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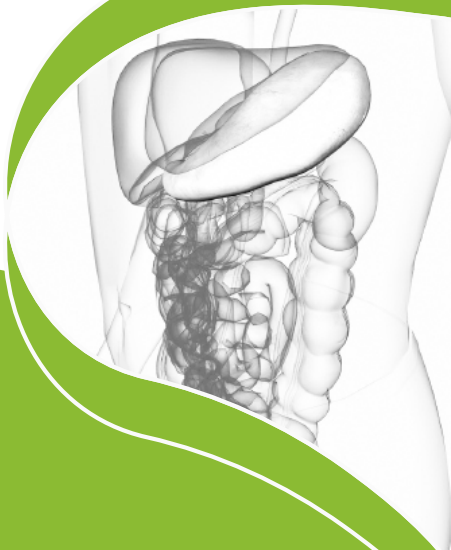
ANDALUSIAN JOURNAL OF DIGESTIVE PATHOLOGY



Official Body
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ANDALUSIAN JOURNAL OF DIGESTIVE PATHOLOGY

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1. RAPD Objectives and characteristics: The Revista Andaluza de Patología Digestiva is the official publication of the Andalusian Society of Digestive Pathology (SAPD), which since 2007 has been published in electronic format only, under the name RAPD Online. Its purpose is to disseminate all epidemiological, clinical, basic and sociological aspects of digestive diseases, through the contributions sent to the journal from Andalusia and from the entire scientific community. The official language for the publication of this journal is Spanish, but some contributions may be accepted in the author's original language in English, French or Italian. RAPD Online is published bimonthly, with one of the issues being specially dedicated to the Annual Meeting of the SAPD and the Editorial Board deciding to reserve one or more issues per year for the monographic development of a topic related to the speciality.

All submitted contributions must be original and not be simultaneously under review for publication in another journal. The publication of abstracts or posters is not considered duplicate publication. Manuscripts will be evaluated by expert reviewers, appointed by the editorial board, before being accepted for publication, in a process that will take less than 30 days.

2. RAPD Contents: *regular numbers of RAPD Online include defined sections such as:*

- *Original articles on clinical or basic research.*
- *Thematic reviews on specific aspects of Gastroenterology.*
- *Consensus documents.*
- *Clinical cases.*
- *Clinical cases with videos or Videoforum.*
- *Images of the month.*
- *News and updates on gastroenterology and hepatology.*
- *Letters to the Editor.*

Other contributions that are considered of interest by the Editorial Board, relating to different aspects of clinical practice in the recent past, biographical comments, or other contents of a cultural nature, or related to scientific activities in any territorial area, will be inserted in RAPD Online in sections designed specifically for this purpose.

3.Submission of manuscripts: *The preferred way to submit manuscripts is through the SAPD website (https://www.sapd. es), by accessing the RAPD Online page and clicking on the "Submit an original" button located on the same access page to the journal. This will take you to the Manuscript Centre, from where you will be able to send manuscripts and all the required documentation. To use this tool you must be previously registered, access requires a username and password. If you are a member of the SAPD, you can use your usual username. If you are not a member, you can request a username for access to the Manuscript Centre using the form on the website. You can write to sulime@sulime.net or RAPDonline@sapd.es, for the solution of any problem in the submission of manuscripts.*

4. Writing standard for manuscripts: *monographic numbers, thematic reviews, updates and annotated articles will be commissioned by the Editorial Board, but the submission of any of these contributions at the request of an author will be considered by the RAPD Online Management and evaluated with great interest for inclusion in the journal.*

All manuscripts will be subject to specific rules, depending on the type of contribution, and to common ethical and legal standards.

A) Specific standard for manuscripts writing

They refer to the recommended length and structure of each type of manuscript. As a basic unit of length for the text, in any of the contributions, a page of 30-31 lines, spaced 1.5 lines apart, with a font size of 12, with 75-80 characters without spaces per line and a total of 400-450 words per page is considered. Texts should be sent spell-checked and in editable format in all their applications (main text, figures, legends or figure captions, tables, graphs, drawings).

Originals: *originals can be up to 12 pages long (5,100 words), excluding bibliographical references and captions to figures and tables. It is not advisable to insert more than 10 images, including tables and figures. Colour illustrations and videos will not represent an economic charge for the authors, but the insertion of videos, for technical reasons, will be previously agreed with the editor. However, the editing method of RAPD Online allows, in specific cases, the acceptance of longer manuscripts, or the inclusion of a greater number of images, provided that the characteristics of the material presented so require. It is not advisable to have more than 9 authors, except in the case of collaborative works. In these originals, the first nine participants will be listed at the head of the paper and the rest of the participants will be listed at the end of the first page of the manuscript.*

Through the Manuscript Centre, the following information will be required for the submission of an original:

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2° Surnames and first names of all authors.
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4° Full postal address of the responsible author, to whom correspondence should be addressed, including telephone, fax and email address.
5° Declaration on the existence or non-existence of a source of funding for the work, or conflicts of interest.

- Main body of the manuscript, containing:

1° Structured abstract in Spanish (optional also in English) and 3-5 keywords. The abstract will have a maximum length of 250 words and should be structured as follows:

a) Introduction and objectives
b) Material and methods
c) Results
d) Conclusions

2° List of abbreviations used in the text.

3° Text: it will include the following sections:
a) Introduction
b) Material and methods
c) Results

d) Discussion
e) Conclusions; each of them appropriately headed.

4° Bibliography: according to the specifications established in the group of common standards (See common standards and other supporting documents).

5° Acknowledgements.

6° Figure captions.

7° Tables and figures in text.

Thematic Reviews: *texts on Thematic Reviews can be up to 15 pages long (6,375 words), excluding bibliographical references and captions to figures and tables, and chapters corresponding to Update series up to 20 pages (8,500 words). In both cases the number of inserted images should not exceed 15, including tables and figures. However, the RAPD Online editing method allows, in specific cases, for manuscripts of greater length, or the inclusion of a greater number of images, provided that the characteristics of the material presented so require. Illustrations in colour will not be charged to the authors. Exceptionally, the inclusion of videos will be accepted. It is not advisable to include more than 4 authors per chapter.*

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3° Centre(s) of origin(s) (department, institution, city and country).
4° Full postal address of the responsible author, to whom correspondence should be addressed, including telephone, fax and email address.
5° Declaration on the existence or non-existence of a source of funding for the work, or conflicts of interest.

- Main body of the manuscript, containing:

1° Structured abstract in Spanish and English. 3-5 key words. The abstract will have a maximum length of 350 words, emphasising the most important aspects of the manuscript.
2° Text: Structured according to the criteria of the author(s), for a better understanding of the topic developed.
3° Bibliography: According to the specifications established in the group of common standards (See common standards and other supporting documents).
4° Acknowledgements.
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2° Surnames and first names of all authors.
3° Centre(s) of origin (department, institution, city and country).
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5° Declaration on the existence or non-existence of a source of funding for the work, or conflicts of interest.

- Main body of the manuscript, containing:

1° Structured abstract in Spanish and English. 3-5 key words. The abstract will have a maximum length of 350 words, emphasising the most important aspects of the manuscript.
2° Text: Structured according to the criteria of the author(s), for a better understanding of the topic developed.
3° Bibliography: According to the specifications established in the group of common standards (See common standards and other supporting documents).
4°Acknowledgements
5° Figure captions.
6° Tables and Figures in the text.

