

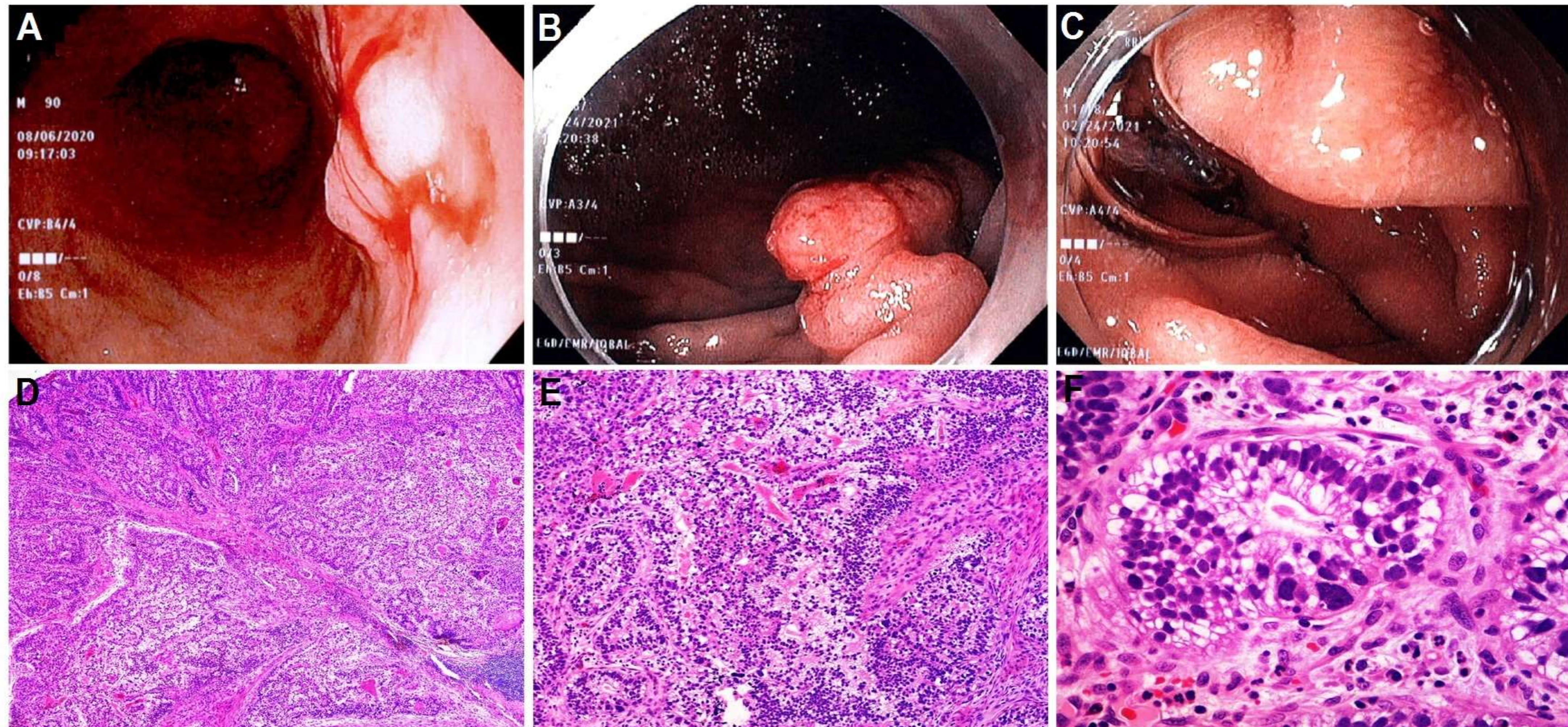
## Introduction

Primary gastric clear cell carcinoma (GCCC) is an exceedingly rare type of adenocarcinoma. It can often be misdiagnosed as metastatic clear cell cancer with primary lesions in other body organs. We hereby present an interesting case of primary GCCC, successfully removed with hybrid endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD).

## Case Descriptions/Methods

A 91-year-old male had ongoing anemia and melena due to intermittent oozing from a gastric body nodule. Previous EGD showed an oozing, nodular lesion in the gastric body (**Figure 1; A**). On EUS, it was a benign, mucosal-based, friable lesion. Pathology revealed gastric intestinal metaplasia. His past history included hyperlipidemia, hypertension, skin cancer, transient ischemic attack, prior colon polyps, and sigmoid resection for diverticulosis. Home medications included cardizem, iron and vitamin C supplements, allopurinol, aspirin, and PPI. He denied recent weight loss, nausea, vomiting, early satiety, chest pain, dyspnea, fever, or dysphagia. He then came to our hospital for endoscopic removal of the gastric lesion. EGD showed a 3-cm sessile polyp on the posterior wall of the gastric body, located along the lesser curvature (**Figure 1; B, C**). The polyp was completely removed by the hybrid EMR and ESD technique. Pathology revealed invasive adenocarcinoma of the intestinal type with clear cell features, arising in a background of extensive intestinal metaplasia (**Figure 1; D, E, F**). He developed post procedure urinary retention and underwent temporary Foley's catheter placement, which was removed shortly after. No fever or GI bleeding was noted. After diagnosis, his oncologist recommended concurrent

## Figure 1: Endoscopic and histological features of the gastric lesion



chemoradiotherapy. His most recent PET scan was unremarkable. No melena was reported at the follow-up after 3 months.

## Discussion

We herein presented a rare and interesting case of primary GCCC. In these patients, it is imperative for endoscopists to differentiate between primary GCCC and metastatic lesions to deliberate upon best therapeutic choice. Pathology with immunohistochemistry is the cornerstone of accurate diagnosis for primary GCCC. Given the extremely rare occurrence, no standard treatment guidelines exist for GCCC. Therefore, the therapeutic approach varies on a case-by-case basis, which largely depends on its

localization. For instance, the 3-cm lesion in our patient was located along the lesser curvature and was successfully removed by hybrid EMR and ESD. Therefore, it did not necessitate total gastrectomy.

## Figure 1

**Figure 1. A:** Previous EGD showing an actively oozing, nodular lesion in the gastric body. **B and C:** EGD showing a 3-cm sessile polyp on the posterior wall of the gastric body, located along the lesser curvature. **D, E, and F:** Pathologic analysis of the polypectomy specimen showing invasive adenocarcinoma of the intestinal type with clear cell morphologic features, arising in a background of extensive intestinal metaplasia.