

広島大学第一内科 同門会賞専修医奨励賞

安佐市民病院での後期研修を振り返って



広島市立安佐市民病院

消化器内科

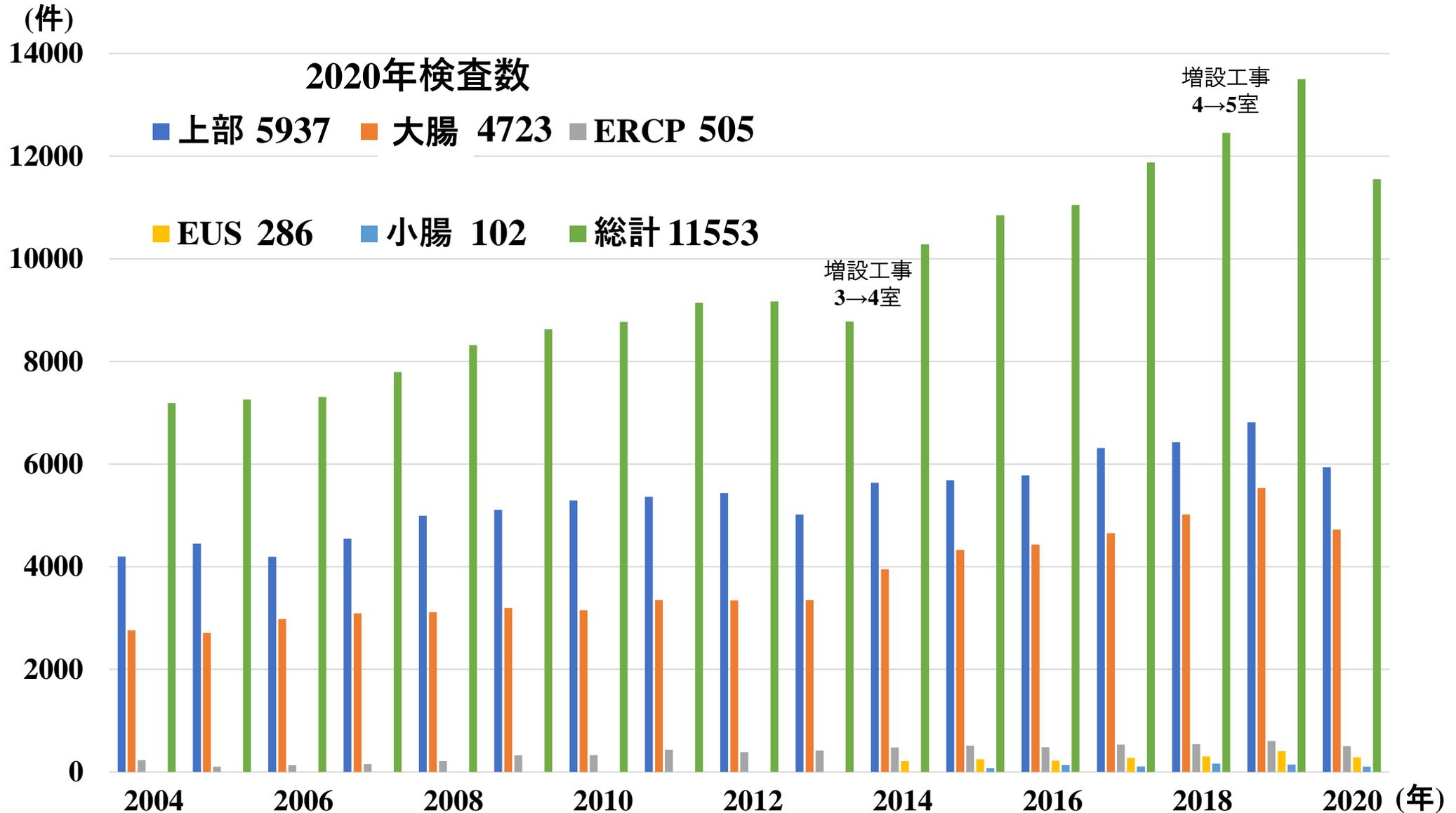
竹内 友香理



地方独立行政法人 広島市立病院機構
広島市立安佐市民病院
Hiroshima City Asa Citizens Hospital



