



# Incontri di aggiornamento del Dipartimento Oncologico

Responsabile Scientifico:  
Dott.ssa Stefania Gori

11 ottobre - 18 ottobre  
5 novembre - 16 novembre  
24 novembre - 29 novembre  
7 dicembre - 13 dicembre  
2016

SEDE: Ospedale "Sacro Cuore - Don Calabria"  
Via Don Angelo Sempredoni, 5 - 37024 Negrar (Verona)



# CARCINOMA DELL'ESOFAGO E DELLA GIUNZIONE ESOFAGO- GASTRICA

*- DIAGNOSI ISTOPATOLOGICA E  
FATTORI PROGNOSTICI -*

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Anatomia Patologica  
Ospedale Sacro Cuore-Don Calabria  
Negrar-VR



Cancer Care Center  
Numero Verde  
**800 143 143**  
Numero per la Cura del Tumore

# Carcinoma dell'esofago e giunzione esofago-gastrica

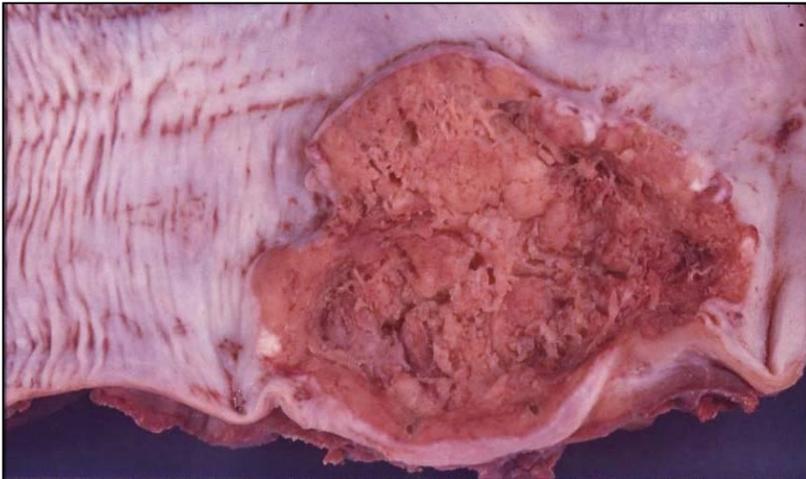
## **Obiettivi**

1. Definizione
2. Diagnosi
3. Lesioni preneoplastiche
4. Fattori prognostico / predittivi

# 1. Definizione

*Due distinti carcinomi, con diversa topografia e patogenesi*

**CARCINOMA SQUAMOSO**

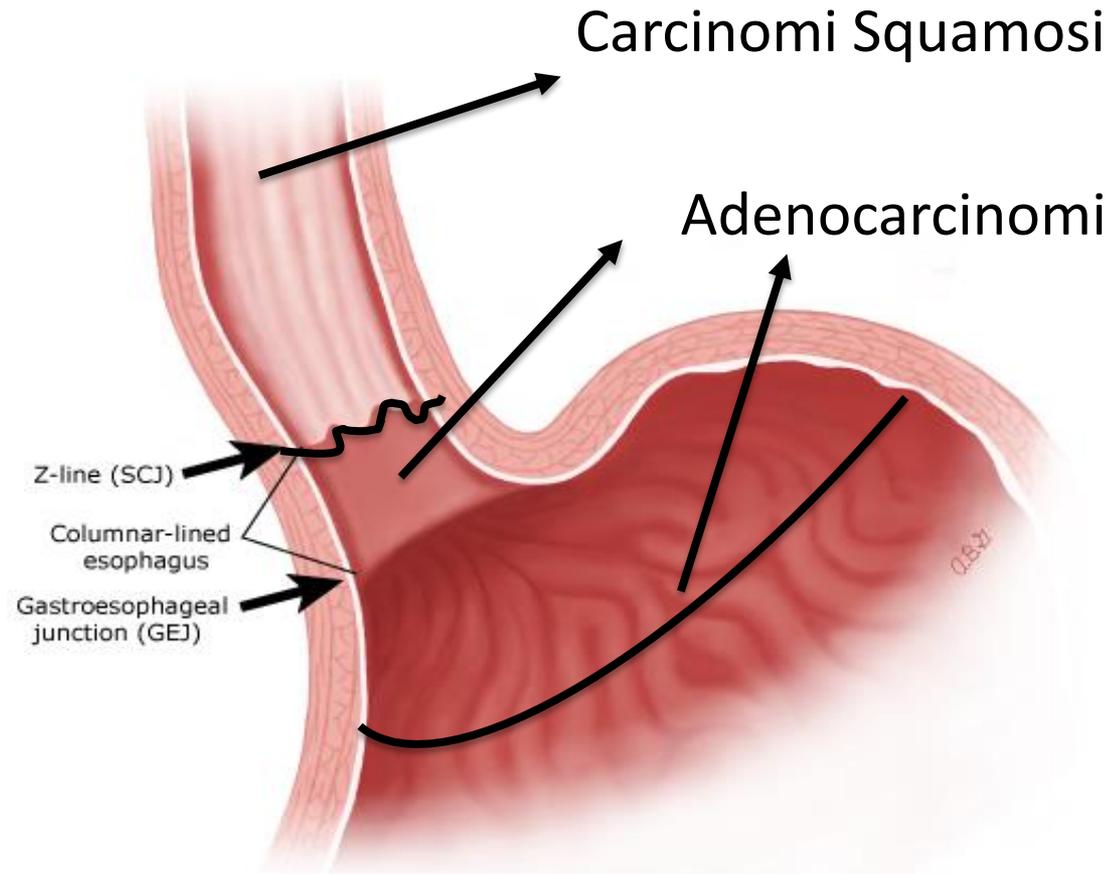
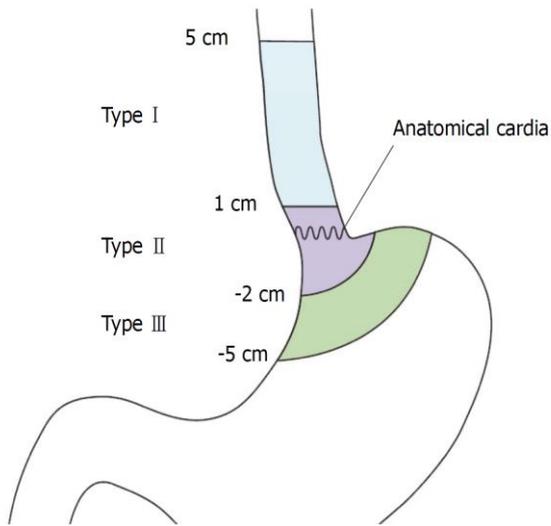


