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Early Gastric Cancer in a Fundic Diverticulum

The prevalence of gastric diverticula ranges from 0.01% to 0.30% (1). Three out of four are located in the posterior wall, close to the esophagogastric junction, and without any sex preponderance. They are usually asymptomatic findings late in life, but may occasionally bleed. Sporadic cases with incidental mucosa-related tumors within a diverticulum have been reported (2, 3).

We present here an unusual case of a Billroth II gastric remnant with a fundic diverticulum, known for 11 years, in which an easily bleeding polypoid malignancy, staged as an early gastric cancer, later developed.

In a 77-year-old man, suffering from increasing dizziness, painless nausea and hemorrhagic vomiting, an emergency gastroscopy revealed a benign stomal ulcer, 4 mm in size, with no signs of ongoing or past bleeding. The ulcer was treated according to routine, and it had healed at the follow-up gastroscopy six weeks later. This examination was performed by an experienced endoscopist, who also discovered a polypoid lesion within the known fundic diverticulum. Based on the endoscopic signs of easy bleeding, superficial necroses and a swollen fold arising from the tumor base, a malignancy was suspected (Figure **1**), precluding any attempt at endoscopic treatment. The histology of the biopsy specimen obtained confirmed the malignant character of the lesion. Although the limited spread of the lesion (Figure **2**) might have been evident from endosonography, its less accessible location would nevertheless have made endoscopic treatment difficult. The patient recovered uneventfully after surgical removal of the gastric remnant.

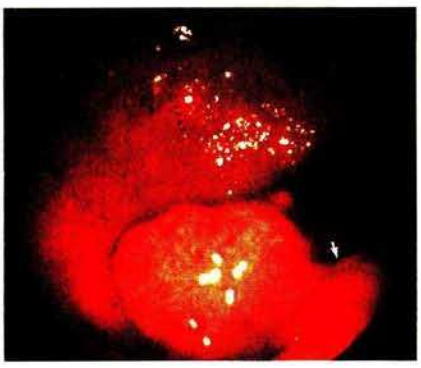

Figure 1: A slightly irregular lesion, 15 mm across, is seen, with an eccentric location within the diverticulum. A thickened fold arising from the base of the lesion is suspected (white arrow).

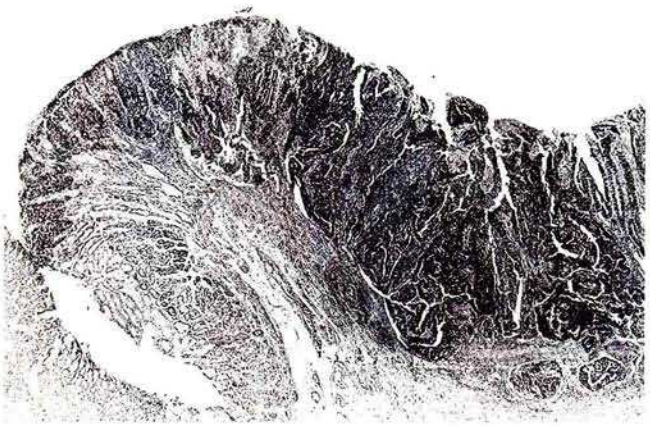

Figure 2: Histological specimen of the surgically removed lesion, showing an early gastric cancer, which extended into the thickened fold described in Figure **1**.

This case illustrates the common experience that lesions may coexist, and that allegedly harmless and rare ones may incidentally constitute a significant threat to the patient (3). It also shows that emergency gastroscopies, which are usually more difficult, ought to be conducted, if possible, by an experienced endoscopist in order to assure the overall quality. Meticulous endoscopic observation of the mucosa adjacent to the polyp base preoperatively may anticipate tumor spread.

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