

Figure 1 The initial conventional endoscopic examination showed short-segment Barrett's esophagus and slight redness of the mucosa. The region outlined by the yellow box indicates the area of adenocarcinoma.

We report here the case of a 78-year-old man who developed a recurrence of an adenocarcinoma, 15 months after initial endoscopic mucosal resection (EMR) of adenocarcinoma arising from short-segment Barrett's esophagus. The recurrent adenocarcinoma had the appearance of a submucosal tumor and was found in an area of squamous epithelium. The new lesion was resected by EMR and the patient has had no further recurrences for 32 months. In the initial endoscopic examination, a red area of short-segment Barrett's esophagus was detected (Figure [1]). The patient underwent examination by magnifying endoscopy and an irregularly round pit and abnormal capillaries were revealed as a cancerous area. The pathological diagnosis was adenocarcinoma. EMR was performed in February 2001. Histological investigation of the proximal edge of the tumor revealed slight submucosal invasion and squamous epithelium covering the carcinoma: the proximal margin of the resected tissue was defined as carcinoma-negative. The diameter of the cancer was 10 mm. Fifteen months after EMR, endoscopic examination revealed a submucosal tumor-like lesion with a nodular appearance in the area of squamous epithelium proximal to the original site of the tumor (Figure [2a]). Two biopsy specimens taken from this area showed adenocarcinoma covered by squamous epithelium. This lesion was resected

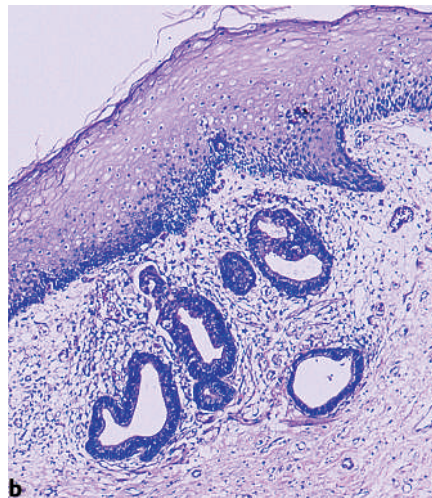
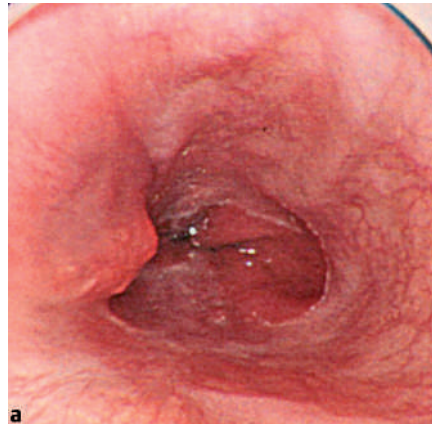


Figure 2 Fifteen months after the original EMR, follow-up endoscopic examination showed a submucosal tumor-like lesion with a nodular appearance, proximal to the squamocolumnar junction (a). Histological examination showed this lesion to be a well-differentiated adenocarcinoma in the lamina propria, 1.5 mm in diameter, and covered by squamous epithelium (b).

by EMR and was found to be a well-differentiated adenocarcinoma, 1.5 mm in diameter, located in the lamina propria and covered with squamous epithelium (Figure [2b]). Endoscopic examination was repeated after the second EMR and no residual or recurrent lesion has been found at the latest follow-up examination in January 2005, 32 months after the second EMR. Recently, adenocarcinoma arising from Barrett's esophagus has been treated by EMR [1–5]. Giovannini et al. [5] reported that out of 21 patients whose tumor re-

section by EMR was initially classified as complete, two patients later presented with local recurrence and underwent further treatment by EMR. Follow-up endoscopic surveillance for tumor recurrence is necessary after initial EMR treatment, because EMR has the potential to become a complete therapy in terms of long-term survival of patients with this disease.

Competing interests: None

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References

- 1 Yagi K, Nakamura A, Sekine A et al. Magnified view of adenocarcinoma in short-segment Barrett's esophagus treated by endoscopic mucosal resection. *Gastrointest Endosc* 2002; 55: 278–281
- 2 Ell C, May A, Gossner L et al. Endoscopic mucosal resection of early cancer and high-grade dysplasia in Barrett's esophagus. *Gastroenterology* 2000; 118: 670–677
- 3 May A, Gossner L, Behrens A et al. A prospective randomized trial of two different endoscopic resection techniques for early-stage cancer of the esophagus. *Gastrointest Endosc* 2003; 58: 167–175
- 4 Seewald S, Akaraviputh T, Seitz U et al. Circumferential EMR and complete removal of Barrett's epithelium: a new approach to management of Barrett's esophagus containing high-grade intraepithelial neoplasia and intramucosal carcinoma. *Gastrointest Endosc* 2003; 57: 854–859
- 5 Giovannini M, Bories E, Pesenti C et al. Circumferential endoscopic mucosal resection in Barrett's esophagus with high-grade intraepithelial neoplasia or mucosal cancer: preliminary results in 21 patients. *Endoscopy* 2004; 36: 782–787

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