**ADENOCARCINOMA**



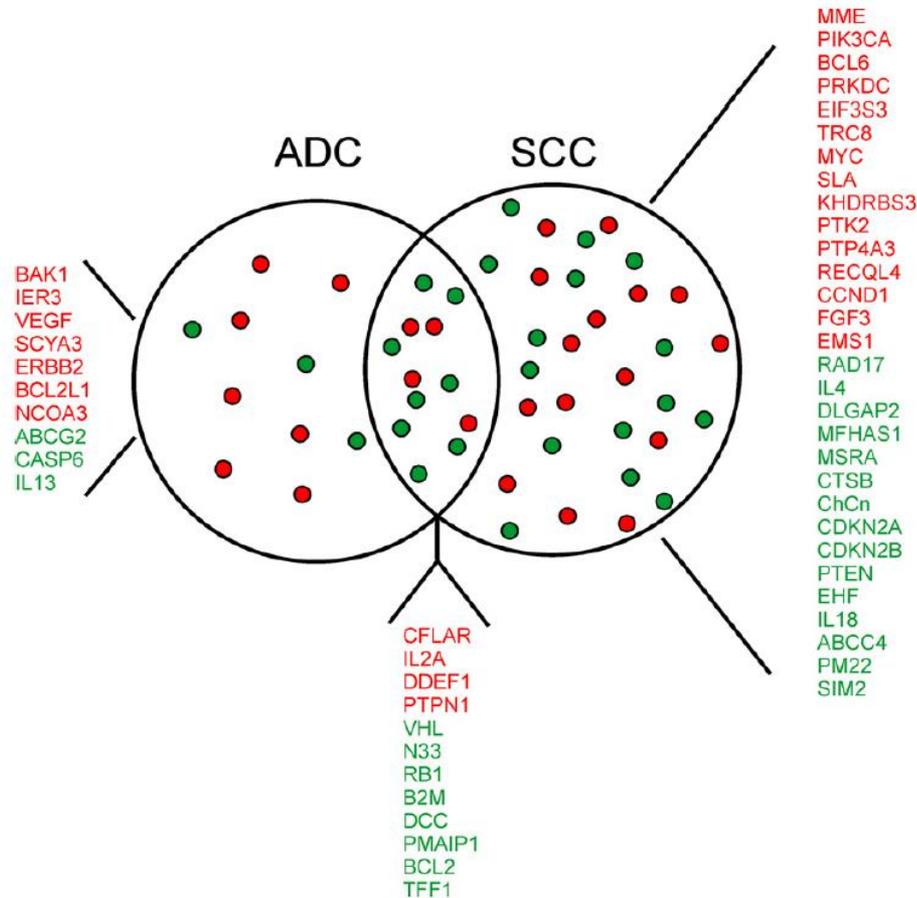
# ➤ Topografia

*Due distinti carcinomi, con diversa topografia e patogenesi*



# ➤ Patogenesi molecolare

*Due distinti carcinomi, con diversa topografia e patogenesi*



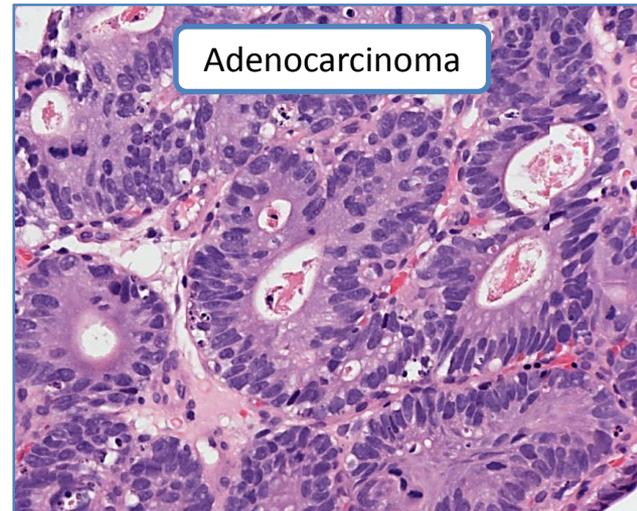
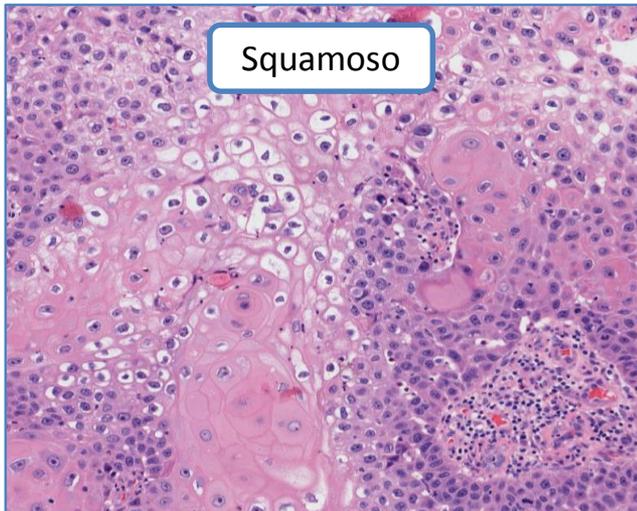
## 2. Diagnosi

### Algoritmo Diagnostico

Lesione Neoplastica

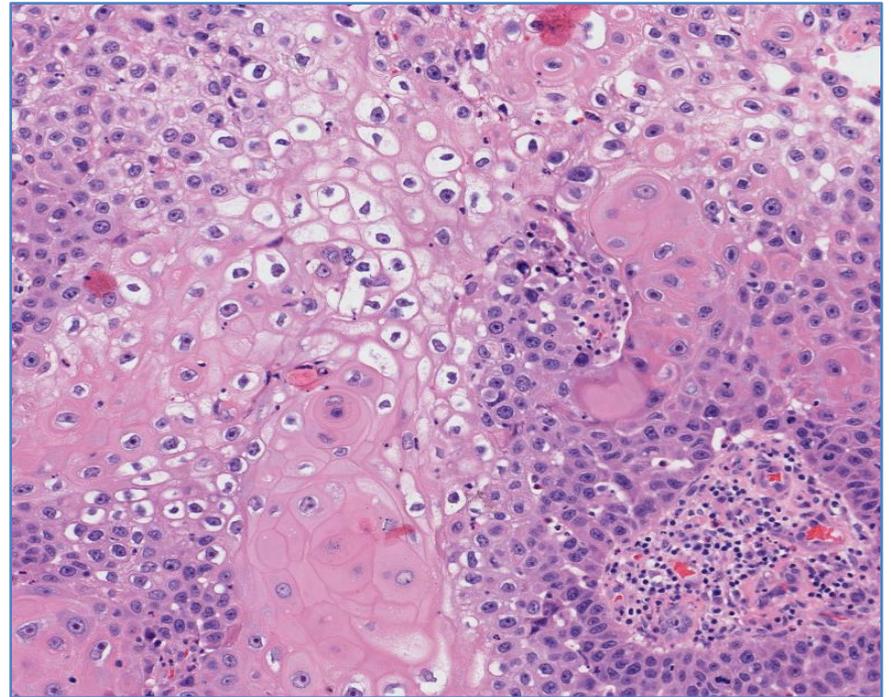
Lesione Preneoplastica

➤ Istotipo e Grado



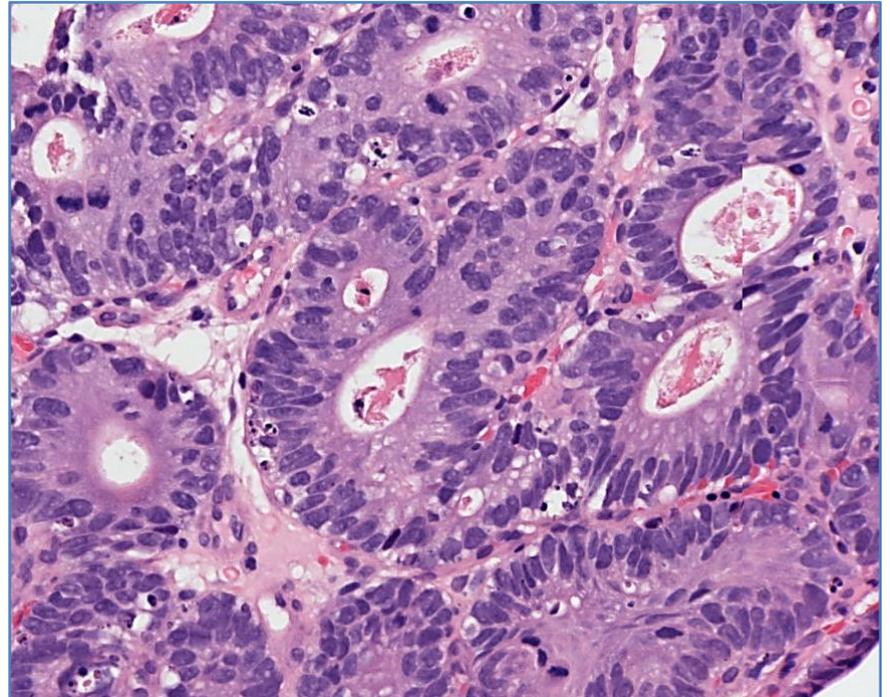
## ➤ Carcinoma Squamoso

- Istotipo prevalente in Italia
- Alcool e tabacco
- 1-3% neoplasie sincrone
- 4-9% neoplasie metacrone