Clinical Cases: *the manuscripts included in this section will include 1-5 clinical cases, which due to their infrequent or unusual clinical behaviour, or because they provide some diagnostic or therapeutic novelty, deserve to be reported.*

The length of the texts in the Clinical Cases section should not exceed 5 pages (2,125 words), excluding bibliographical references and captions to figures and tables, and the number of inserted images should not exceed 5, including tables and figures. However, the RAPD Online editing method allows, in specific cases, the acceptance of longer manuscripts, or the inclusion of a greater number of images, provided that the characteristics of the material presented so require. Colour illustrations and videos will not represent a financial charge for authors, but the insertion of videos, for technical reasons, will be previously agreed with the editor. No more than 5 authors will be admitted, except in specific and reasoned cases.

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3° Centre(s) of origin(s) (department, institution, city and country).
4° Full postal address of the responsible author, to whom correspondence should be addressed, including telephone, fax and e-mail address.

- Main body of the manuscript, containing:

1° Structured abstract in Spanish and English. 3-5 key words. The abstract will have a maximum length of 250 words.
2° Introduction. To present the clinical problem reported.
3° Description of the clinical case.
4° Discussion. To highlight the peculiarities of the case and its consequences.
5° Bibliography: According to the specifications established in the group of common standards (See common standards and other supporting documents).
6°Acknowledgements.7° Figure captions.
8° Tables and text figures.

Clinical Cases with Videos or Videoforum: *the manuscripts included in this section will include 1-5 clinical cases, which due to their infrequent or unusual clinical behaviour, or because they provide some diagnostic or therapeutic novelty, deserve to be communicated.*
The length of the texts in the Videoforum section should not exceed 5 pages (2,125 words), excluding bibliographical references and captions to figures and tables, and the number of images inserted should not exceed 5, including tables and figures. However, the RAPD Online editing method allows, in specific cases, the acceptance of longer manuscripts, or the inclusion of a greater number of images, provided that the characteristics of the material presented so require. Colour illustrations and videos will not represent a financial charge for authors, but the insertion of videos, for technical reasons, will be previously agreed with the editor. No more than 5 authors will be admitted, except in specific and reasoned cases.

Videos should be submitted in AVI, MPEG, MP4 OR MOV format, and at a recommended high quality resolution (720p or 1080p). They must not contain personal data of the patients. It is recommended that they be edited to minimise editing time, which should not exceed 10 minutes. If the video includes sound, it must be processed in MP3 format. If the videos to be included are in other formats, please contact the publisher

to verify their validity. They should not exceed 2GB.
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1° Full title of the work in Spanish and English. 2° Surnames and first names of all authors.
3° Centre(s) of origin (department, institution, city and country).
4° Full postal address of the responsible author, to whom correspondence should be addressed, including telephone, fax and email address.

- Main body of the manuscript, containing:

1° Structured abstract in Spanish and English. 3-5 key words. The abstract will have a maximum length of 250 words.
2° Introduction. To present the clinical problem reported. 3° Description of the clinical case.
4° Discussion. To highlight the peculiarities of the case and its consequences.
5° Bibliography: According to the specifications established in the group of common standards (See common standards and other supporting documents).
6°Acknowledgements.7° Figure captions.
8° Tables and figures in text.
9° Videos.

Link tutorial videos: https://www.sapd.es/videoteca/varios/ tutoriales/

Images of the month: *the manuscripts included in this section can take two formats, depending on the authors' preference.*

- Format A. Images with educational value: these shall include images of any kind, clinical, radiological, endoscopic, anatomopathological, macro and microscopic, which contribute to postgraduate training and therefore deserve to be shown because of their peculiarity, or because they represent a characteristic example.
- Format B. Key images for a diagnosis: These will include images of any kind, clinical, radiological, endoscopic, anatomopathological, macro and microscopic, together with a summarised clinical history, which will provide the possible final diagnostic resolution. This will be presented in a separate section in the same issue of the journal.

The length of the texts in the Images of the Month section must not exceed 1 page (425 words) in the clinical approach to the image presented and 2 pages (850 words), excluding bibliographical references and captions to figures and tables, in the commentary on the image (Format A) or in the diagnostic resolution of the case (Format B). However, the RAPD Online editing method allows, in specific cases, the acceptance of longer manuscripts, or the inclusion of a greater number of images, provided that the characteristics of the material presented so require. Colour illustrations and videos will not represent a financial charge for authors, but the insertion of videos, for technical reasons, will be previously agreed with the editor. No more than 3 authors will be accepted, except in specific and reasoned cases.

Through the Manuscript Centre, and for the submission of an Image of the Month, the following information will be required:

-General data:

1° Full title of the work in Spanish and English.. 2° Surnames and first names of all authors.
3° Centre(s) of origin (department, institution, city and country).
4° Full postal address of the responsible author, to whom correspondence should be addressed, including telephone, fax and email address.
5° Type of Image of the Month format chosen.

-Main body of the manuscript, containing:

1° Structured abstract in Spanish and English and 3-5 key words. The abstract will have a maximum length of 250 words.
2° Description of the image.
3° Comments on the image.
4° Bibliography: According to the specifications established in the group of common standards (See common standards and other supporting documents).
5° Figure captions.

New developments and updates in gastroenterology and hepatology: this section will be devoted to commenting on the scientific and medical developments that have occurred in recent years in the speciality of Gastroenterology and Hepatology.

This section will systematically and periodically analyse all facets of the speciality.

Texts on " New developments in Gastroenterology" may be up to 5 pages long (2,125 words), excluding bibliographical references and captions to added figures and tables. In both cases the number of inserted images must not exceed 5, including tables and figures. However, the RAPD Online editing method allows,

in specific cases, the acceptance of longer manuscripts, or the inclusion of a greater number of images, provided that the characteristics of the material presented so require. It is not advisable to have more than 3 authors per chapter.

Through the Manuscript Centre, you will be asked to provide the following information:

- General data:

1° Name of the bibliographic area reviewed and period analysed 2° Surname and first name of all authors. It is advisable to place a hyphen between the first and second surname.
3° Centre(s) of origin (department, institution, city and country).
4° Full postal address of the responsible author, to whom correspondence should be addressed, including telephone, fax and email address.
5° Declaration on the existence or non-existence of a source of funding for the work, or conflicts of interest.

- Main body of the manuscript, containing:

1° Structured abstract in Spanish and English. 3-5 key words. The abstract will have a maximum length of 250 words.
2° Description of the bibliographic material analysed.
3° Critical comments on the results contained in the selected works.
4° Bibliography: According to the specifications established in the group of common standards (See common standards and other supporting documents). If two or more originals have been chosen for the analysis, it is advisable to divide the section into sections at the authors' discretion.
5° Figure captions.
6° Tables and Figures in text.

Letters to the Editor: *this section will be dedicated to comments on any manuscript published in RAPD Online. This section may also include comments of a more general nature, establishing the authors' own hypotheses and suggestions, within the scientific field of Gastroenterology. The length of the texts in this section of Letters to the Editor should not exceed 2 pages (850 words), including bibliographical references. Two figures or tables may be included and the number of authors should not exceed four.*

Through the Manuscript Centre, and for the submission of a Letter to the Editor, the following information will be required:

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2° Surnames and first names of all authors. It is advisable to place a hyphen between the first and second surname.
3° Centre(s) of origin (department, institution, city and country).
4° Full postal address of the responsible author, to whom correspondence should be addressed, including telephone, fax and e-mail address.
5° Declaration on the existence or non-existence of a source of funding for the work, or conflicts of interest.

