

Endoscopically resected giant esophageal carcinosarcoma

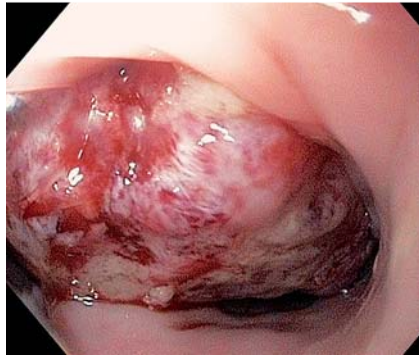


Fig. 1 Tumor in the proximal esophagus of a 79-year-old man with dysphagia evolving over months.



Fig. 3 The polyp base after resection.

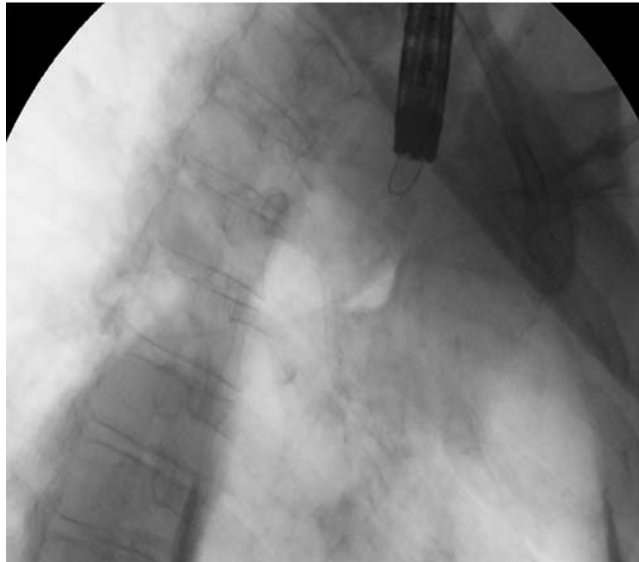


Fig. 2 Looped snare around the polyp stalk under fluoroscopy.



Fig. 4 Macroscopic view of the removed tumor.

A 79-year-old man presented with dysphagia evolving over months. Notably, he underwent right upper lung lobe resection in his sixties and has emphysema and coronary heart disease. Gastroscopy showed a large, inhomogeneous tumor in the proximal esophagus, with a diameter exceeding 5 cm (► **Fig. 1**), which was judged to be unresectable endoscopically. Biopsies revealed stromal cells without definite malignancy. Surgical resection was refused due to comorbidities and localization of the tumor; therefore an endoscopic approach was again discussed. In the 1990s, experienced endoscopists started to resect early esophageal cancers with encouraging results [1]. The improved endoscopic mucosal resection results brought the gastroenterologists to attempt a decade later complete en bloc resection of larger lesions [2]. Currently endoscopic resection of early esophageal

cancer up to stage T1, N0 is established for the primary curative approach [3]. However, our particular case was different. Within the esophageal lumen, the stalk of the tumor was not appraisable. Endoscopic ultrasound was incomplete due to the compressed lumen. To attempt an endoscopic resection, we looped a guidewire around the base to estimate the stalk size under fluoroscopy. Having only about 1 cm tissue in the loop (► **Fig. 2**), resection with an electrocautery snare was carried out. The base of the tumor was macroscopically clean (► **Fig. 3**). Extraction of the polyp was hampered by the upper esophageal sphincter. The 6.5-cm tumor

(► **Fig. 4**) was a histologically proven squamous cell carcinoma strictly defined to the mucosa with sarcomatoid differentiation, staged as pT1b, G3. This rare distinct entity with polypoid appearance seems to have a better long-term prognosis than a squamous cell carcinoma [4]. Two years after endoscopic resection, the patient is doing well without signs of local recurrence and is able to feed sufficiently orally.

Endoscopy_UCTN_Code_TTT_1AO_2AG

Competing interests: None

C. Gubler, P. Bauerfeind

Clinic of Gastroenterology and Hepatology,
University Hospital Zurich, Switzerland

References

- 1 Soehendra N, Binmoeller KF, Bohnacker S et al. Endoscopic snare mucosectomy in the esophagus without any additional equipment: a simple technique for resection of flat early cancer. *Endoscopy* 1997; 29: 380–383
- 2 Rosch T, Sarbia M, Schumacher B et al. Attempted endoscopic en bloc resection of mucosal and submucosal tumors using insulated-tip knives: a pilot series. *Endoscopy* 2004; 36: 788–801
- 3 Das A, Singh V, Fleischer DE et al. A comparison of endoscopic treatment and surgery in early esophageal cancer: an analysis of surveillance epidemiology and end results data. *Am J Gastroenterol* 2008; 103: 1340–1345
- 4 Wang L, Lin Y, Long H et al. Esophageal carcinosarcoma: a unique entity with better prognosis. *Ann Surg Oncol* 2013; 20: 997–1004

Bibliography

DOI <http://dx.doi.org/10.1055/s-0033-1344406>
Endoscopy 2013; 45: E288–E289
 © Georg Thieme Verlag KG
 Stuttgart · New York
 ISSN 0013-726X

Corresponding author**Dr. C. Gubler**

Klinik für Gastroenterologie und Hepatologie
 Universitätsspital Zürich
 Rämistrasse 100
 8091 Zürich
 Switzerland
 Fax: +41-44-2554598
christoph.gubler@usz.ch