## ➤ Adenocarcinoma

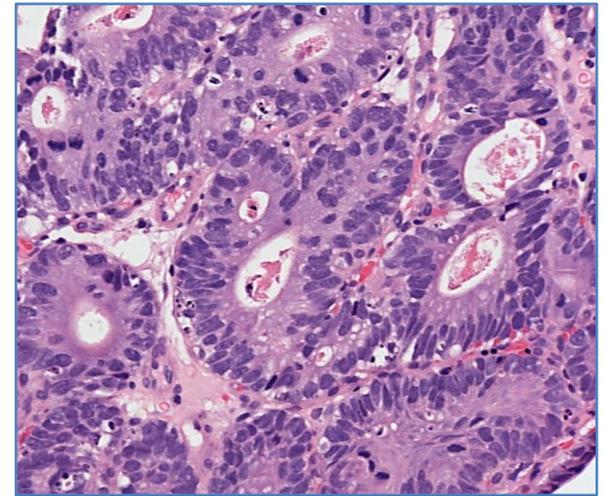
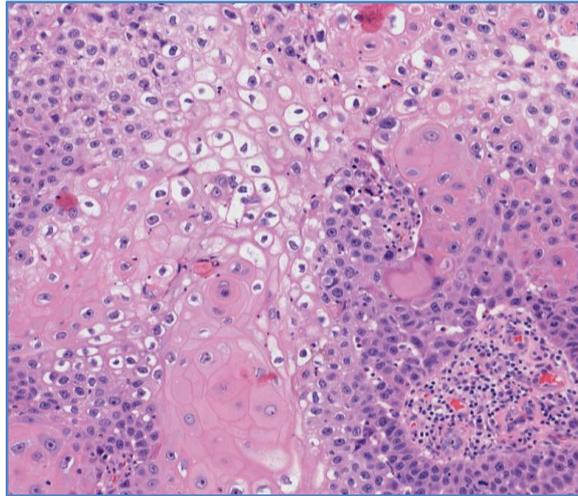
- Aumento dell'incidenza
- Esofagite da Reflusso ed Esofago di Barrett
- Multifocale



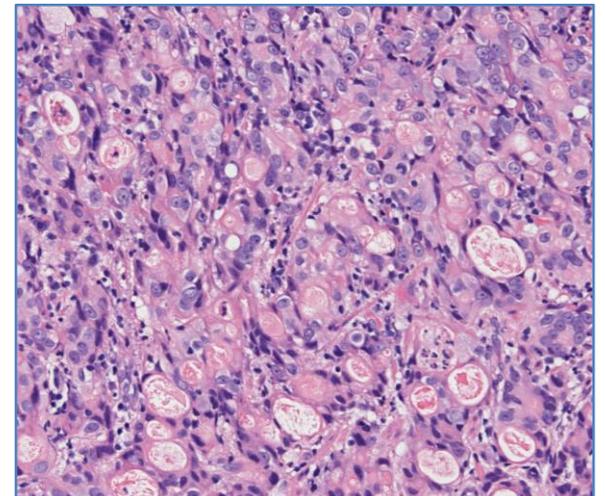
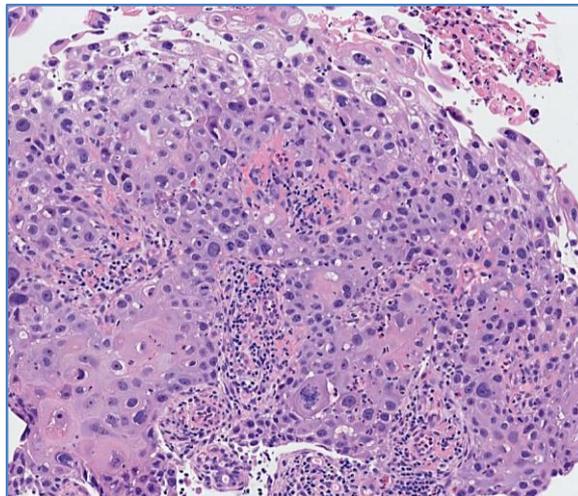
# ➤ Carcinoma squamoso /Adenocarcinoma

## Grado

Basso Grado

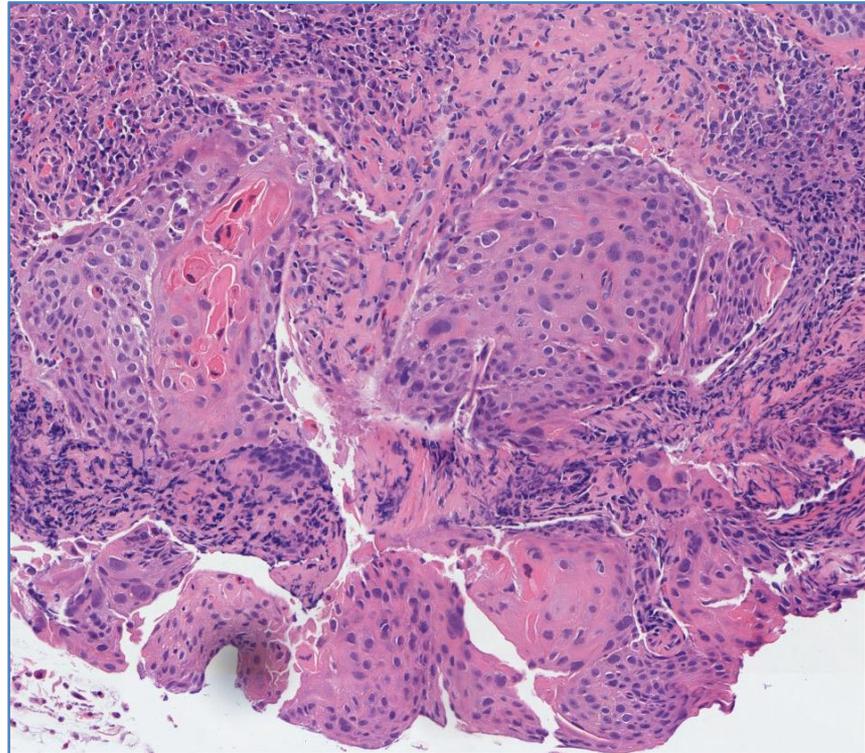
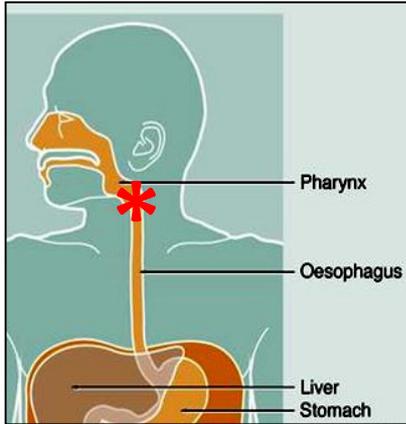