- Basic body of the manuscript, containing:

1° Text of the manuscript.
2° Bibliography: According to the specifications set out in the common standards group (See common standards and other supporting documents).

B)Common standards and other supporting documents

This refers to the set of mandatory standards, both for uniformity in the presentation of manuscripts and for compliance with current legal regulations. In general, the style of manuscripts should follow the guidelines set out in the Vancouver Agreement of the International Committee of Medical Journal Editors. (http://www.ICMJE.org).

Units, generic names and abbreviations:

- Units. Biochemical and haematological parameters shall be expressed in International Units (SI), except haemoglobin which shall be expressed in g/dL. Length, height and weight measurements shall be expressed in decimal metric units and temperatures in degrees Celsius. Blood pressure shall be measured in millimetres of mercury.
There is an aid for the conversion of non-international (non-SI) units into international (SI) units. (http://www.techexpo.com/techdata/techcntr.html).

- Generic names. The generic names of medicinal products, clinical instruments and tools and software shall be used. When a brand name is the subject of research, the brand name and the name of the manufacturer, city and country shall be included in parentheses the first time the generic name is mentioned in the Methods section.

- Abbreviations. Abbreviations should be avoided, but if they have to be used, in order not to repeat long technical names, the full word should appear the first time in the text, followed by the abbreviation in brackets, which will already be used in the manuscript.

Bibliographical references: bibliographical references should be presented in the order in which they appear in the manuscript, with a sequential number, which will appear in the appropriate place in the text, in brackets. This numbering will be maintained and will serve to order the list of all references at the end of the manuscript, as normal text and never as a footnote. Personal communications and unpublished data will not be included in the final list of bibliographical references, although they will be mentioned in the appropriate place in the text, in brackets, as appropriate, i.e. personal communication or unpublished data. When the bibliographic citation includes more than 6 authors, the first 6 authors should be cited, followed by the abbreviation et al.

The style of bibliographic references will depend on the type and format of the source cited:

- Medical journal article: journal names should be abbreviated according to the style of the Index. Medicus/Medline (http://www.ncbi.nlm.nih.gov/journals?itool=sidebar).

- Article already published in print and online journals Internet:
The authors (surname and initial of the first name, comma separation between authors), the full name of the manuscript, the abbreviation of the journal, the year of publication and after a semicolon the volume of the journal and after a colon the complete numbers of the first and last page of the paper.

Kandulsky A, Selgras M, Malfertheiner P. Helicobacter pylori infection: A Clinical Overview. Dig Liver Dis 2008; 40:619-626.

Alvarez F, Berg PA, Bianchi FB, Bianchi L, Burroughs AK,Cancado EL, et al. International Autoimmune Hepatitis Group Report: review of criteria for diagnosis of autoimmune hepatitis. J Hepatol 1999; 31:929-938.

- Admitted article, published only on the Internet, but not yet included in a regular number of the journal: the authors, the full name of the manuscript, the abbreviation of the journal, the year and month since the article is available on the Internet and DOI will be noted. The original paper to which reference is made usually details how to cite the manuscript.

Stamatakos M, Sargedi C, Stefanaki C, Safi oleas C, Matthaiopoulou I, Safi oleas M. Anthelminthic treatment: An adjuvant therapeuticstrategy against Echinococcus granulosus. Parasitol Int (2009), doi:10.1016/j.parint.2009.01.002

Inadomi JM, Somsouk M, Madanick RD, Thomas JP, Shaheen NJ. A cost-utility analysis of ablative therapy for Barrett'sesophagus, Gastroenterology (2009), doi: 10.1053/j.gastro.2009.02.062.

- Article from a journal that is published only on the Internet, but arranged in a conventional way: the authors, the full name of the manuscript, the abbreviation of the journal (can be added in brackets online), the year of publication and after a semicolon the volume of the journal and after a colon the complete numbers of the first and last page of the paper. If the original work being referenced provides the DOI and Internet address (URL), these can be added at the end of the reference.

Gurbulak B, Kabul E, Dural C, Citlak G, Yanar H,Gulluoglu M, et al. Heterotopic pancreas as a leading point for small-bowel intussusception in a pregnant woman. JOP (Online) 2007; 8:584-587.

Fishman DS, Tarnasky PR, Patel SN, Raijman I. Managementof pancreaticobiliary disease using a new intra-ductal endoscope: The Texas experience. World J Gastroenterol 2009; 15:1353-1358. Available from: URL: http://www.wjgnet.com/1007-9327/15/1353.asp. DOI: http://dx.doi.org/10.3748/wjg.15.1353

- Article from a journal that is published only on the Internet, but is not conventionally arranged: the authors, the full name of the manuscript, the abbreviation of the journal, the year of publication and the DOI will be listed.

Rossi CP, Hanauer SB, Tomasevic R, Hunter JO, Shafran I, Graffner H. Interferon beta-1a for the maintenance of remission in patients with Crohn's disease: results of a phase II dose-finding study.BMC Gastroenterology 2009, 9:22doi:10.1186/1471-230X-9-22.

-Article published in an abstract or in a supplement of a journal: the authors (surname and first initial, separated by commas between authors), the full name of the manuscript, the word abstract in square brackets, the abbreviation of the journal, the year of publication and after a semicolon the volume of the journal, followed by the abbreviation Suppl, or Supl, in brackets and after a colon the complete numbers of the first and last page of the paper.

Klin M, Kaplowitz N. Differential susceptibility of hepatocytesto TNF-induced apoptosis vs necrosis [Abstract]. Hepatology 1998; 28(Suppl):310A.

- Books: the authors of the book (surname and first initial, comma separated by the authors), the title of the book, the city where it was published, the name of the publisher and the year of publication will be listed.

Takada T. Medical Guideline of Acute Cholangitis and Cholecystitis. Tokyo: Igaku Tosho Shuppan Co; 2005.

- Chapter of a book: the authors of the chapter should be listed (surname and first initial, separated by commas between authors), followed by In: the names of the editors of the book and, after a full stop, the name of the book. The city where it was published, the name of the publisher, the year of publication and after a colon the complete numbers of the first and last page of the work.

Siewert JR. Introduction. In: Giuli R, Siewert JR, Couturier D, Scarpignato C, eds. OESO Barrett's Esophagus. 250 Questions. Paris: Hors Collection, 2003; 1–3.

- Information from a document produced at a meeting: this type of reference should be avoided whenever possible. However, if it has to be cited, the title of the subject, the name of the meeting and the city where it was held should be given. The entity that organised the meeting, and the year. The e-mail address through which the document can be accessed.

U.S. positions on selected issues at the third negotiating session of the Framework Convention on Tobacco Control. Washington, D.C.: Committee on Government Reform, 2002. (Accessed March 4, 2002, at:http://www.house.gov/reform/min/inves_tobacco/index_accord. htm.)

Figures, tables and videos: iconography, whether photographs, radiographs, diagrams or graphs, should be referred to under the generic name of "Figure". References to figures, tables and videos should be highlighted in bold. They should be numbered with Arabic numerals, according to their order of appearance in the text. Panels of two or more photographs grouped together will be considered as a single figure and may be referred to as "Figures 1A, 1B, 1C".

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Endoscopic images and other techniques generating colour images, if not directly available in electronic format, shall be scanned in colour. Special details shall be indicated by arrows, using for these and any other type of symbols the maximum contrast plot with respect to the figure.

