High definition endoscopy has improved the diagnosis of early gastric cancer but still has a miss rate of 20%–25%. Magnification endoscopy with narrow-band imaging (NBI) helps to further characterize histology in early gastric cancer [1–3]. A 62-year-old woman attended screening esophagogastroduodenoscopy, and white-light endoscopy showed a slightly depressed lesion of size 10 × 5 mm (Paris type 0-IIc) on the anterior wall of the stomach in the antrum. NBI showed a line of demarcation with absent microsurface pattern and irregular microvascular pattern [4]. Near focus showed a dilated and tortuous corkscrew type of microvascular pattern and intralobular loop type 2 pattern (▶Fig. 1), as described by Nakayoshi et al., which was suggestive of poorly differentiated adenocarcinoma [1, 5]. Biopsies showed a signet cell type of carcinoma.

Intramucosal undifferentiated type adenocarcinoma of size ≤2 cm is a candidate for endoscopic resection under expanded criteria in Japanese guidelines 2018. Circumferential marking was done using a noninsulation-tipped endoscopic submucosal dissection knife under Forced Coag mode (▶Video 1). Submucosal injection using a 25-gauge needle with indigo carmine was performed to lift the lesion (▶Fig. 2a). An initial mucosal incision was performed on the proximal side of the lesion with the same knife and incision was completed using Endocut I (▶Fig. 2b). Bleeding was controlled using Coagrasper. Dissection was completed using the ITknife2 (Olympus Corp., Tokyo, Japan) (▶Fig. 2c).

The resected specimen measured 40 × 25 × 2 mm and revealed a signet ring cell carcinoma, with the deepest invasion...
confined to the mucosa and negative margins (Fig. 3). Follow-up esophagogastroduodenoscopy after 1 year showed resolution of the lesion with no recurrence.

Magnification endoscopy with NBI is a useful modality that helps to characterize and manage early gastric carcinoma, and in our case prevented gastrectomy.

Competing interests

The authors declare that they have no conflict of interest.

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