

(4) A MORPHOLOGICAL CLASSIFICATION OF THE GASTRIC VARICES DETECTED AS ELEVATED LESIONS OF THE STOMACH

Osamu FUKUI, M.D.

Head, Dept. Gastroenterology, National Osaka Hospital, Osaka

Varix of the upper digestive tract is a sign seen in patient with the portal hypertension. According to Samuel¹⁾ Nishioka²⁾ and Yasumoto³⁾ gastric varices are detectable in advance of esophageal ones while the varix develops in the upper digestive tract as a sign of the portal hypertension.

This report has been made on the basis of endoscopic examinations of the gastric varix in 30 patients with various disorders, including 16 liver cirrhosis, 7 chronic hepatitis, 1 primary hepatoma and 6 idiopathic portal hypertension. The simultaneous presence of the esophageal varix was seen in the X-ray film in 17 (56.7%) of these patients, while there was no correlation between the esophageal and gastric varices with reference to the degree of varix.

The gastric varices detected endoscopically were classified into 4 morphological types as shown below.

- 1) Winding type; winding vein dilatation in the submucosal layer, reaching the angle in a certain case. This type was seen in 13 of 30 cases (43.3%).
- 2) Nodular type; showing multiple nodular or polypoid lesions along with winding veins. This type was seen in 11 of 30 cases (36.6%).
- 3) Tumorous type; The X-ray film shows a tumorous shadow in the fornix, which is necessary to be differentiated from the carcinoma, and frequent increase in phrenico-fornix distance. This type was classified further into 2 subtypes; a) submucosal tumor type and b) polyp type, each of which was seen in 2 cases (6.7%), respectively. While the mucosal color of tumorous lesions was indistinguishable from the one of neighborhood in 3 of all 4 tumorous types, a case of the submucosal tumor type showed a vein-like bluish tinge on the surface. This difference in surface color tinge suggests that the former develops and enlarges predominantly in the subserosa layer and the latter in the submucosal layer.
- 4) Mixed type; the simultaneous presence of the above described various types. This type was seen in 2 cases (6.7%).

In 17 of 30 patients with the gastric varix the examination revealed the simultaneous presence of the ulcer or the ulcer scar.

The gastric varix is not so difficult to be diagnosed because of its characteristic morphology examined with in mind.

References

- 1) Samuel, E.: Gastric varices, *Br. J. Radiology* 21: 519-522, 1948.
- 2) Nishioka, K. et al.: On the gastric varices its roentgenographic features and diagnostic method, *Nippon Acta Radiologica* 28: 1180-1188, 1968.
- 3) Yasumoto, M.: Clinical observation on 100 cases of gastric varices, *Japanese J. of Gastroenterology* 68: 721-738, 1971.

(5) POLYPOID LESION OF STOMACH

Hisayuki FUKUTOMI, Takao SAKITA

National Cancer Center Hospital

Recently the detection of the polypoid lesion in the stomach has increased remarkably and studies on polypoid lesion is being carried out from all approaches. In this paper we describe an endos-

copic differential diagnosis of polypoid lesion and follow-up observation.. At 1965 we tried to divided the polypoid lesion into the following four groups, smooth elevated, sessile, subpedunculated, pedunculated. And it was concluded that pedunculated polyp smaller than 2 cm, subpedunculated polyp smaller than 1cm and sessile polyp smaller than 0.5 cm are all benign. Therefor it is very important to observe the size and type of tumor in differentiation. These conclusion has not change with only a few exceptions. Recently we experienced 2 cases of pedunculated early carcinoma smaller than 2 cm. These polyps were very difficult to differentiate whether benign or malignant. Fiberscopic biopsy is indispensable for these questionable cases. But we experience a few exceptional cases which early carcinoma was found after operation in spite of fiberscopic biopsy was negative. There was cancerous change in a small part of polypoid lesion in these cases. It is important to pick up uniformly from polypoid lesion.

If polyp is diagnosed benign careful follow up examination must be done in view of the fact the repeated examination is not only useful for detection of malignancy in early stage but also enable us to know the growing process of polypoid lesion.

Next our endoscopic study of 4 cases of elevated type early carcinoma 76 cases of adenomatous polyp and 8 cases of atypical epithelium which were retrospectively observed for long period more than 6 months. Remarkable growth of tumor was not seen during our observation for 3 cases out of 4 cases of early carcinoma.

But 1 case presented increase of largeness of tumor. At the first time slightly elevation like adenomatous polyp was observed. At the second time it is very easy to diagnosed because of remarkable cancerous growth with central depression more than 5 years later. From this case it may be possible to speculate that early carcinoma of type IIa change to type IIa+IIc. Generally it is difficult to observed the course of development of polypoid cancer because it must be operated on as soon as it is diagnosed.

We could seen the process of 78 cases of adenomatous polyp. 5 cases in it has markedly enlarged and 4 cases have deformed and 3 cases have disappeared. Other polyps remained unchanged during the follow up period from 1 to 6 years. We are going to continue this kind of study.

Supplement 1.

PROTRUDED LESIONS OF THE STOMACH: A REAPPRAISAL OF BASIC TYPES

Yasutake YAMAMOTO and Takeshi SUZAKI

Department of Gastroenterology, TENRI HOSPITAL

A revised macroscopic classification of protruded lesions was proposed from analysis of histologically proven 75 cases (adenomatous polyp 31, atypical epithelium 7, early cancer 35, submucosal tumor 2). By combination of parameters of a protrusion such as maximal horizontal diameter (d), maximal height in the same plane of "d" (h), size of body (α) and size of base (β), three basic types were distinguished: Type-A (high and narrow-based), Type-B (broad-based) and Type-C (low and narrow-based). Most of adenomatous polyps exhibit Type-A appearance in contrast to Type-C which includes majority of early cancer and atypical epithelium. Additional remarks were made of dissecting-microscope appearances of gland openings and capillaries which can serve as differentiating features of protruded lesions.