Figure files will be identified according to their order of appearance in the text, with the name of the file, its number and surname of the first signatory (e.g.: fig1_Gómez.jpg) or the title of the article. Each image must have an associated figure caption that serves as a description. Figure captions must be submitted in a separate text document with clear reference to the figures to which they refer. Images may be inserted in Word/PowerPoint files to facilitate their identification or association with the figure captions, but they must always be submitted as separate images in the formats mentioned above.

Photographs of patients must not make them unidentifiable. If it is not possible to obtain them, the publication of the photograph must be accompanied by written permission (Model Photograph Permission Form).

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- Videos: videos must be submitted in AVI or MPEG format, processed with the CINEPAC RADIUS or MPEG codec and at a resolution of 720x576 or 320x288. It is recommended that they are edited to minimise their length, which should not exceed 2 minutes. If the video includes sound, it must be processed in MP3 format. If the videos to be included are in other formats, please contact the publisher to verify their validity. For the inclusion of videos in articles, prior authorisation must be obtained from the editorial board.

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The personal data requested from the authors will be used by the Andalusian Society of Digestive Pathology (SAPD), exclusively for the purpose of managing the publication of the article submitted by the authors and accepted in the RAPD online. Unless otherwise indicated, by submitting the article the authors expressly authorise that their data relating to name, surname, institutional postal address and e-mail address be published in the RAPD online, possibly in the annual abstracts published by the SAPD on CD support, as well as on the SAPD website and in Medline, or other bibliographic search agencies, to which the RAPD online may have access.

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- The statistical methods used, as well as the software and the name of the software used must be clearly stated in the Material and Methods Section.
-To express mean, standard deviation and standard error, the following formats must be used: "mean (SD)" and "mean ± SE". To express the median, the values of the interquartile range (IQR) must be used.
- The P must be used in capital letters, reflecting the exact value and expressions such as less than 0.05, or less than 0.0001 should be avoided.
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ORIGINAL

ANALYSIS OF THE IMPLEMENTATION OF ENDOSCOPIC TREATMENT FOR ACHALASIA USING THE POEM TECHNIQUE

Caetano Barrera IA, Martín Guerrero JM, Guil Soto A, Suárez Toribio A, Vallejo Vigo RM, García Fernández FJ

VIRGEN DEL ROCÍO UNIVERSITY HOSPITAL. SEVILLE.

Abstract

Description of the first cases of Peroral Endoscopic Myotomy (POEM) performed at Virgen del Rocio Hospital. The objective of the study is to assess outcomes, evaluate complications, and demonstrate treatment efficacy.

We prospectively analyzed treatment efficacy and complication occurrence at 3-6 months post-procedure. Changes in anthropometric parameters and symptom-related quality of life were considered, utilizing various subjective scales such as Eckardt, EAT-10, or MDADI.

The initial 26 cases from March '22 to October '23 were collected, including 3 type I achalasia, 21 type II, and 2 type III. One case had prior treatment with toxin, one with toxin and dilation, and another with dilation, the rest were treatment-naive. Mean age was 50 years.

Average intervention time was 86 minutes per procedure, with no notable incidents; Four pneumocenteses were performed. No major complications during hospital stay, with a two-day hospitalization period, all tolerating blended diet upon discharge. Improvement in symptoms and quality of life was observed in all cases, with an associated mean weight gain of 9.2 kilograms.

Six-month manometry showed hypotonia/normotonia of the lower esophageal sphincter in all cases examined. Endoscopy in 11 patients revealed grade A esophagitis in 4 of

Ignacio Arturo Caetano Barrera
Virgen del Rocío University Hospital. Seville.
ignacaebar@gmail.com

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them, controlled heartburn with proton pump inhibitors (PPIs) in 100% of patients.

POEM as a safe and effective treatment in expert hands. Manageable number of complications and procedure duration. Gastroesophageal reflux as the most common symptom, without serious consequences and controlled under PPI therapy.

Keywords: achalasia, POEM, endoscopy.

Introduction

The treatment of achalasia has been revolutionised in recent years by the implementation of advanced endoscopic techniques of the third space, beyond botulinum toxin injection, dilations and laparoscopic Heller myotomy associated with fundiplasty as a surgical alternative[1-3].

Since the first peroral endoscopic myotomies (POEM) were performed at the beginning of this century, many centres have made efforts to train and implement this technique as a minimally invasive alternative for the treatment of achalasia.

The evidence from various published studies points to similar results to the surgical alternative, with fewer serious complications, although with a higher rate of GER than in cases undergoing surgical myotomy[1,2,4,5].

The main objective of this study was to collect information on the first cases of POEM performed at the Virgen del Rocío University Hospital; to identify the patient profile, collect parameters intrinsic to the technique, monitor the occurrence of adverse effects and complications, and demonstrate efficacy based on surveys based on symptom assessment and improvement in quality of life.

Material y methods

Prospective descriptive observational study of the first 26 cases undergoing POEM in our centre, between the months of March 2022 and October 2023. All patients included had received a diagnosis of achalasia based on endoscopic findings, oesophagogastroduodenal barium study and high-resolution oesophageal manometry (HRM).

All cases were performed in a chirophanised ward with anaesthetic support, orotracheal intubation and invasive mechanical ventilation. They received oral Fluconazole the previous week. They were performed with the Hybrid knife T dissector (ERBE) and ERBE-jet injection system, with pressures of 40 bar (15-20 bar in cardia) and VIO3 electrosurgical source. Posterior myotomy was performed in all 26 patients[6].

The protocol established the introduction of a liquid diet 24 hours after the procedure and a triturated diet 48 hours later. During admission, empirical antibiotic therapy was started with Amoxicillin/Clavulanic acid, which was maintained for 5 days, or Ciprofloxacin in those patients with confirmed drug allergies.

Anthromopometric assessment parameters were collected prior to the intervention and at 3-6 months. The assessment of achalasia-related symptoms and their impact on quality of life was also carried out. For this purpose, we used the specific Eckardt (Figure 1) and EAT-10[7] (Table 2) scales, but given that these scales do not include variables that specifically assess the psychosocial sphere of the patients, we decided to add the MDADI scale[8] (Table 3), specific for the assessment of dysphagia in patients with head and neck tumours, and extrapolate the assessment to patients with achalasia. This assessment was also performed prior to the procedure and at 3-6 months after the intervention.

Other parameters were also analysed, such as geographical dispersion of the patients, type of achalasia, duration of the procedure, endoscopist, hospitalisation time, the occurrence of immediate and delayed complications, as well as the need for pneumocentesis.

Results

A total of 26 patients from different healthcare areas of western Andalusia were included (50% from the Virgen del Rocío Univ. H. area, the rest referred from other centres). The mean age was 50 years, with a range between 17 and 74 years, with a female/male ratio of 1:1. Anthropometric parameters were determined before the procedure, with a mean weight of 71.12 kg (range: 50-120 kg), with a mean BMI of 26.

The most prevalent type of achalasia in our series was type II, accounting for 81% of patients (21 cases), 11% were type I (3 cases) and 8% were type III (2 cases). A total of 88.5% had not received any previous endoscopic or surgical treatment, while 11.5% received previous endoscopic treatment, endoscopic dilatations (1), botulinum toxin injections (1) or both options (1).

Endoscopic myotomies were performed by two endoscopists with extensive experience in endoscopic submucosal dissection (ESD). The first eight cases were performed under the supervision of an expert tutor, with

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advice during the procedure, but without tutor intervention. Subsequently, the remaining POEMs were performed autonomously and alternately by each endoscopist. The mean duration of the POEM was 86 minutes with a range of 50 to 145 minutes (Figures 1 and 2), with no notable incidents and the need for pneumocentesis, during or at the end of the procedure, in 4 patients.