年次別内視鏡検査数

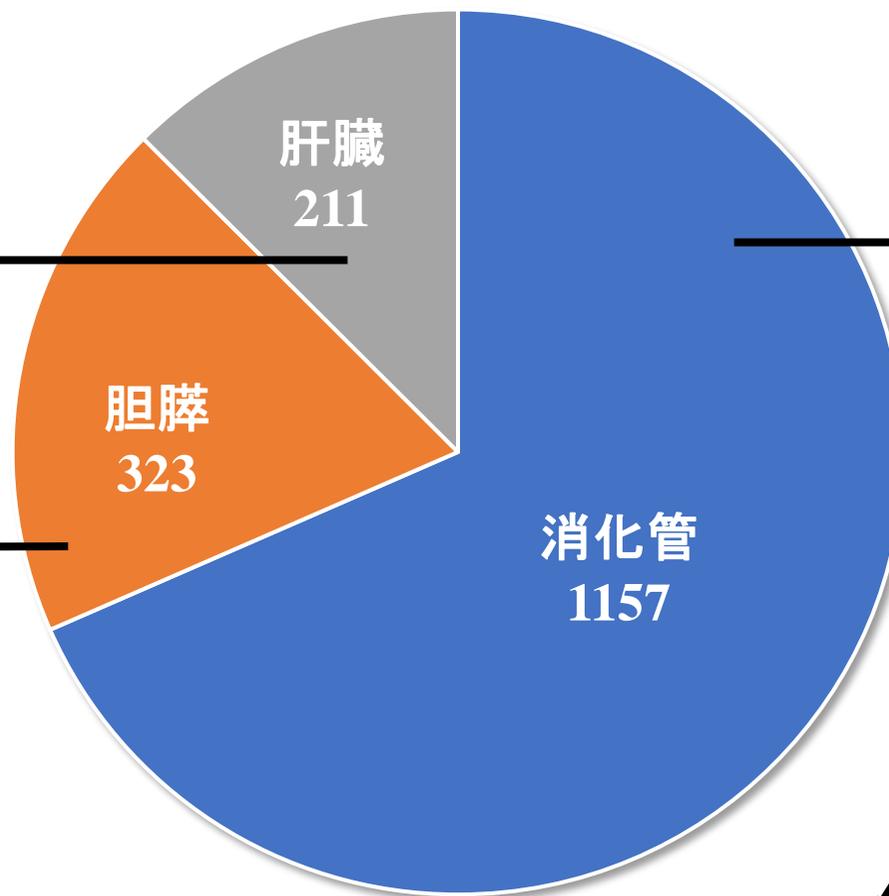


担当入院患者

～3年間を通して～

- ・肝細胞癌
- ・ウイルス性肝炎
- ・食道静脈瘤破裂

等



- ・出血性胃潰瘍
- ・十二指腸潰瘍
- ・食道癌, 胃癌, 大腸癌
- ・炎症性腸疾患

等

- ・急性胆管炎
- ・急性胆嚢炎
- ・急性膵炎
- ・膵癌・胆管癌