Alto Grado



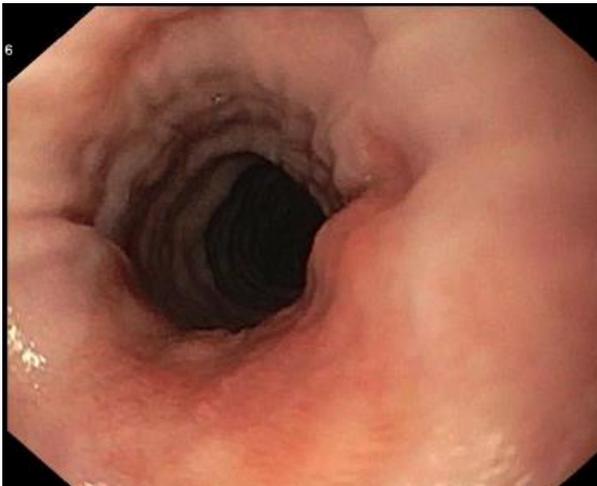
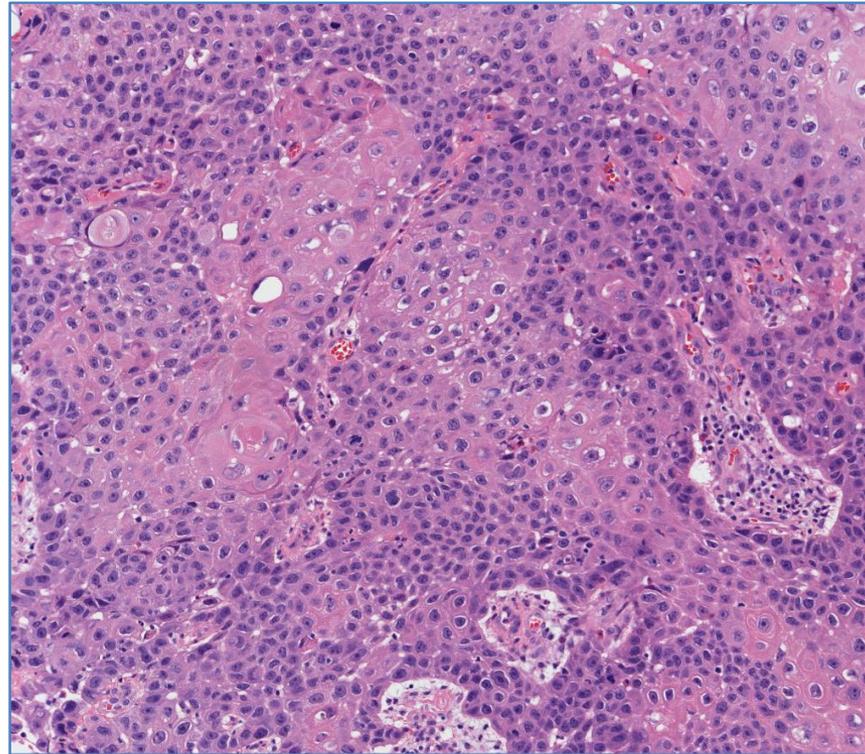
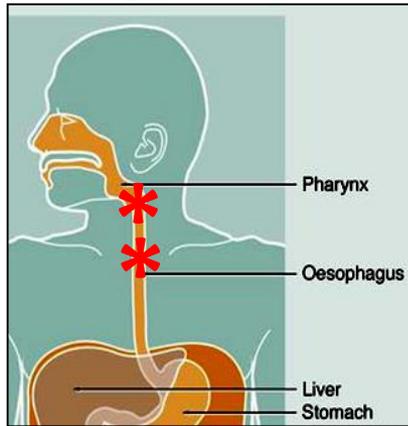
# ➤ Carcinoma Squamoso

Uomo, 63 a.  
Tabagista, alcolista



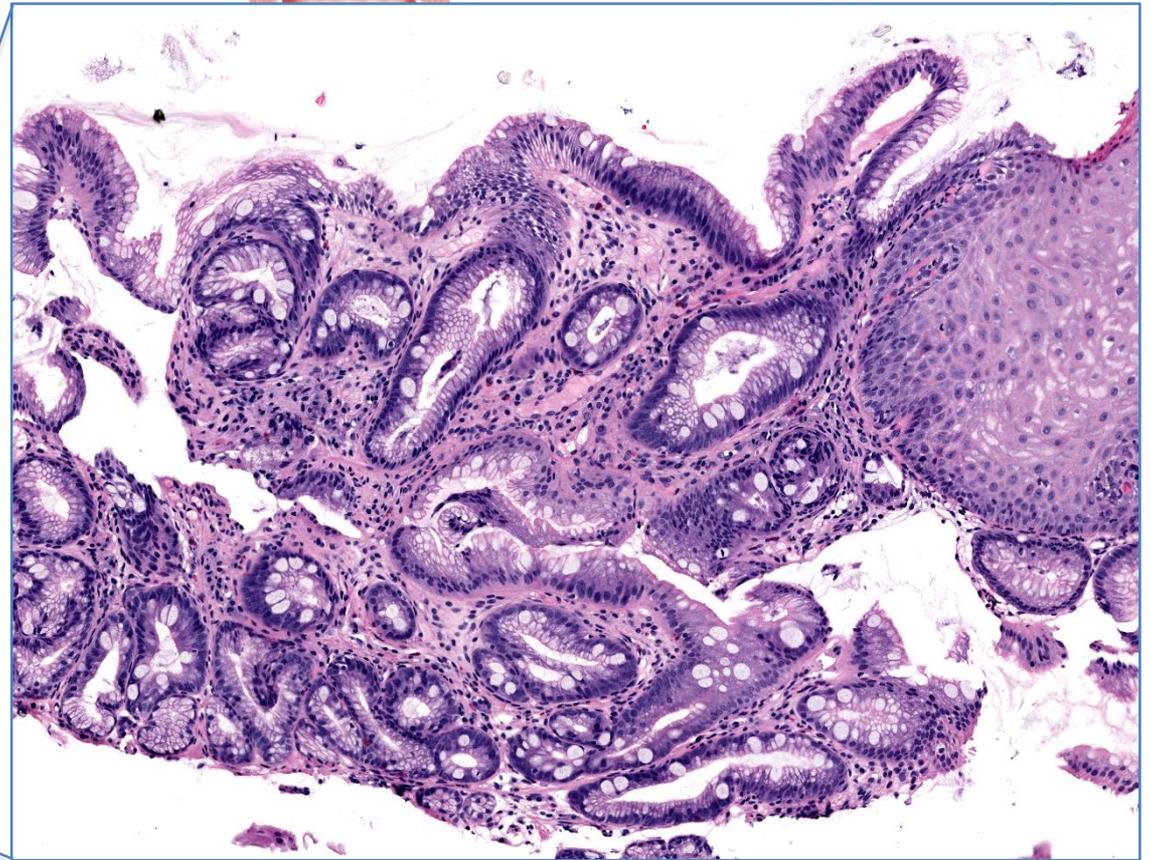
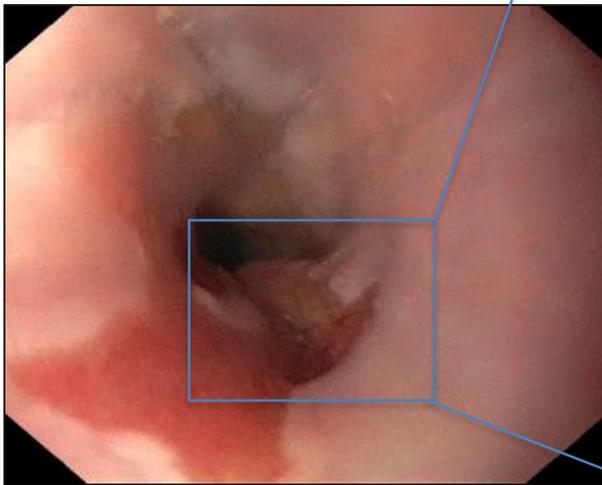
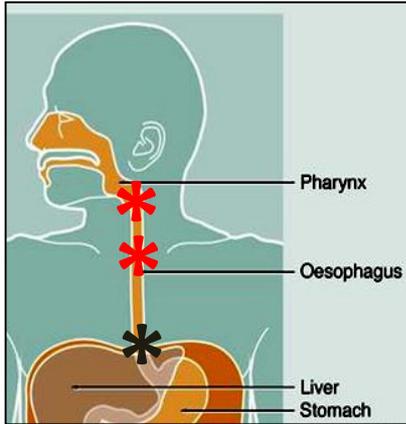
# ➤ Carcinoma Squamoso