The average hospitalisation time was 2 days, with the introduction of a liquid diet after the first 24 hours and a triturated diet after 48 hours. Symptom and quality of life assessment scales were applied by telephone and/or face-to-face at six months after POEM.

In all cases there was a great improvement in symptoms at three months, with a mean score on the EAT-10 and Eckardt scales <3 points after the procedure. As for the MDADI scale, which includes items referring to the patients' quality of life, there was a marked improvement, with a mean score of 95.69 points (Table 4). This was accompanied by an objective weight gain of 9.2 kilograms at six months (Figure 3).

Gastro-oesophageal reflux (GER) was the most frequent undesirable effect, in line with what is described in the scientific literature, and was present in 50% (13 cases) of the patients surveyed. All with symptoms controlled with PPIs and with expression of mild oesophagitis (Los Angeles grade A) in 4 cases out of a total of 11 examinations. Six control manometry scans were performed and hypotonia/ normotonia was found in 100% of cases (Figure 3).

There were no significant differences in the type of patients treated, examination time, incidence of complications, symptomatic improvement or presence of GER between the two endoscopists.

Discussion

Endoscopic treatment of achalasia by performing peroral endoscopic myotomy (POEM), is safe and effective, achieving significant improvement in symptoms and quality of life[1,2,5]. It is feasible to incorporate this technique through a specific training programme for expert endoscopists, with very good results.

Both the mean operative time and hospital stay were significantly shorter for the endoscopic technique compared to the surgical technique (86 minutes in our study compared to 97.6 minutes described in some reviews)[1]. Recovery was early, with all patients tolerating a triturated diet at discharge. It is also worth noting the absence of relevant complications in the entire series, including the first cases, both during the intervention and in the subsequent evolution, which reinforces the safety of this procedure.

The scales described above (Eckardt, EAT-10 and MDADI) showed a great improvement in both symptoms and quality of life after endoscopic intervention. Most patients were asymptomatic at clinical examination. In symptomatic patients, the main symptom was mild GER which was controlled with single dose PPI treatment, as described in published series[4,5,6]. Also, in the follow-up endoscopy, peptic lesions were mild (grade A) and not always correlated with clinical GER.

Given the published clinical evidence and the experience at our centre, we believe that the development of this technique represents a paradigm shift in the therapeutic algorithm for achalasia, with POEM being non-inferior to classic surgical treatment, and therefore both treatment options should be offered to a patient diagnosed with achalasia[1,2,5]. The other classical endoscopic treatment options (botulinum toxin and pneumatic dilatation) should be relegated to special cases, mainly for patients rejected for POEM due to high anaesthetic risk.

(0-12)	Eckardt scale			
	Weight loss (kg)	Dysphagia	Regurgitation	Chest pain
0	Absence	Absence	Absence	Absence
1	<5	Occasional	Occasional	Occasional
2	5 to 10	Daily	Daily	Daily
3	>10	At every meal	At every meal	At every meal

Table 1. ***Assessment of achalasia symptoms using the Eckardt scale (0-12 points).***

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Questions set out in EAT-10	0-40
0= not a problem 1 2 3 4= is a serious problem	
My swallowing problem causes me to lose weight	
My swallowing problem interferes with my ability to eat away from home	
Swallowing liquids is an extra effort for me	
Swallowing solids takes extra effort	
Swallowing pills takes extra effort	
Swallowing is painful	
The pleasure of swallowing is affected by my swallowing problem	
When i swallow, food sticks to my card	
Coughing when i eat	
Swallowing is stressful.	

Table 2. ***EAT-10 questionnaire for dysphagia assessment (0-40 points).***

M.D. Anderson Dysphagia Inventory MDADI	0-100
Strongly disagree=1 Agree=2 No opinion=3 Disagree=4 Strongly disagree=5	
My swallowing difficulties limit my daily activities.	
I am embarrassed by my eating habits	
People often have difficulty cooking for me.	
I have more difficulty swallowing at the end of the day	
I hold back/feel self-conscious when I eat.	
I feel uncomfortable with my swallowing problem.	
I have a hard time swallowing	
My swallowing difficulty causes me to lose income (earnings).	
I take longer to eat because of my swallowing problems.	
People ask me why can't you eat that?	
Other people are bothered by my eating problems.	
I cough when I try to drink liquids	
My swallowing problem limits my social and personal life.	
I have trouble eating out with my friends, neighbours and family.	
I limit the amount of food I eat because of my difficulty swallowing.	
I am unable to maintain my weight because of my swallowing problem.	
I have low self-esteem because of my swallowing problems.	
I feel as if I am swallowing too much food.	
I feel left out because of my eating habits.	

Table 3. ***MD Anderson Dysphagia Inventory Questionnaire (100-0 points). Assessment of dysphagia and its impact on patients' quality of life.***

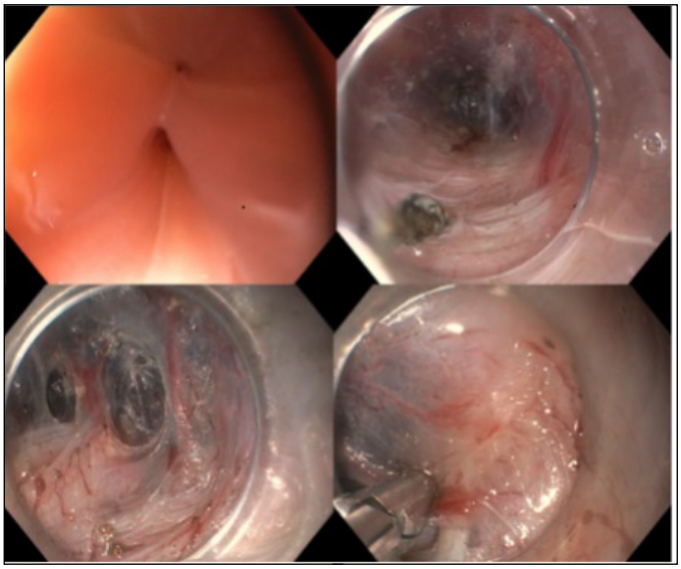

Figure 1. ***Graphic description of the endoscopic technique. Mucosotomy and endoscopic tunnelling can be seen, performing haemostatic treatment on the vessels located in the submucosa.***

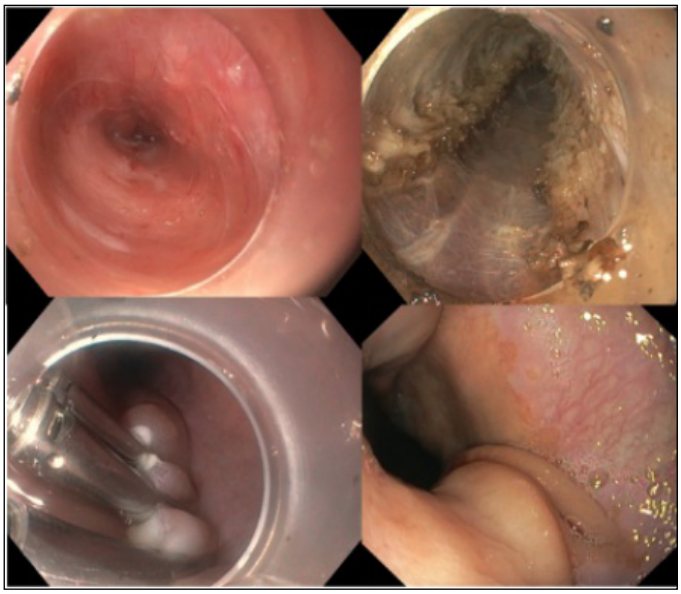

Figure 2. ***The result after tunneling and mucosotomy closure is shown. The lower right quadrant shows the endoscopic result months after completion of POEM.***

One of the limitations of this study is that it is a short series of patients treated and from a single centre. We have also had difficulties in performing the manometric and endoscopic controls within the times established by the initial protocol (3-6 months), due to the high demand for these examinations. The lack of standardisation of the MDADI scale to specifically assess dysphagia in patients with achalasia may also be a limitation, although we believe it can be extrapolated.