- ・肝膿瘍

等

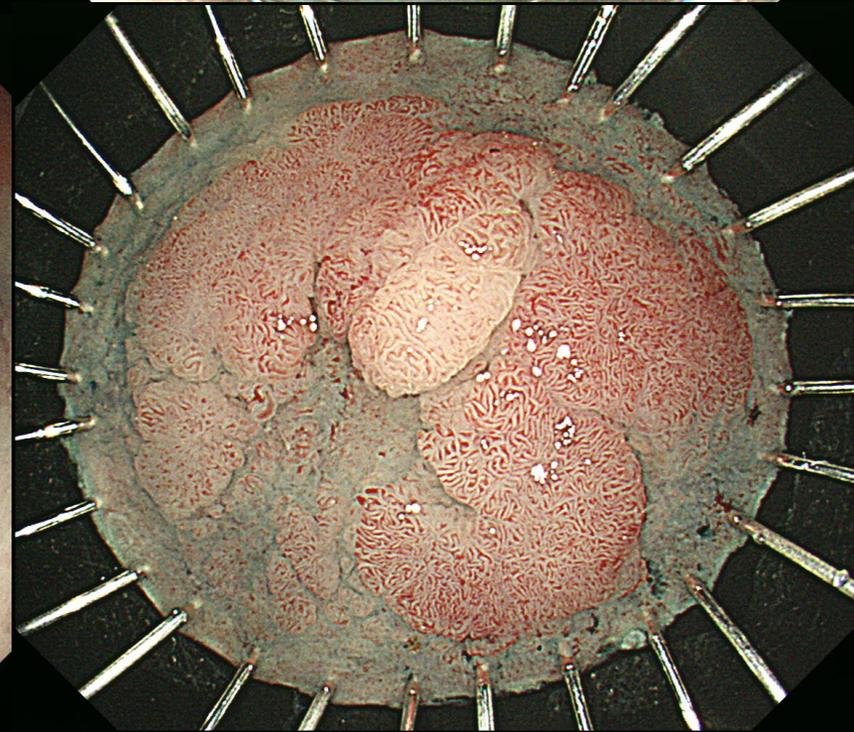
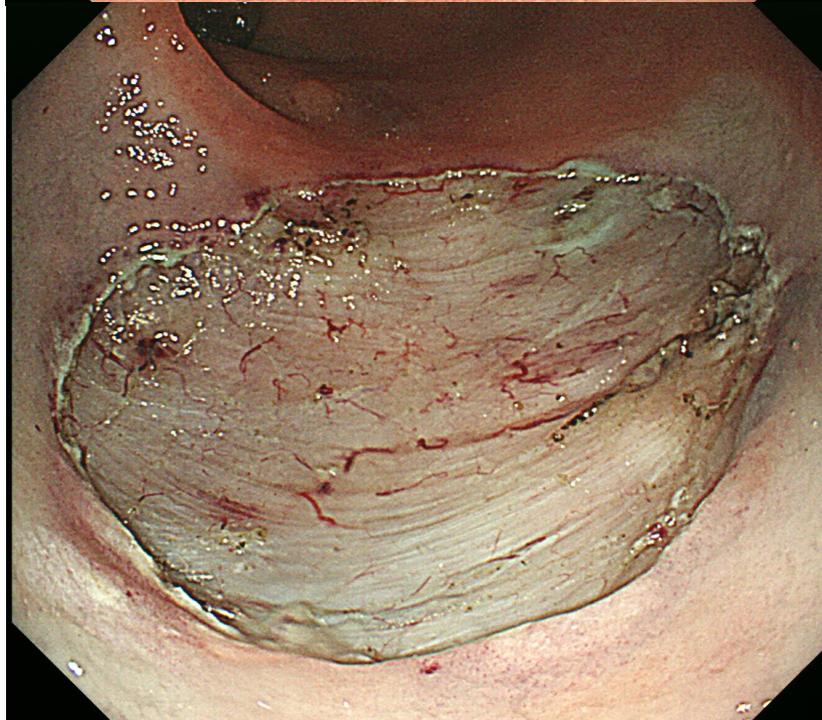
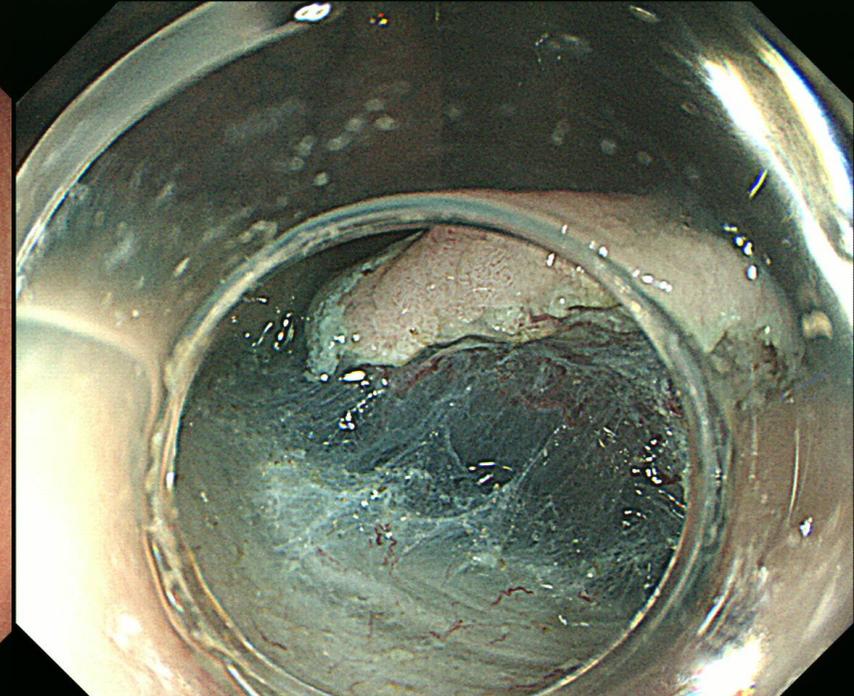
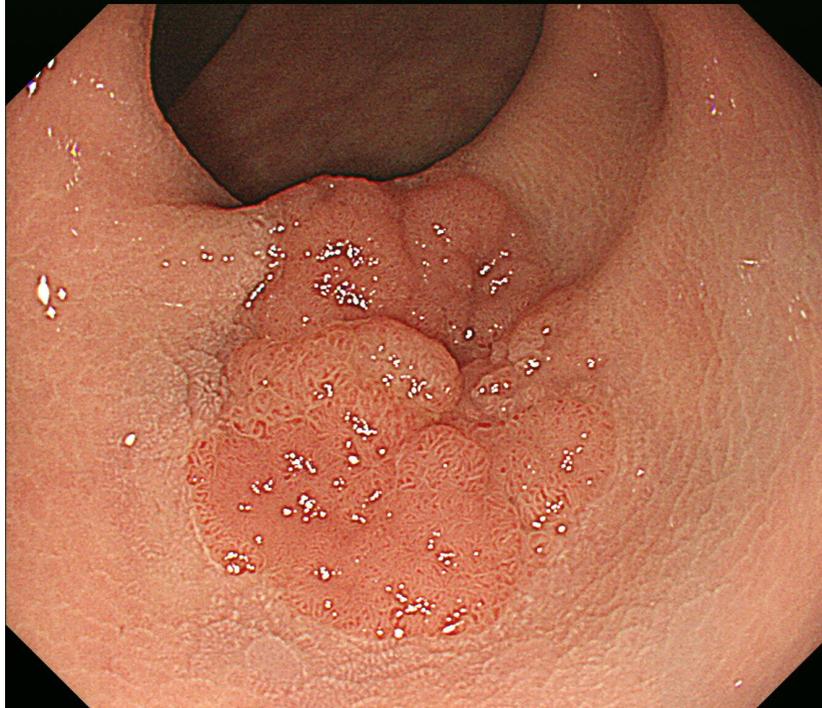
総計 1691人

