シンポジウム | 全診療科
2026年11月21日(土) 13:30 ~ 14:45 | 第5会場（1F 会議室102）
シンポジウム 8　Cutting edge of endoluminal/ transanal surgery for colorectal cancer
Moderator: Kotaro Maeda (Himawari Seishinkai Izumi Clinic Medical Checkup Plaza, Japan), Motohiko Kato (Center for Diagnostic and Therapeutic Endoscopy, Keio University School of Medicine, Japan)

[SY8-9] Treatment Strategy for T1 Rectal Adenocarcinoma with Extensive Involvement of the Anal Canal: ESD or Surgical Resection?

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Background:
Endoscopic resection is widely accepted for early colorectal cancer. However, for T1 tumors extensively involving the anal canal, endoscopic treatment can be technically challenging due to severe pain and limited maneuverability, and achieving en bloc resection may be difficult. In such cases, transanal local excision or even abdominoperineal resection (APR) may be considered. We report a case of T1 rectal adenocarcinoma with extensive involvement of the anal canal that was treated with endoscopic submucosal dissection (ESD).
Case:
A 76-year-old man with a history of prior lung cancer surgery and a brainstem tumor under observation presented with hematochezia. Colonoscopy revealed a 30-mm type 0-Is lesion extending approximately 1.5 cm into the anal canal from the rectum, which was diagnosed as cT1a–T1b adenocarcinoma. Although surgical resection was considered, diagnostic endoscopic resection was initially planned due to its lower invasiveness. Given the anticipated severe pain, ESD was performed under general anesthesia.
En bloc resection was successfully achieved using the underwater technique, pocket-creation method, and a tapered hood(CAST hood; TOP, Tokyo, Japan). Histopathological findings were as follows: tub1 > tub2, 22 × 19 mm, pT1a (submucosal invasion: 600 μm), BD1, ly0, v1, HM0, and VM0, indicating R0 resection. The estimated risk of lymph node metastasis was approximately 3.0%. After explaining these findings, the patient opted for close surveillance and has remained recurrence-free to date.
Discussion:
In this case, ESD under general anesthesia enabled en bloc and R0 resection without complications, providing both diagnostic and therapeutic benefits. However, the optimal treatment strategy for T1 rectal adenocarcinoma with extensive involvement of the anal canal remains unclear and should be individualized based on tumor characteristics and institutional expertise.

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