We have now increased the number of cases in our series to 38, which we will evaluate to check the consistency of the

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Origin	Area HVR	13 (50%)
	Other areas	13 (50%)
Average age	50 years (17 - 74)	
M:F	1 (13:13)	
Type	I	11%
	II	81%
	III	8%
Naive	23	88.5%
POEM time	86 min (50 - 145)	
Hospitalisation	2 days (2-4)	
Weight Kg	71.12 (50-120)	
BMI	26	
Weight gain kg	9.2	
	pre-POEM	post-POEM
ECKARDT (0-12)	7.96	0.67
EAT-10 (0-40)	27.87	2.27
MDADI (100-20)	44.71	95.69

Table 4. ***Summary of the most relevant results collected in the study.***

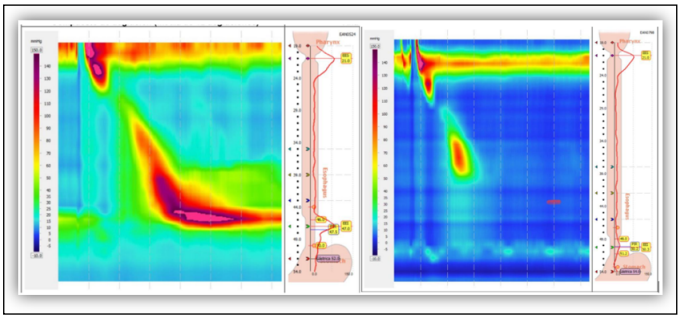

Figure 3. ***The manometric changes that occurred on the lower esophageal sphincter after the POEM were carried out can be seen.***

results. The SAPD digestive endoscopy working group has also proposed the creation of an Andalusian registry of POEMs with the aim of carrying out a multicentre study.

Conclusions

Peroral endoscopic myotomy can be safely incorporated into the therapeutic arsenal of endoscopy with adequate tutoring, in the hands of expert endoscopists.

It is a safe technique, with few complications, achieves a long-lasting improvement in symptoms and quality of life, with reasonable operating time (< 90 min) and an average hospital stay of less than 3 days.

The most common adverse effect is gastro-oesophageal reflux, only some with mild oesophagitis and symptomatic control with low doses of PPIs.

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CLINICAL CASE

ENTEROPATHY-ASSOCIATED T-CELL LYMPHOMA: FROM INDOLENT TO AGGRESSIVE.

Moreno Barrueco M, Bailón Gaona MC, Gijón Vilanova R, Berdugo Hurtado F, García Robles A
SAN CECILIO UNIVERSITY CLINICAL HOSPITAL. GRANADA.

Abstract

Enteropathy-associated T-cell lymphoma (EATL) is a rare neoplasm that accounts for <5% of peripheral T-cell lymphomas. EATL is derived from malignant transformation of intestinal intraepithelial lymphocytes and is the most common neoplastic complication of celiac disease. It is rare in patients diagnosed at a young age, although in long-standing coeliac disease it may be the debut of the disease. Its diagnosis involves imaging techniques, biopsies and immunohistochemistry, the main tool needed being a high diagnostic suspicion. The prognosis is poor and there is currently no consensus on the best therapeutic approach.

Keywords: T-lymphoma, celiac disease, indolent.

Introduction

The gastrointestinal tract is a common site for the seat of extranodal lymphomas. Primary gastrointestinal lymphomas are predominantly type B, and T-cell neoplasms are rare and account for 13-15% of gastrointestinal lymphomas. Enteropathy-associated T-cell lymphoma (EATL) is a rare neoplasm, accounting for <5% of peripheral T-cell lymphomas and is a frequent complication of celiac disease.

Clinical case

A 59-year-old man with a history of incidental finding in 2016 of mesenteric adenopathies by abdominal CT in the context of epigastralgia and constitutional symptoms, subsequently studied by haematology by PET-CT (Figure 1), which describes the presence of retroperitoneal and mesenteric non-catching adenopathies, without being able to rule out the possibility of indolent mature lymphoid neoplastic involvement; An excisional biopsy was therefore performed on one of the lymph nodes, in which the anatomopathologists described mild lymphoid hyperplasia, with no signs of malignancy. Subsequently, he was diagnosed with coeliac disease in April 2022 due to a study of hypertransaminasemia with positive transglutaminase antibodies and HLA DQ2 +. An upper gastrointestinal endoscopy (EGD) and duodenal biopsies were performed to confirm the diagnosis, describing partial villous flattening (Marsh type 3a lesions) and intraepithelial

Melody Moreno Barrueco
San Cecilio University Clinical Hospital. Granada.
melodymoreeb@usal.es

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lymphocytosis (more than 6 CD3+ lymphocytes per 20); with a good response to the gluten-free diet. In May 2022, she was admitted to neurology in May 2022 for the debut of seronegative myasthenia gravis, with treatment commencing in December 2022 with azathioprine 1mg/kg due to persistent diplopia.

He was admitted to our department in June 2023 due to afternoon fever, watery diarrhoea and loss of more than 15 kg in the last 3 months. After verifying good adherence to the gluten-free diet, a new EDA was performed with biopsies that described intense villous atrophy and CD3+ intraepithelial lymphocytosis, which in numerous points was greater than 100 lymphocytes per 100 enterocytes and on average far exceeded 50 lymphocytes per 100 enterocytes, as well as the presence of intense superficial plasmacytosis together with crypt hypertrophy. Immunophenotypically, loss of CD8- and clonal rearrangement for the TCR gamma gene, probably related to refractory celiac disease type II.

The study was completed with capsule endoscopy with the finding of multiple ulcerated areas at the level of the jejunum with surrounding thickening (Figure 2). Given the torpid clinical course, with persistent diarrhoea, fever and clear signs of malnutrition, as well as the findings previously described in imaging tests, a repeat PET-CT scan was performed to re-evaluate the lymphadenopathies previously studied, with the latter showing hypermetabolic supra- and infra-diaphragmatic lymphadenopathies suggestive of a neoplastic process (Figure 3).

The patient suffered an abrupt clinical and analytical deterioration in the following 48 hours with signs of liver failure and possible associated haemophagocytosis, and so the haematology department was informed of the possibility of marrow infiltration by the neoplastic process, and a bone marrow biopsy was performed with the result of infiltration by a CD30+ large T-cell lymphoproliferative process, together with macrophages with signs of haemophagocytosis. Empirical treatment with chemotherapy (mini-CHOP) was started urgently without success, and the patient died in the following days due to acute liver failure.