経験した手技

～3年間を通して～

	件数
上部消化管内視鏡(緊急)	1263(94)
大腸内視鏡(緊急)	1268(22)
ERCP	164
肝生検・腫瘍生検	29
EVL	9
食道ESD	3
胃ESD/EMR	71/11
大腸ESD/EMR	16/321

大腸ESD



業績 ～3年間を通して～

論文

直腸 pT1 癌に対する内視鏡治療～ peranal endoscopic myectomy (PAEM) の経験も含めて～, J. Colon Exam 2020: Vol.36 No.2: 24-32.

口演

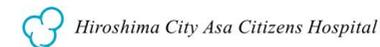
1. 大腸内視鏡診療におけるNBIの診断能と効率化に関する検討, 第36回日本大腸検査学会総会シンポジウム, 2018年10月12日-13日.
2. クリップ法による内視鏡治療が間接的に有用であった回腸末端憩室出血の1例, 第121回日本消化器内視鏡学会中国支部例会, 2018年12月1日-2日.
3. 甲状腺切迫クリーゼに高度肝機能障害を伴った1例, 第121回広島消化器病研究会, 2019年4月13日.
4. 大腸病変におけるNBIの診断能と低確信度症例に関する検討, 第97回日本消化器内視鏡学会総会シンポジウム, 2019年5月31日-6月2日.