Uomo, 63 a.  
Tabagista, alcolista



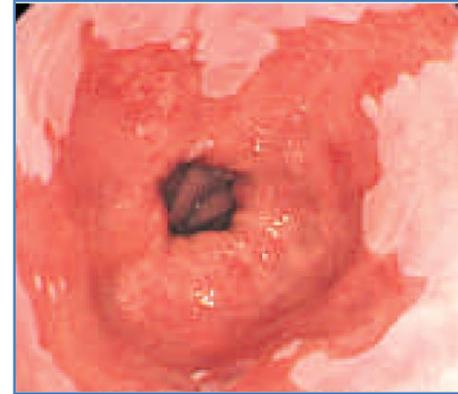
# ➤ Esofago di Barrett

Uomo, 63 a.  
Tabagista, alcolista

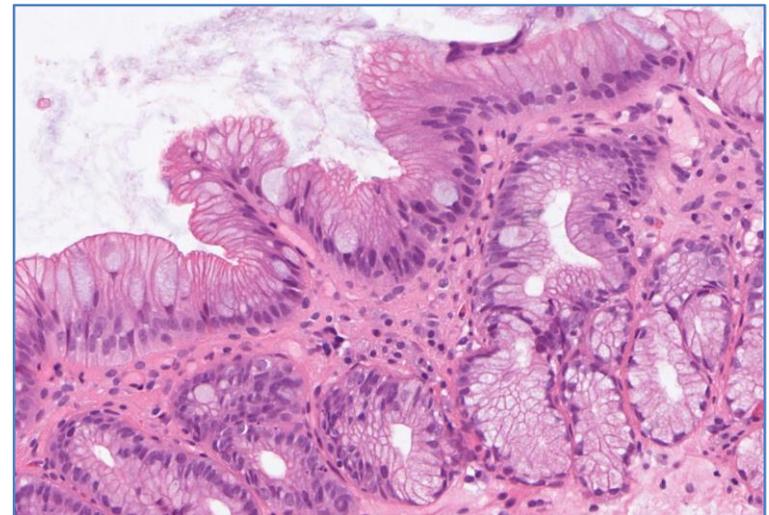


## ➤ Esofago di Barrett

1) Evidenza **endoscopica** che la mucosa colonnare si estende al sopra della giunzione gastro-esofagea

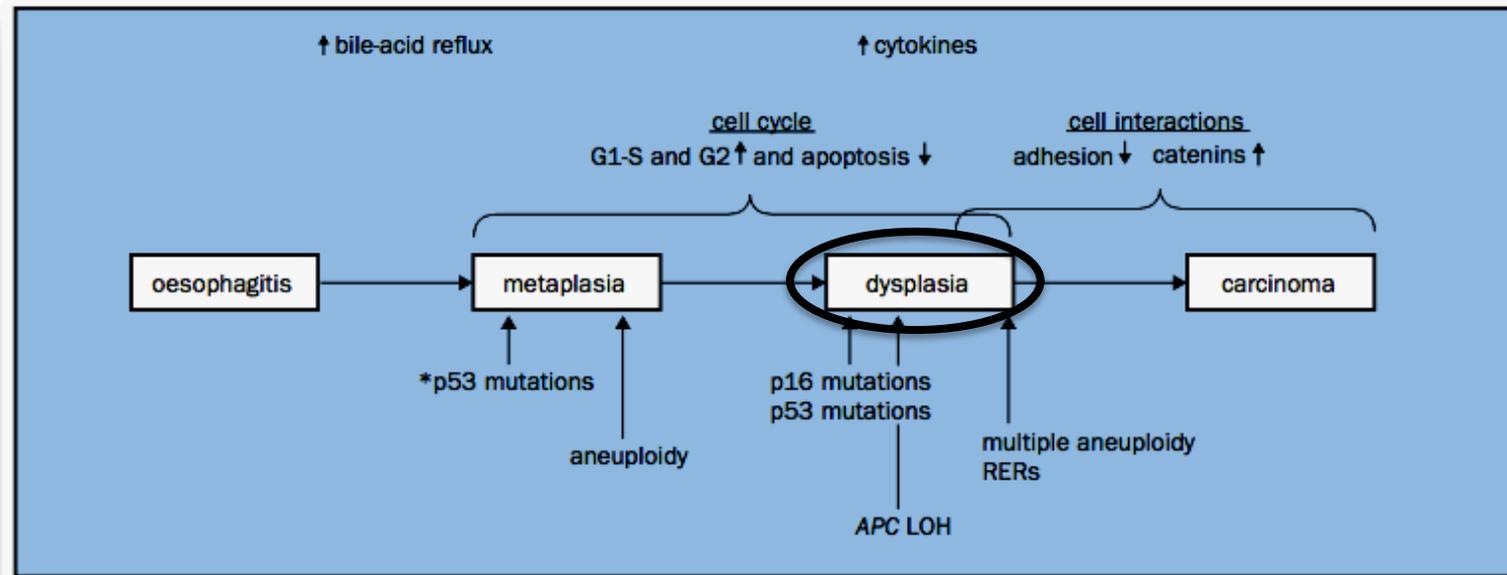


2) Conferma **istologica** della metaplasia intestinale, definita dalla presenza di cellule di goblet



3) L'esofago di Barrett non include pazienti che hanno metaplasia intestinale a livello del cardias.

# Esofagite- Esofago di Barrett-Displasia e Carcinoma



Inequivocabile alterazione neoplastica dell'epitelio, non invasiva (confinata entro la membrana basale).

## 2. Diagnosi

### Algoritmo Diagnostico

Lesione Neoplastica

Lesione Preneoplastica

➤ Istotipo

➤ Grado

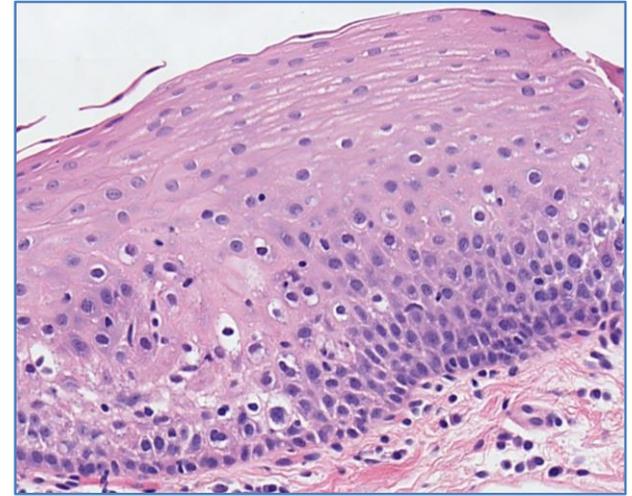
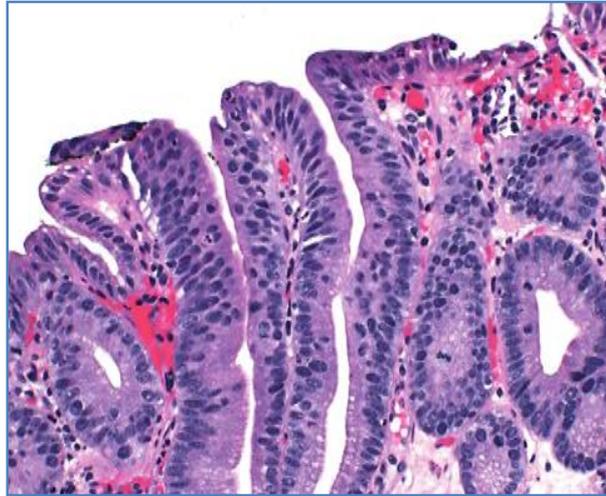
DISPLASIA  
Basso Grado

