A pseudosarcomatous lesion resembling a malignant tumor of the esophagocardiac junction, diagnosed by a total biopsy with endoscopic surgery

A pseudosarcomatous lesion is a benign lesion resembling sarcoma either clinically or histologically, which often leads to unnecessary or excessive treatments, including esophagectomy [1–3]. This report presents a case of a pseudosarcomatous lesion which was correctly diagnosed by a total biopsy with endoscopic submucosal dissection (ESD) [4].

A 60-year-old man was examined by esophagogastroscopy to screen the upper gastrointestinal tract. A 5-mm elevation with a thick white coating was detected in the lower esophagus (Fig. 1a). Narrow band imaging (NBI) [5] revealed petal-like clusters of regularly dilated capillaries through a crack in the white coating (Fig. 1b).

Histological examination of biopsy specimens showed dysplastic spindle cells with no immunoreactivity for epithelial or mesenchymal markers other than vimentin (Fig. 2a), thus suggesting spindle cell sarcoma. The lesion was not clinically consistent with a typical sarcoma, therefore ESD was performed to make a definitive diagnosis. Histological examination of the specimen showed granulation tissue with augmentations of vessels and spindle-shaped cells. Atypical-grade tissue tended to become less atypical in the deeper areas of the lesion (Fig. 2b, c), thus resulting in a final diagnosis of reactive inflammatory granuloma with no tumorous component.

This case suggests that a total biopsy by ESD, which can accurately control the depth of submucosal exfoliation under endoscopic view [4], is helpful for the diagnosis of sarcoma-like lesions, thereby avoiding excessive treatments including esophagectomy. From the 18 reported cases of esophageal pseudosarcomatous lesions (Table 1) [1–3, 6–9], a polypoid lesion with ulcers and reflux esophagitis is a typical endoscopic finding. The present case shows the characteristic NBI findings for a pseudosarcomatous lesion, which may be key for discrimination of pseudosarcomatous tissue from malignant lesions.

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Competing interests: None
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<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Location</th>
<th>Symptom</th>
<th>Endoscopic findings</th>
<th>Diagnosis at biopsy</th>
<th>Treatment</th>
<th>Reference</th>
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<td>64</td>
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<td>Esophagus</td>
<td>Dysphagia</td>
<td>Ulcer with stricture</td>
<td>Carcinoma</td>
<td>Esophagectomy</td>
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<td>52</td>
<td>F</td>
<td>Esophagus</td>
<td>Dysphagia</td>
<td>Ulcer</td>
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<td>Improved on treatment</td>
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<td>ECJ</td>
<td>Epigastric pain</td>
<td>Necrotic lesion</td>
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<td>Dirschmid, 1983</td>
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<td>M</td>
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<tr>
<td>21</td>
<td>F</td>
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<td>Dysphagia</td>
<td>Stricturing mass</td>
<td>None</td>
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<tr>
<td>53</td>
<td>M</td>
<td>ECJ</td>
<td>None</td>
<td>Small polyp with erosion and linear erosion at oral side</td>
<td>Suspicious for spindle cell sarcoma</td>
<td>Segmental resection</td>
<td>Moriyama, 2003</td>
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### References


### Bibliography

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