業績 ～3年間を通して～

5. 内視鏡的切除術を施行した十二指腸球部gangliocytic paragangliomaの1例, 第122回日本消化器内視鏡学会中国支部例会, 2019年6月30日.
6. 粘膜内病変が保たれたまま浸潤したIIa+IIc型pT1a癌の1例, 第29回大腸IIc研究会, 2019年9月15日.
7. Clinicopathological features and therapeutic strategy for left-sided sessile serrated adenoma/polyps, UEG Week 2019, October 19–23.
8. 第306回広島胃と腸疾患研究会 症例検討, 2019年10月29日.
9. 甲状腺切迫クリーゼに高度肝機能障害を伴った1例, 第112回日本消化器病学会中国支部例会, 2019年11月30日・12月1日.
10. 高齢者大腸pT1癌に対する内視鏡治療の安全性と適応拡大に関する検討, 第99回日本消化器内視鏡学会総会パネルディスカッション, 2020年9月2日-3日.
11. 局在別にみたSessile Serrated Lesionsの臨床病理学的特徴と治療適応, 第28回日本消化器関連学会週間, 第100回日本消化器内視鏡学会総会ワークショップ, 2020年11月5日-8日.

Yukari Takeuchi, MD¹, Kenjiro Shigita, MD, PhD², Shinji Nagata, MD, PhD¹, Naoki Asayama, MD, PhD¹, Taiki Aoyama, MD, PhD¹, Akira Fukumoto, MD, PhD², Shinichi Mukai, MD, PhD¹

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Conclusion

Left-sided SSA/Ps can be distinguished from HP by endoscopic findings.

The endoscopic and pathological features of left-sided SSA/P are different from those of right-sided SSA/P.

Lesions with an adenomatous pit pattern accompanied by type II/open II pit pattern should be treated, but the lesion size of left-sided SSA/P is not an important indication of resection unlike that of right-sided SSA/P.

Background

Although sessile serrated adenoma/polyps (SSA/Ps) are considered premalignant lesions and their clinicopathological features have been previously reported, the differences based on lesion location (left- and right-sided colon) have not been clarified.

Aims

This study aimed to investigate the clinicopathological features and therapeutic strategy for left-sided SSA/P.

Patients and Methods

666 consecutive lesions diagnosed as SSA/P by experienced endoscopists after endoscopic examinations (white light, narrow-band imaging, and pit pattern) and resected endoscopically in Hiroshima Asa Citizens Hospital between August 2010 and March 2017 were enrolled.

The pathological diagnosis of each SSA/P was evaluated by two pathologists on the basis of the following Japanese Society for Cancer of the Colon and Rectum criteria.

	Left-sided	Right-sided	
SSA/P	173	340	513 lesions
HP	94	59	153 lesions
Total	267	399	666 lesions

Evaluated endoscopic and pathological findings of left-sided SSA/P were compared with those of left-sided HP and right-sided SSA/P.

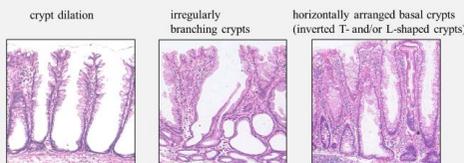
- Age • Sex
- Size • macroscopic classification
- mucus cap • NBI: varicose microvascular vessel • pit pattern
- crypt dilation
- irregularly branching crypts
- horizontally arranged basal crypt

Endoscopic findings



The pathological diagnostic criteria of SSA/P³⁾

When at least two of the three criteria were met in ≥10% of the lesion area, the serrated lesion was diagnosed as SSA/P.

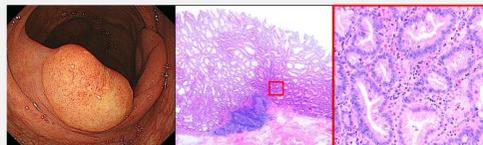


SSA/P with cytological dysplasia⁴⁾



Serrated dysplasia⁴⁾

SSA/P showing proliferation of atypical cells that are more cuboidal in shape and have eosinophilic cytoplasm, enlarged round nuclei with open vesicular prominent chromatin, and prominent nucleoli in addition to increased mitoses.