DISPLASIA  
Alto Grado

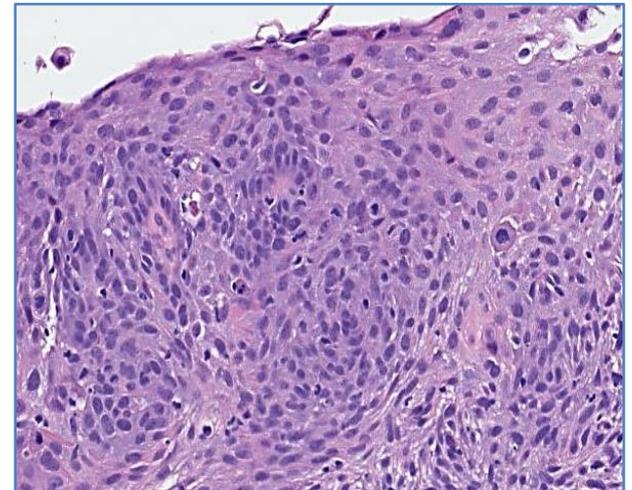
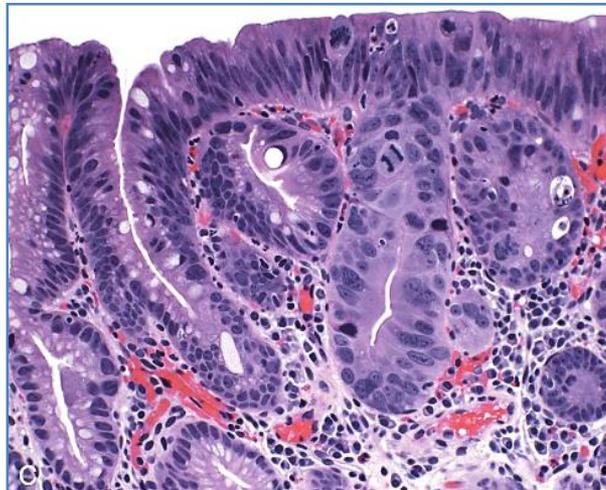
### 3. Lesioni Preneoplastiche

## Displasia

Basso Grado



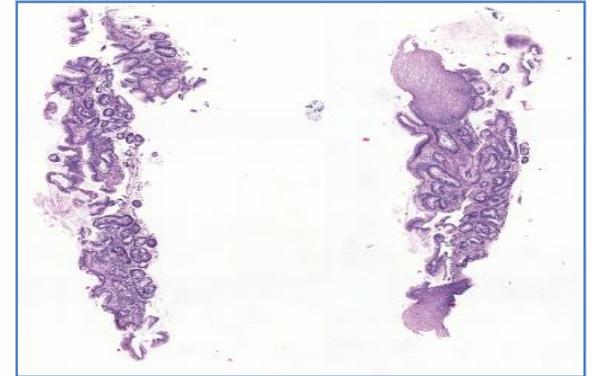
Alto Grado



## 4. Fattori Prognostici

- Istotipo
- Grado

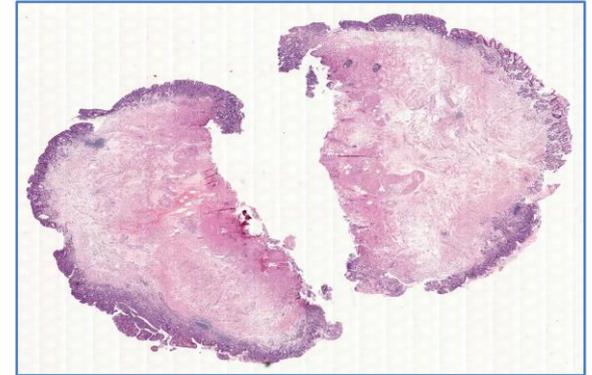
Biopsie endoscopiche



## 4. Fattori Prognostici

- Istotipo
- Grado
- Invasioni perineurali e angiolinfatiche
- Profondità di infiltrazione
- Margine di resezione LATERALE e PROFONDO

Resezioni endoscopiche



## 4. Fattori Prognostici

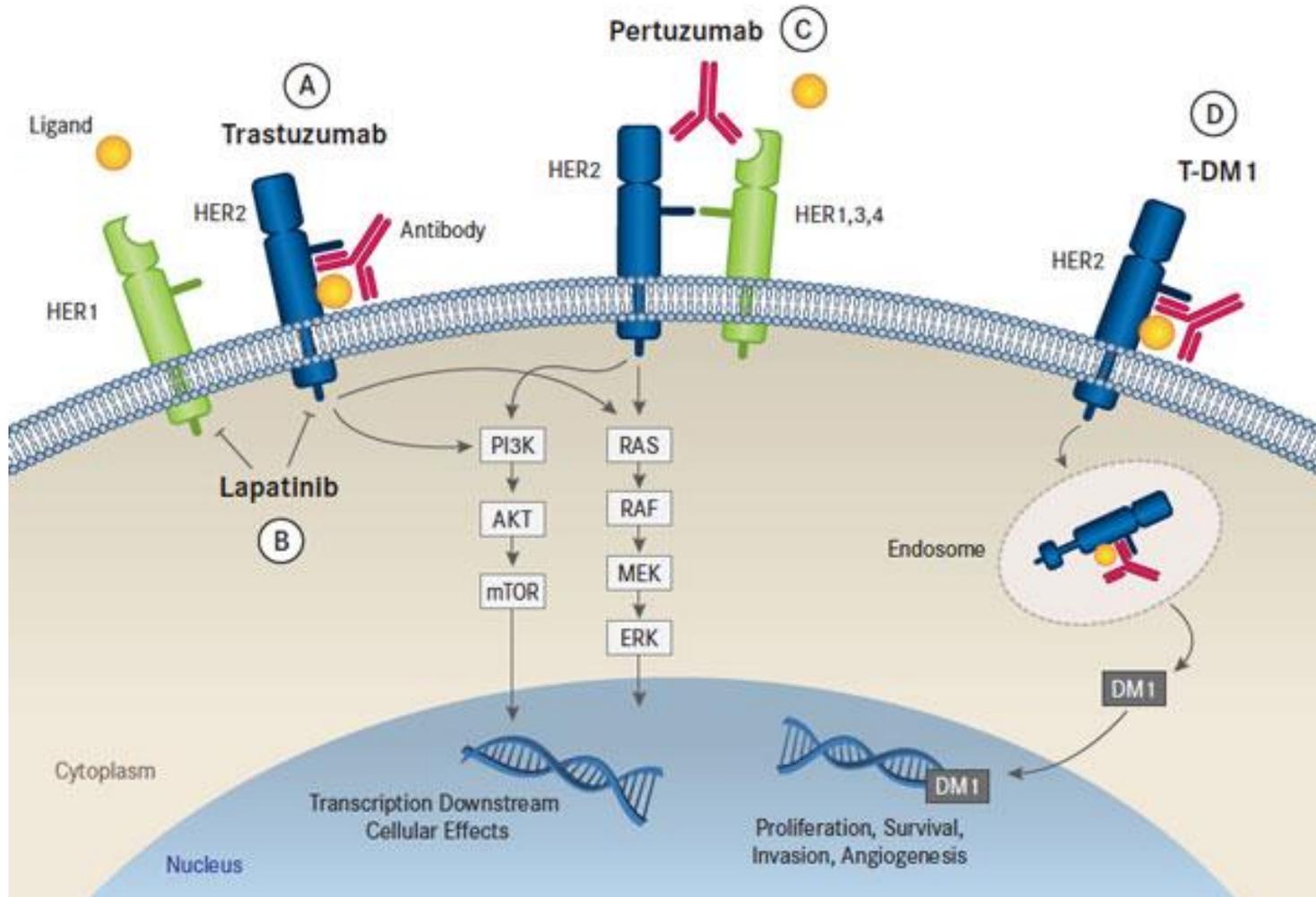
- Istotipo
- Grado
- Invasioni perineurali e angiolinfatiche
- Profondità di infiltrazione
- Margine di resezione LATERALE e PROFONDO
- Margine di resezione CIRCONFERENZIALE
- Status Linfonodale
- Localizzazione (istotipo SQUAMOSO)