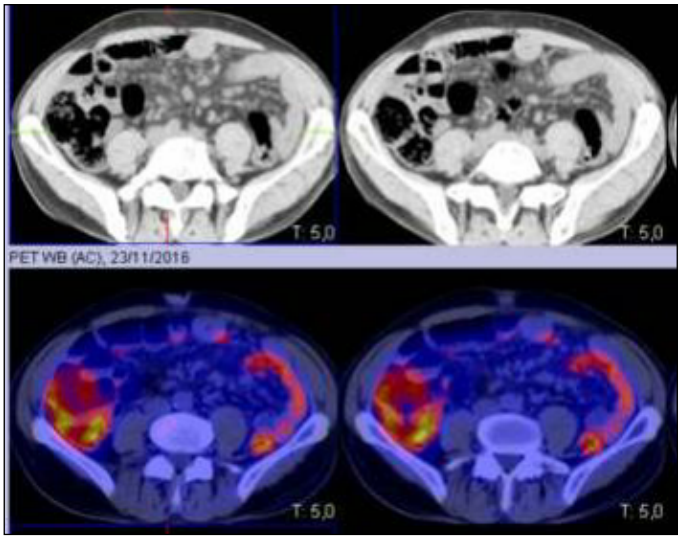

Figure 1. ***PET-CT scan performed in 2016 described the presence of retroperitoneal and mesenteric non-catching adenopathies, without being able to rule out the possibility of indolent mature lymphoid neoplastic involvement.***

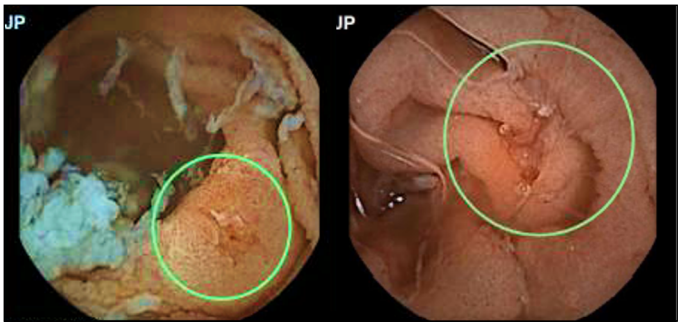

Figure 2. ***Endoscopic capsule images showing multiple ulcerated and thickened surrounding areas at the level of the jejunum.***

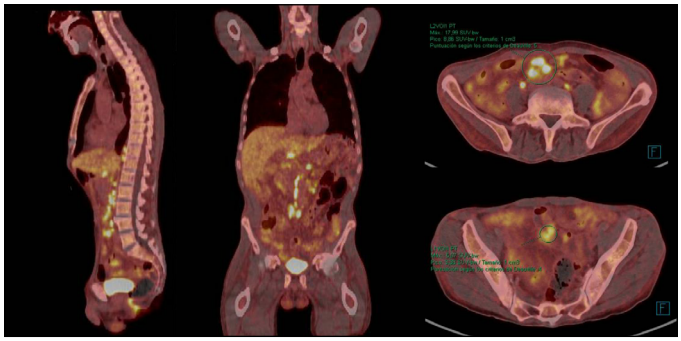

Figure 3. ***PET-CT scan for re-evaluation of previously studied adenopathies with the finding of hypermetabolic supra and infra diaphragmatic adenopathies suggestive of a neoplastic process.***

Discussion

Enteropathy-associated T-cell lymphoma (EATL) arises from malignant transformation of intestinal intraepithelial lymphocytes and is the most common neoplastic complication of celiac disease. It slightly predominates in males (54%), mainly older than 50 years. It is uncommon in patients diagnosed early or with long-standing coeliac disease, and may even present as the initial form of the disease. Other factors associated with its occurrence are viral infection and the presence of the HLA-DQ2 haplotype. Although there are sporadic cases, refractory coeliac disease (RCD) type II is strongly associated as a preneoplastic process.

90% of cases of EATL are located in the small intestine, mainly in the jejunum, where multiple ulcers are often found. They can spread beyond the gastrointestinal tract, the most

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relevant locations being abdominal lymph nodes (35%), bone marrow (3-18%), pulmonary and mediastinal lymph nodes (5-16%).

Clinically, it may present with symptoms similar to RCD, such as diarrhoea, abdominal pain, weight loss and hypoalbuminaemia. Therefore, computed tomography (CT), PET-CT and capsule endoscopic imaging are useful to identify the progression of RCD to LTLE. It may also manifest with vomiting due to intestinal obstruction, intestinal haemorrhage and intestinal perforation in up to 50% of patients. Haemophagocytic syndrome is reported in 16-40% of cases.

Information on the pathogenic mechanisms is limited due to its rarity, although it has been suggested that an inflammatory microenvironment, especially mediated by the JAK-STAT pathway, might have a high impact on its lymphomagenesis.

Early diagnosis requires a high degree of suspicion and careful examination of intestinal biopsies. Morphologically, it is characterised by pleomorphic cytology, so immunohistochemistry is crucial for diagnosis. Neoplastic cells are usually CD3 + CD7 +, CD103 + cells, TCRβ +/-, CD4-, CD8- and CD5-, with primary expression of CD30 and negativity for CD56. Genetic susceptibility has been demonstrated in patients with HLA-DQ2.5 homozygosity, observed in up to 53.3% of patients with EATL.

The prognosis is poor, with survival rates of around 1 and 5 years. There is no standardised treatment for this aggressive lymphoma. Surgery and chemotherapy (CHOP regimen) are considered treatment options, but EATL tends to be refractory to these therapies, with an overall median survival of 6 months despite their application.

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CLINICAL CASE

EDEMOASCITIS DECOMPENSATION. IS IT ALWAYS LIVER CIRRHOSIS?

Fernández Carrasco M, López González J, Campos Serrano N
TORRECARDENAS UNIVERSITY HOSPITAL. ALMERIA.

Abstract

Portal hypertension (PH) is a clinical syndrome characterized by an increase in the portal hepatic venous pressure gradient (HVPG), defined as the gradient between the portal vein and the inferior vena cava. When there is clinically significant PH, it is usually associated with clinical events such as the development of esophagogastric varices (EGV), oedemoascitic decompensation, encephalopathy... these being more frequent in the case of PH due to liver cirrhosis.

In all etiologies of PH there is an increase in resistance to portal blood flow, followed by an increase in said flow. Depending on the location of the increased resistance, it will be classified as prehepatic, intrahepatic or posthepatic PH[1]. Posthepatic portal hypertension occurs when there is a deterioration in hepatic venous outflow, increasing resistance at this level.

We present the case of a patient where a striking portal dilation led to the diagnosis of posthepatic PH.

Keywords: posthepatic portal hypertension, ascites, membranous occlusion of the inferior vena cava.

Clinical case

A 72-year-old man with no personal history of interest or toxic habits was admitted for diarrhoea of two months' duration, associated with constitutional syndrome, ascites and new-onset oedema.

Laboratory tests showed slight leukocytosis with neutrophilia, slight deterioration of renal function with creatinine 1.34mg/dl and hypoalbuminaemia, with normal platelets, hepatobiliary profile and coagulation.

Marta Fernández Carrasco
Torrecardenas University Hospital. Almeria.
mfcarrasco16@gmail.com

Fernández Carrasco M, López González J, Campos Serrano N. Edemoascitis decompensation. Is it always liver cirrhosis? RAPD 2024;47(5):187-189. DOI: 10.37352/2024474.3

During admission, abdominal ultrasound, computed tomography (CT) and angioCT (imaging) were performed, showing findings suggestive of chronic liver disease and very striking dilatation of the main portal and both intrahepatic branches, with reduced calibre at the level of the inferior vena cava, in the segment entering the liver that appears practically filiform, as well as reduced calibre of the proximal segment of the suprahepatic veins, these being permeable, with no associated splenomegaly. Upper gastrointestinal endoscopy ruled out the presence of varicose veins and echocardiography was performed, with no abnormalities.