Result

Table 1. Comparison of endoscopic and pathological findings of SSA/P and HP group

Variables	Left-sided colon			Right-sided colon		
	SSA/P (n=173)	HP (n=94)	p value	SSA/P (n=340)	HP (n=59)	p value
Age (≥65)	86 (50)	50 (53)	N.S.	208 (61)	39 (66)	N.S.
Sex (female)	40 (23)	18 (19)	N.S.	134 (39)	12 (20)	p<0.01
Size (≥10mm)	61 (35)	6 (6)	p<0.01	180 (53)	7 (12)	p<0.01
macroscopic classification (IIa)	44 (25)	21 (22)	N.S.	169 (50)	12 (20)	p<0.01
mucus cap (+)	61 (35)	9 (10)	p<0.01	237 (70)	14 (24)	p<0.01
VMV (+)	83 (48)	21 (22)	p<0.01	168 (49)	7 (12)	p<0.01
pit pattern (type II open pit)	92 (53)	17 (18)	p<0.01	263 (77)	11 (19)	p<0.01
crypt dilation (+)	171 (99)	17 (59)	p<0.01	340 (100)	11 (73)	p<0.01
irregularly branching crypts (+)	160 (92)	4 (14)	p<0.01	316 (93)	0 (0)	p<0.01
horizontally arranged basal crypt (+)	108 (62)	0 (0)	p<0.01	286 (84)	0 (0)	p<0.01

Values are presented as number (%) unless otherwise indicated. N.S.: not significant

The proportion of lesions with size ≥10 mm, mucus cap, VMV, and type II open pit was significantly higher in the left-sided SSA/P group than in the left-sided HP group.

Table 2. Comparison of endoscopic and pathological findings of left- and right-sided SSA/P group

Variables	Left-sided SSA/P (n=173)	Right-sided SSA/P (n=340)	p value
Age (≥65)	86 (50)	208 (61)	p<0.01
Sex (female)	40 (23)	134 (39)	p<0.01
Size (≥10mm)	61 (35)	180 (53)	p<0.01
macroscopic classification (IIa)	44 (25)	169 (50)	p<0.01
mucus cap (+)	61 (35)	237 (70)	p<0.01
VMV (+)	83 (48)	168 (49)	N.S.
pit pattern (type II open pit)	92 (53)	263 (77)	p<0.01
crypt dilation (+)	171 (99)	340 (100)	N.S.
irregularly branching crypts (+)	160 (92)	316 (93)	N.S.
horizontally arranged basal crypt (+)	108 (62)	286 (84)	p<0.01

Values are presented as number (%) unless otherwise indicated. N.S.: not significant

The proportion of females and lesions with size ≥10 mm, flat morphology, mucus cap, and type II open pit was significantly lower in the left- than in the right-sided SSA/P group.

Table 3. Univariate analysis and multivariate analysis of endoscopic findings of SSA/P with CD group

Variables	SSA/P-CD (+) (n=27)	SSA/P-CD (-) (n=486)	analysis	
			univariate	multivariate
			p value	p value
Age (≥65)	23 (85)	271 (56)	p<0.01	N.S.
Sex (female)	14 (52)	160 (33)	N.S.	N.S.
Size (≥10mm)	13 (48)	228 (47)	N.S.	N.S.
Location (left)	8 (30)	165 (34)	N.S.	N.S.
macroscopic classification (IIa)	8 (30)	205 (42)	N.S.	N.S.
mucus cap (+)	16 (59)	282 (58)	N.S.	N.S.
VMV (+)	16 (59)	235 (48)	N.S.	N.S.
pit pattern (type II open pit)	20 (74)	335 (69)	N.S.	N.S.
with an adenomatous pit pattern	24 (89)	15 (3)	p<0.01	p<0.01

Values are presented as number (%) unless otherwise indicated. N.S.: not significant

The independent endoscopic finding of SSA/P-CD was an adenomatous pit pattern accompanied by type II/open II pit pattern in the multivariate analysis.