Pezzo operatorio



# 4. Fattori Predittivi

## HER2

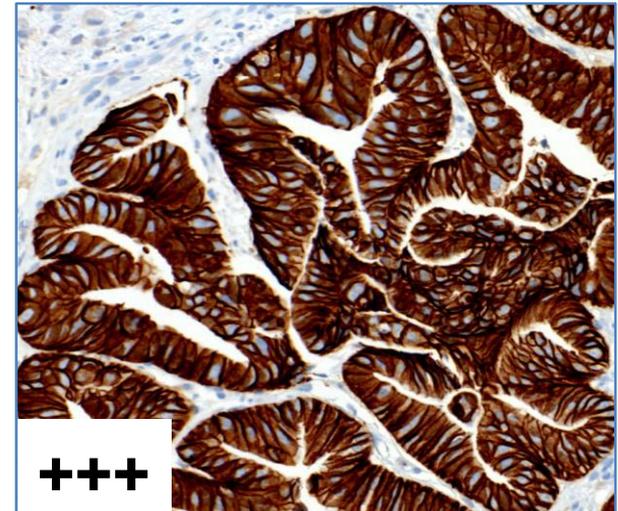
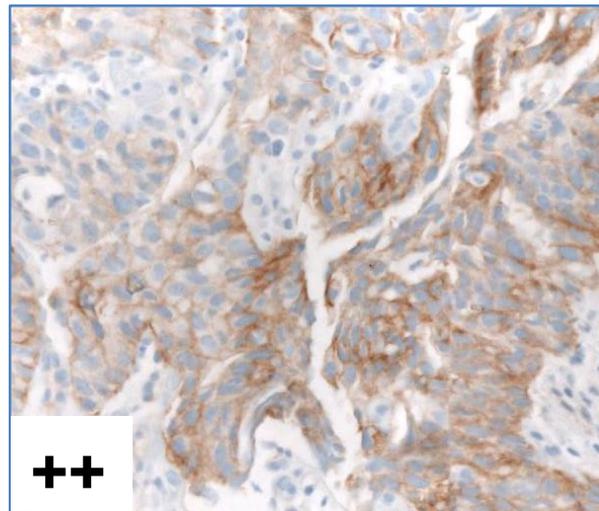
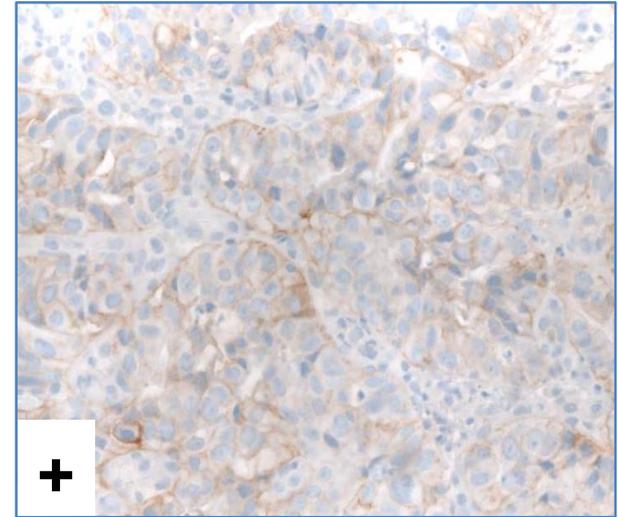
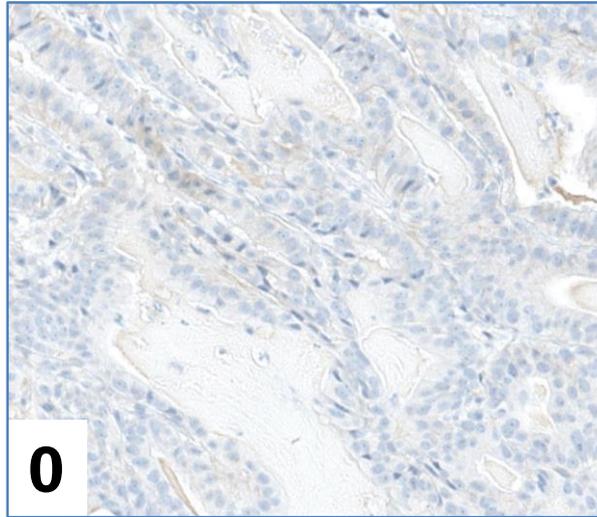


## 4. Fattori Predittivi: HER2

### Metodiche

Espressione Proteina:

•Immunoistochimica

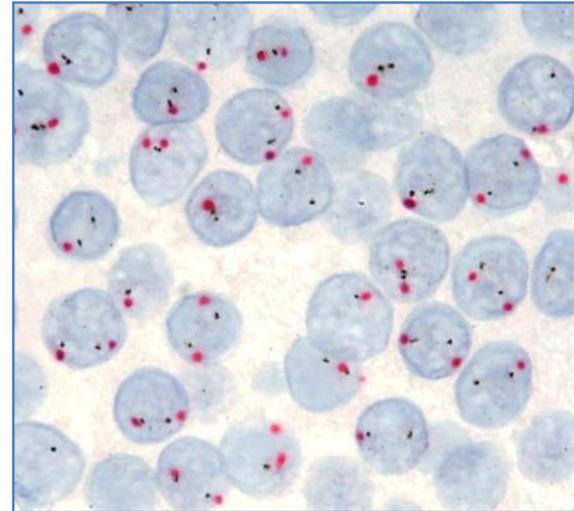


## 4. Fattori Predittivi: HER2

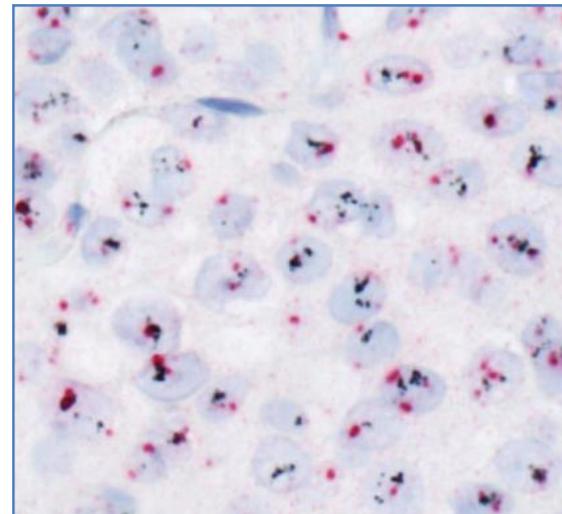
### Metodiche

Amplificazione Genica:

- Ibridazione in situ: FISH
- CISH
- SISH



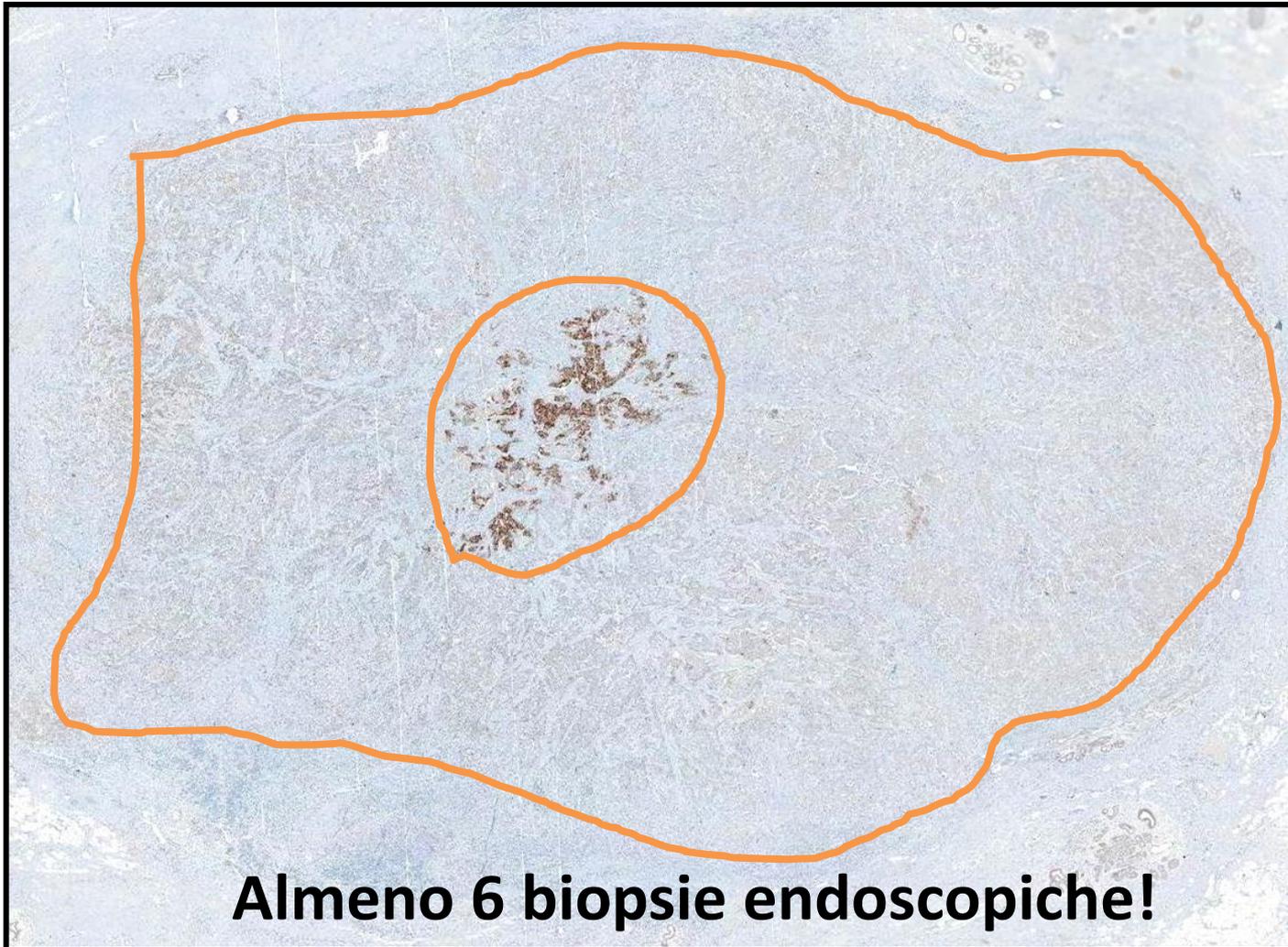
Non amplificato



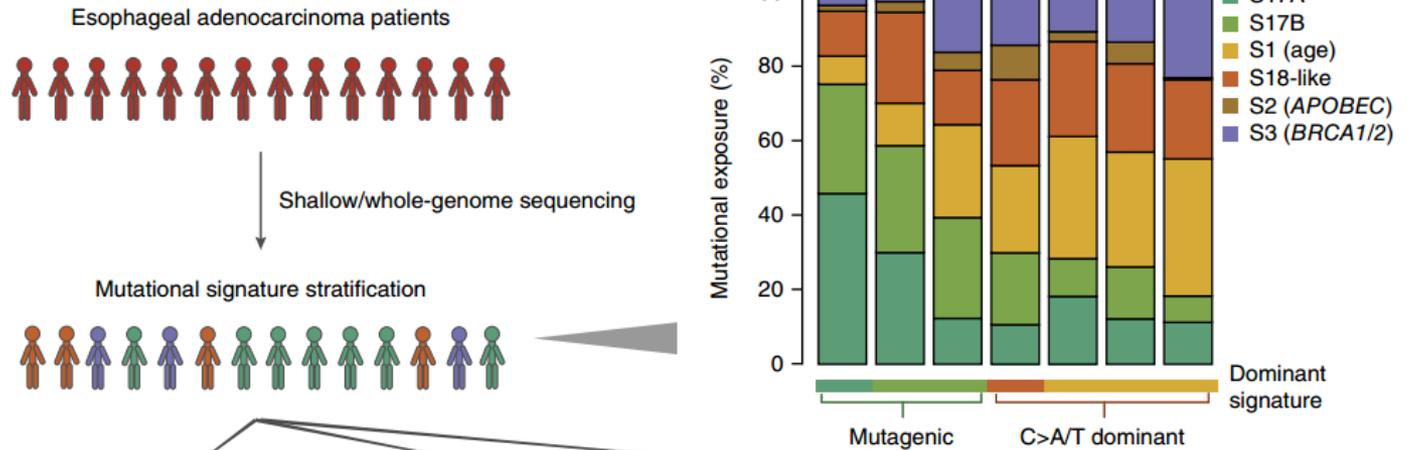
Amplificato

## 4. Fattori Predittivi: HER2

**Eterogeneità**



# 4. Fattori Predittivi



	C>A/T dominant (29%)	DDR impaired (18%)	Mutagenic (53%)
Etiology			
Description	<ul style="list-style-type: none"> <li>• Dominant C&gt;A/T mutational pattern</li> <li>• Aging as a pervasive risk factor</li> <li>• Fewer unstable genomes and large duplication events</li> </ul>	<ul style="list-style-type: none"> <li>• Prevalent defects in homologous recombination and chromosome segregation pathways</li> </ul>	<ul style="list-style-type: none"> <li>• Dominant T&gt;G mutational pattern</li> <li>• Highest mutational burden</li> <li>• Highest neoantigen load</li> </ul>
Therapy	<ul style="list-style-type: none"> <li>• Conventional chemotherapy</li> <li>• Tailored ERBB2/MET inhibition</li> </ul>	<ul style="list-style-type: none"> <li>• DNA-damaging agents combined with PARPi</li> <li>• Proton irradiation</li> <li>• Photon irradiation with PARPi</li> </ul>	<ul style="list-style-type: none"> <li>• CHK/WEE1 inhibition</li> <li>• Immunotherapy:                             <ul style="list-style-type: none"> <li>◦ CTLA4-targeting agents</li> <li>◦ PD-1/PD-L1-targeting agents</li> </ul> </li> </ul>

## Conclusioni

- Sede e caratteristiche istologiche determinati per la strategia terapeutica e per l'attribuzione a diversi gruppi prognostici
- Collaborazione anatomo-clinica per la diagnosi delle lesioni preinvasive
- Nel caso di sospetto di lesione neoplastica almeno 6 biopsie endoscopiche per la caratterizzazione molecolare