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Letters to the editor

Multiple synchronous early gastric carcinoma with seven lesions

To the Editor: Recent advances in diagnostic techniques have enabled us to identify small gastric cancers, and reports of multiple synchronous gastric cancers (MSGC) have been increasing. We report the case of a man diagnosed with multiple synchronous early gastric cancer with seven lesions. The patient visited our hospital for further evaluation of abnormal radiographic findings of the stomach at a yearly physical checkup on February 2002. Endoscopic examination of the upper digestive tract revealed two II c lesions on the posterior wall of the upper third area (U area) (lesions 1 and 2), two II c lesions on the anterior wall of the U area (lesions 5 and 7), a wide II c lesion in the lesser curvature of the middle third area (M area) (lesion 3), a II a lesion in the greater curvature of the lower third area (L area) (Lesion 4), and a II c lesion in the lesser curvature of the cardia (lesion 6) (Fig. 1). These lesions were surrounded by atrophic mucosa. The biopsy specimens obtained from the seven lesions revealed well-differentiated adenocarcinomas. There was also a flat, white, elevated lesion on the anterior wall of the lower body (lesion A) and it seemed to be an adenoma (Fig. 1). Total gastrectomy with radical lymph node dissection was carried out. The whole resected specimen was divided into pieces, and detailed histological examinations were done. Histological examination of the resected specimen revealed an adenoma and seven lesions of well-differentiated adenocarcinoma. Six of the carcinomatous lesions (all except for lesion no. 3) were diagnosed as well-differentiated adenocarcinoma with mucosal invasion (ly0, v0). Lesion no. 3 revealed well-differentiated adenocarcinoma with submucosal invasion (ly0, v0). Lymph node metastasis was not seen.

The incidence of MSGC is thought to be about 4%–15% in patients with gastric cancer.[1,2] Patients with two or three cancer lesions are frequently seen; however, there are few reports describing patients with four or more multiple gastric cancer lesions.[3] Cases of MSGC with seven or more lesions are very rare. It is difficult to diagnose all lesions of MSGC by endoscopic examination before treatment. The more lesions there are, the more chances there are of overlooking a lesion. Also, it is difficult to identify very small lesions by the endoscopic examination before treatment because occasionally there are some minute lesions that are correctly diagnosed as cancer only by detailed histological examination.

A review of the literature revealed that many cases of MSGC had accessory lesions that were overlooked preoperatively and detected after surgery by histological examination.[3,4] Regarding the macroscopic type of these overlooked lesions, many were small type II c and type II b lesions.[4] Thus, we must always take care in searching for small type II c or type II b lesions. We were able to identify seven lesions of early gastric cancer and an adenoma before surgery in the present patient. This case emphasizes the importance of careful observation, in consideration of the problem of MSGC, during routine endoscopies.

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References

1. Honmyo U, Misumi A, Murakami A, Mizumoto S, Yoshinaka I, Maeda M, et al. Clinicopathological analysis of synchronous multiple gastric carcinoma. Eur J Surg Oncol 1989;15:316–21.
2. Kang GH, Kim CJ, Kim WH, Kang YK, Kim HO, Kim YI, et al. Genetic evidence for the multicentric origin of synchronous multiple gastric carcinoma. Lab Invest 1997;76:407–17.
3. Tatsuzawa Y, Maeda K, Shimizu J, Kawaura Y, Wakabayashi T, Hayakawa Y, et al. A case of synchronous multifocal early gastric carcinoma with seven lesions (in Japanese with English abstract). Gastroenterol Endosc 2001;43:261–5.
4. Isozaki H, Okajima K, Hu X, Fujii K, Sako S. Multiple early gastric carcinomas. Cancer 1996;78:2078–86.