Table 4. Endoscopic and pathological findings of serrated dysplasia group

Variables	Left-sided colon			Right-sided colon		
	SSA/P-SD (+) (n=7)	SSA/P-SD (-) (n=158)	p value	SSA/P-SD (+) (n=36)	SSA/P-SD (-) (n=285)	p value
Age (≥65)	5 (71)	76 (48)	N.S.	22 (61)	168 (59)	N.S.
Sex (female)	0 (0)	36 (23)	N.S.	15 (42)	109 (38)	N.S.
Size (≥10mm)	2 (29)	56 (35)	N.S.	25 (69)	145 (51)	p=0.04
macroscopic classification (IIa)	1 (14)	42 (27)	N.S.	21 (58)	141 (49)	N.S.
mucus cap (+)	1 (14)	57 (36)	N.S.	28 (78)	196 (69)	N.S.
VMV (+)	5 (71)	75 (47)	N.S.	20 (56)	135 (47)	N.S.
pit pattern (type II open pit)	4 (57)	84 (53)	N.S.	27 (75)	220 (77)	N.S.
crypt dilation (+)	6 (100)	157 (99)	N.S.	36 (100)	285 (100)	N.S.
irregularly branching crypts (+)	6 (86)	146 (92)	N.S.	36 (100)	261 (92)	N.S.
horizontally arranged basal crypt (+)	7 (100)	93 (59)	p=0.04	32 (89)	235 (82)	N.S.

Values are presented as number (%) unless otherwise indicated. N.S.: not significant

Although there was no significant difference in crypt dilation and irregularly branching crypts in the left- and right-sided SSA/Ps, the proportion of horizontally arranged basal crypts was significantly lower in the left- than in the right-sided SSA/P group.

The proportion of lesions with size ≥10 mm was significantly higher in the right-sided SSA/P-SD (+) than SSA/P-SD (-) group.

Table 5. Comparison of sizes of left- and right-sided serrated dysplasia group

	<5mm	≥5mm, <10mm	≥10mm	p value
Right side colon (n=36)	0% (0/11)	8% (11/140)	15% (25/170)	p=0.08
Left side colon (n=7)	6% (1/16)	4% (4/91)	3% (2/58)	p=0.88

Values are presented as number (%) unless otherwise indicated.

No significant endoscopic findings of SSA/P-SD, except for lesion size, were found in either the left- or right-sided SSA/Ps. The proportion of right-sided SSA/P-SD increased with larger lesion size, while that of left-sided SSA/P-SD was low, regardless of lesion size.

Disclosure Information

Yukari Takeuchi, MD
Clinicopathological features and therapeutic strategy for left-sided sessile serrated adenoma/polyps

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FINANCIAL DISCLOSURE:
We declare that we have not received any financial support for this present study.

UNLABELED/UNAPPROVED USES DISCLOSURE:
No unlabeled/unapproved material were used in this study.

CONFLICT OF INTEREST:
None.

