site of the previous ESD, with no signs of residual or disease recurrence. At the same time, EUS and CT scan ruled out signs of disease recurrence or metastasis.

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## Competing interests

The authors declare that they have no conflict of interest.

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## Bibliography

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CORRECTION

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In the above-mentioned article, the institutions of Roberta Maselli have been corrected. This was corrected in the online version on April 14, 2022.