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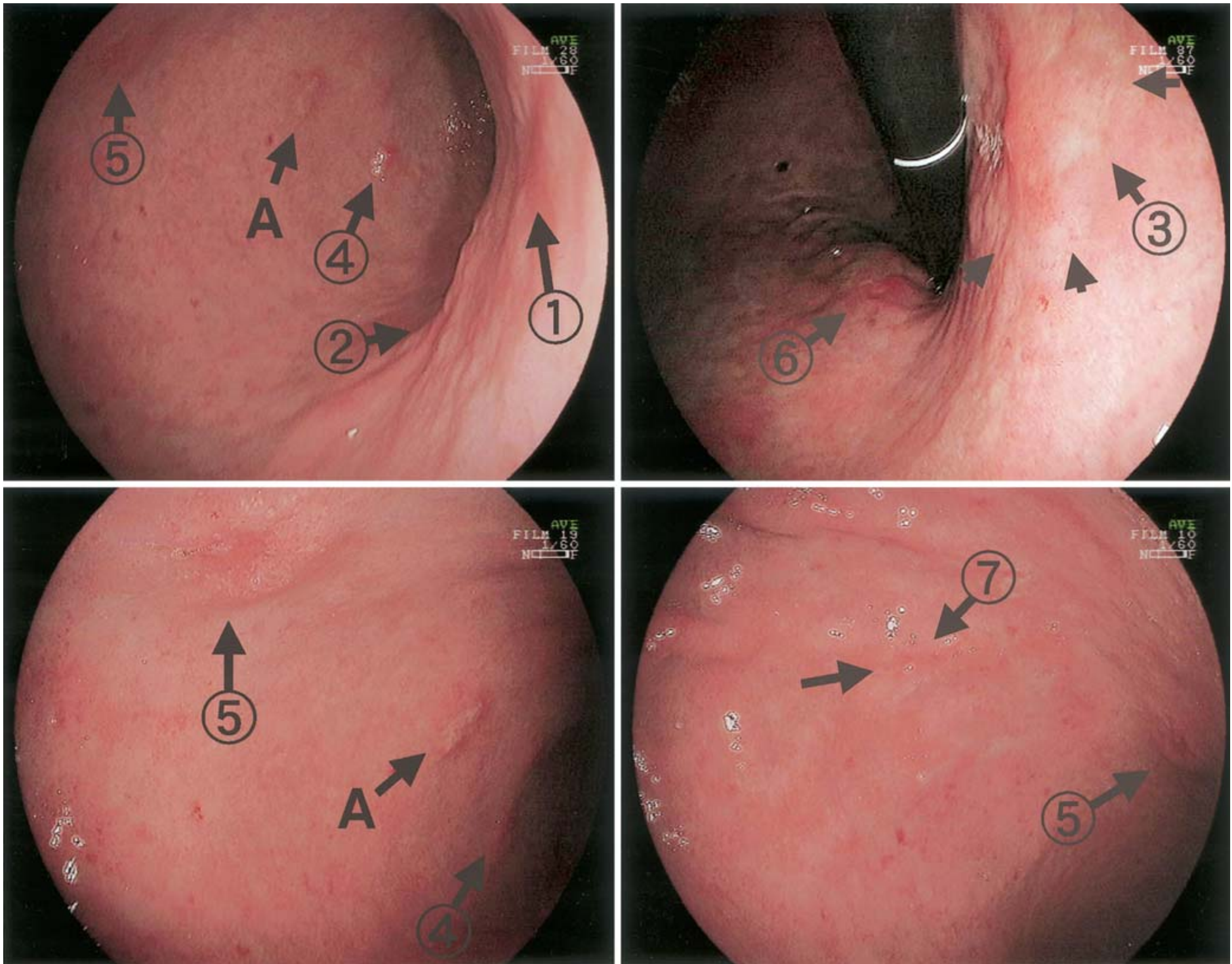

Fig. 1. Endoscopic appearance of the stomach. Six type II c (superficial depressed type) lesions (*1–3*,*5–7*), one type II a lesion (superficial elevated type) (*4*), and an adenoma (lesion *A*) were observed

A case of ischemic colitis during pregnancy

Several reports of ischemic colitis in young adults have appeared in the literature.[1–3] However, cases of ischemic colitis associated with pregnancy are very rare.[4,5] We report a case of ischemic colitis occurring in the eighth week of pregnancy.

A 27-year-old woman was referred to our hospital because of abdominal pain and bloody diarrhea that had lasted for 2 days. She usually had a bowel movement every 4 to 5 days. She was 8 weeks pregnant. She had had a normal delivery a year earlier and had no history of spontaneous abortion. Three weeks before coming to our hospital, she had experienced a similar episode, with a self-limited course, during this pregnancy. On admission, her vital signs were stable. Emergency colonoscopy showed a longitudinal ulcer demarcated from the surrounding mucosa, which was hyperemic and edematous in the descending colon (Fig. 1). Biopsy samples were examined histologically. The samples showed transmural inflammation, including degeneration of the muscularis mucosae and submucosa. The crypts were partly destroyed, with a ghost-like appearance characteristic of ischemic colitis (Fig. 2a). In the small capillaries in the submucosal layer, some fibrin thrombi were observed, showing a blue color with phosphotungstic acid-hematoxylin (PTAH) staining (Fig. 2b). Having ruled out an infectious cause, we diagnosed her illness as ischemic colitis. She was treated conservatively by fasting and intravenous hydration. She recovered and was discharged on the seventh hospital day. After a normal delivery, she remains asymptomatic, at 11 months after discharge.

Ischemic colitis is a disorder of older adults, who frequently show generalized atherosclerosis as a predisposing condition. However, it is being recognized more frequently in young healthy adults, in whom transient ischemic colitis typically presents with an abrupt onset of left-side abdominal pain, occasional nausea and vomiting, and bloody diarrhea.[3] In a young adult thought to have transient ischemic colitis, the illness is generally benign and self-limited.[3] Most patients have only a single episode of transient