原 著

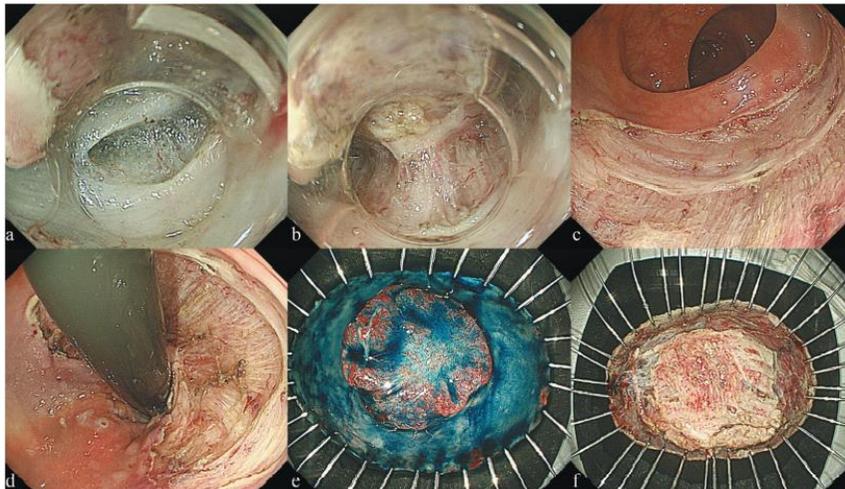
直腸pT1癌に対する内視鏡治療

～ peranal endoscopic myectomy (PAEM) の経験も含めて～

竹内友香理¹⁾, 嶋田賢次郎²⁾, 野村 理紗¹⁾, 益田 啓志¹⁾, 竹元 裕紀¹⁾, 朝山 直樹¹⁾, 青山 大輝¹⁾, 福本 晃²⁾, 向井 伸一¹⁾, 永田 信二¹⁾

要 旨：直腸は術後のQOLの観点から外科手術よりも内視鏡切除のメリットが大きい部位であり、直腸pT1癌に対する内視鏡治療の適応拡大が議論されている。今回、根治基準外pT1直腸癌149例を治療法別に3群（内視鏡切除後追加外科切除群、内視鏡切除後経過観察群、初回外科切除群）に分類し、各群の臨床病理学的特徴と予後について検討した。また、従来のESDでは垂直断端が陽性/不明となるリスクのあるcT1b癌に対して、粘膜下層に内輪筋を含めて切除するperanal endoscopic myectomy (PAEM)を行った。根治基準外pT1直腸癌は、SM浸潤距離だけが危険因子の場合のリンパ節転移は低率であり、初回外科手術例でも再発例は存在するため、患者の基礎疾患や社会背景とリンパ節転移率を総合的に判断し外科手術適応を決定すべきである。また、T1直腸癌に対する局所切除では垂直断端陰性となることが必須であり、PAEMは有用な手法となりうる。

Key word：直腸T1癌, リンパ節転移, 予後, peranal endoscopic myectomy (PAEM)



Endoscopic treatment for pT1 rectal cancer: Our experience with peranal endoscopic myectomy

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Endoscopic resection is preferred over surgery for rectal lesions from the viewpoint of patients' postoperative quality of life, and expanded indications for endoscopic treatment for pT1 rectal cancer are being widely investigated and applied in clinical practice. In this study, 149 patients with non-curative pT1 rectal cancer were categorized into the following groups based on the treatment method employed: endoscopic resection with additional surgery, endoscopic resection without additional surgery, and initial surgical resection. We investigated the clinicopathological features and clinical outcomes in each group. We also performed peranal endoscopic myectomy (PAEM) for cT1b rectal cancer associated with a risk of positive or unknown vertical margin resection based on conventional endoscopic submucosal dissection. The rate of lymph node (LN) metastasis of non-curative pT1 rectal carcinoma without risk factors except submucosal invasion depth was low, and recurrence occurred even in the initial surgical resection group. Therefore, patients' comorbidities, social background, a definitive risk of LN metastasis and the operative method need to be considered. Additionally, PAEM could be useful because local resection for T1 rectal

表4 PAEMを施行した6例の治療成績

症例	性別	年齢 (歳)	術前診断	治療時間 (分)	病理組織結果	垂直断端 (VM)	穿孔	後出血	腹部症状	血液検査 (ESD翌日)		追加治療
										WBC (μL)	CRP (mg/dL)	
1	男性	78	cT1b	80	pT2, L ₁ a, V1a, BD3	陰性	なし	なし	なし	10200	1.9	手術
2	男性	83	cT1b	55	pT1b, L ₁ a, V1a, BD2	陰性	なし	なし	なし	10300	0.7	手術
3	女性	39	SMT (NET)	30	NET G1, V1a	陰性	なし	なし	なし	6480	0.2	手術
4	男性	67	cT1b	140	pT1b, L ₁ 0, V1a, BD1	陰性	なし	なし	なし	11600	1.8	CRT
5	女性	52	cT1b	60	pT1s, L ₁ 0, V0, BD1	陰性	なし	なし	なし	8200	0.6	—
6	男性	81	cT1b	70	pT1b, L ₁ 0, V1b, BD1	陰性	なし	なし	なし	8420	1.7	手術

CRT：化学放射線療法