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Gastric Adenocarcinoma of Fundic Gland Type Masquerading as A Polypoid Lesion

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A 61-year-old woman presented with a two-weeks history of abdominal distension. Esophagogastroduodenoscopy revealed a solitary 1.5 cm polypoid elevated lesion in the gastric fundus, characterized by a central depression with erythematous and eroded mucosal surface (Figure 1A). Indigo carmine staining sharply defined the lesion's contour (Figure 1B). Endoscopic mucosal resection was performed. Histopathological examination demonstrated irregular branching and fusion of the neoplastic glands with submucosal invasion (Figure 1C). Immunohistochemical staining revealed diffuse expression of Pepsinogen-1 and MUC6, consistent with the morphological and immunophenotypic features of gastric adenocarcinoma of fundic gland type. Gastric adenocarcinoma of the fundic gland type is an extremely rare subtype of gastric cancer, characterized by distinct biological behavior and pathological features. The mean age at diagnosis is approximately 66 years, with a male predominance in elderly patients. Most patients are asymptomatic, with lesions typically detected during routine health check-ups. Most patients test negative for *Helicobacter pylori*, which is distinct from the pathogenesis of conventional gastric cancer. Gastric adenocarcinoma of the fundic gland type consists of chief cells, parietal cells, or a mixed cell population, with the chief cell-predominant subtype being the most common. Gastric adenocarcinoma of fundic gland type most commonly arises in the upper gastric body adjacent to the cardia, with the submucosal tumor-like elevated subtype (0-Ior 0-IIa) being the predominant endoscopic morphology. Dilated arborescent blood vessels are visible on the surface of the lesion[1]. Endoscopic features of gastric adenocarcinoma of fundic gland type vary by individual factors, lesion size and invasion depth, with definitive diagnosis requiring combined histopathological and immunohistochemical assessment[2]. Endoscopic resection is the first-line treatment, yielding a favorable prognosis in the majority of patients. Follow-up upper gastrointestinal endoscopy at 10 months showed no recurrence of the lesion (Figure 1D).

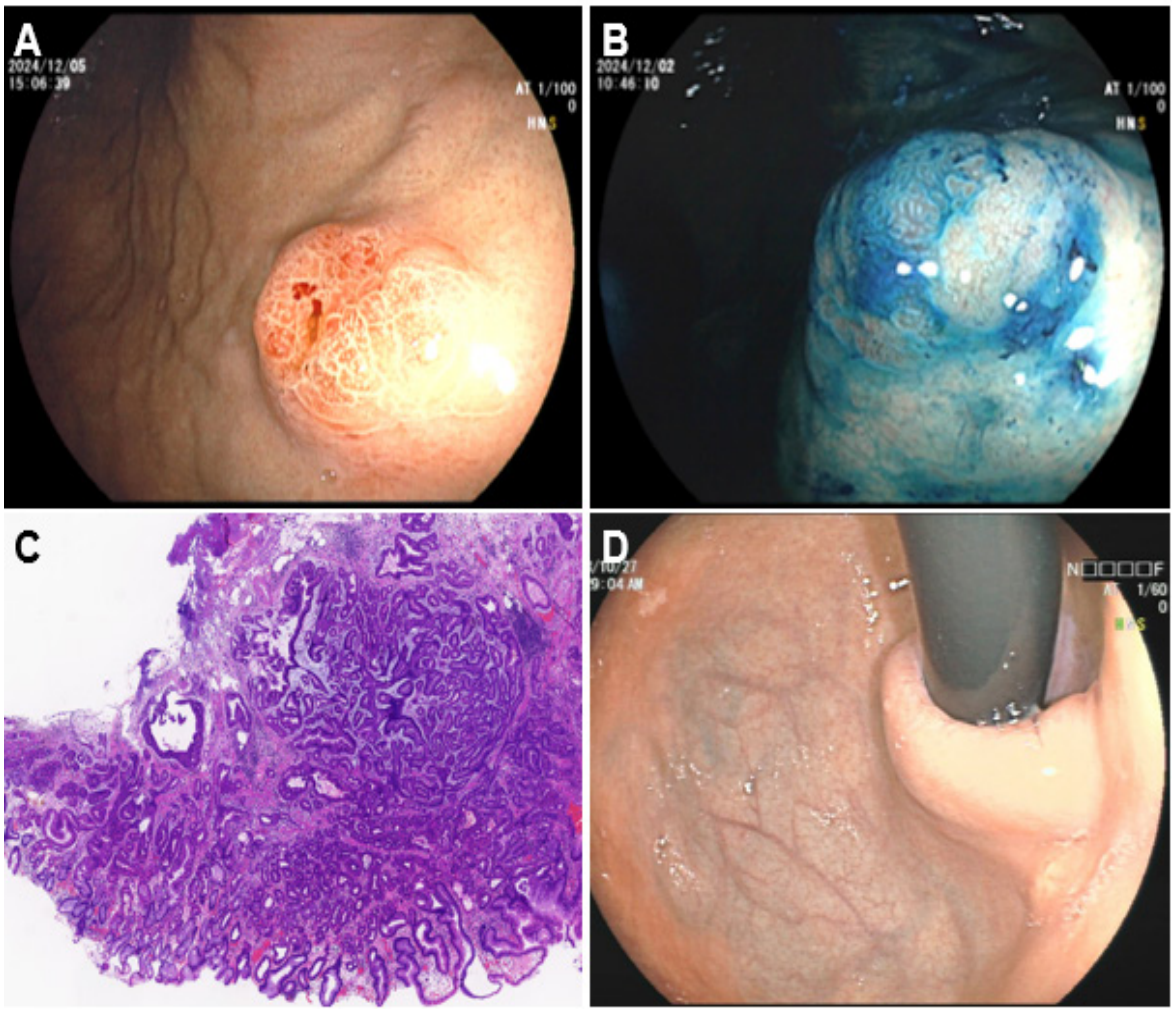

Figure 1: A). White light endoscopy review. B). Indigo carmine staining. C). Hematoxylin and eosin staining. D) Follow-up esophagogastroduodenoscopy review.

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3. References

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