During admission, the patient evolved favourably, maintaining a good diuresis rate, decreasing oedema and abdominal perimeter with depletive treatment, reaching the diagnosis of post-hepatic PH secondary to membranous obliteration of the inferior vena cava.

Discussion

Post-hepatic portal hypertension occurs when there is impaired hepatic venous outflow and increased resistance at this level[1]. The most common cause of posthepatic PH is Budd-Chiari syndrome (BCS), right heart failure or obstruction of the inferior vena cava by tumours, thrombosis or caudate enlargement[2].

BCS is a clinical entity that encompasses a group of syndromes that can cause obstruction of hepatic venous drainage at any level, from the small hepatic veins to the junction of the IVC with the right atrium[2].

It is a rare entity. The main causes are neoplastic, haematological, inflammatory, infectious and pharmacological. However, after ruling out these aetiologies, other less common ones should be considered, such as membranous occlusion of the IVC (MOIVC), also known as obliterative hepatocavopathy, or hepatic vena cava syndrome[3].

Regarding the pathophysiology, a congenital origin due to a failure in the embryogenesis of the inferior vena cava (IVC) has been proposed, although different studies have established the probable acquired origin or the possible membranous transformation that causes stenosis at the level of the inferior vena cava[4].

Clinically, it manifests with signs of PH. Analytically, there is no major alteration of liver function. It has also been associated with the development of hepatocarcinoma, a priori less aggressive than that due to other aetiologies. Imaging tests will provide the diagnosis, with the "IVC reverse flow" sign

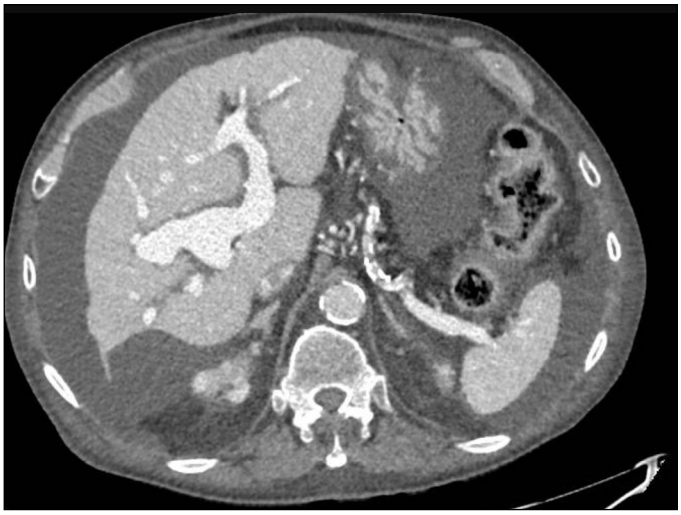

Figure 1. ***Abdominal CT image in venous phase showing large dilatation of both intrahepatic portal branches.***

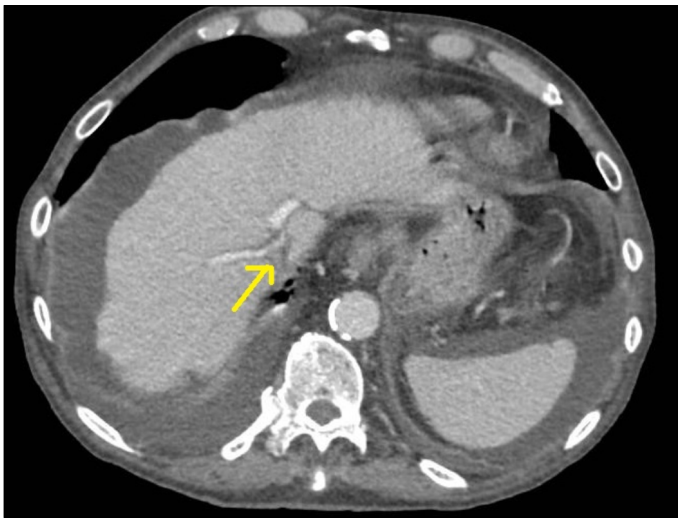

Figure 2. ***AngioCT image in the venous phase showing a decrease in the calibre of the inferior vena cava in the segment entering the liver, appearing practically filiform, with reduced calibre of the proximal segment of the suprahepatic veins.***

and the "jet bleed" sign on CT and MRI being specific to BCS subtype membranous obliteration[5].

Diagnosis is based on clinical features mentioned above and visualisation on imaging tests, and can distinguish complete from partial occlusion. Computed tomography or cavography by contrast administration can highlight the level of obstruction at which a retrograde leak or IVC reverse flow sign occurs[3].

The treatment of choice for MOIVC is endovascular recanalisation of the obstructed area by percutaneous balloon angioplasty, which is effective in up to 91% of cases. Other less commonly used surgical techniques include membranotomy, membranectomy or shunts[1,3]. Complications associated with PH are treated similarly to other aetiologies.

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Currently, MOIVC is included among the possible causes of Budd-Chiari syndrome, although some authors suggest that it could be considered a distinct syndrome[3]. The importance lies in the possibility of curative treatment, which would avoid the high morbidity and mortality secondary to PH decompensation, as well as the risk of developing hepatocarcinoma.

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FROM CAUSTIC SODA INGESTION TO FEEDING JEJUNOSTOMY

Campos Gonzaga L, Aguilar Martínez JC, Moreno García A
HOSPITAL OF JEREZ DE LA FRONTERA. CÁDIZ.

Abstract

We present the case of a young woman who after ingestion of caustic soda for autolytic purposes presented diffuse stenosis in the middle and lower thirds of the esophagus and extensive and marked stenosis of the body, gastric antrum and duodenal bulb that required a feeding jejunostomy due to total intolerance to solids and liquids.

Given the characteristic endoscopic and radiological findings, as well as its difficult subsequent management, it is a challenging clinical case.

Keywords: caustic ingestion, stricture, jejunostomy.

Introduction

Caustic ingestion often leads to high morbidity and mortality, ranging from mild cases without lesions to severe cases with total necrosis of the upper digestive tract. The intensity and location of the lesions depend on several factors, the most important being the type of caustic (alkalis have greater penetrating power).

Clinical case

32-year-old woman with a personal history of anxious-depressive syndrome under follow-up since 2019 by the Mental Health unit with several self-harm attempts. In July 2023 she made an autolytic attempt due to caustic ingestion, showing caustic oesophagitis Zargar grade IIIb (Figure 1), caustic gastritis Zargar grade IIIb, caustic duodenitis Zargar grade IIIb (Figure 2) and caustic lesions in Killian's mouth on upper gastrointestinal endoscopy (EGD), performed at 24 hours, and caustic lesions in Killian's dehishence. She was admitted to the ICU for 7 days and then to the ward with parenteral nutrition for 3 weeks. Prior to discharge, tolerance to liquids and triturates was started with a good response. In the following months the patient visited the emergency department on several occasions, presenting in September 2023 with marked intolerance to solids and liquids that caused vomiting and made it impossible to take oral treatment.

A barium study performed during follow-up showed diffuse stenosis in the middle and lower thirds of the oesophagus and extensive and marked stenosis of the body, gastric antrum and duodenal bulb (Figure 3). For this reason, IC was referred to surgery, proposing a feeding jejunostomy, after performing an

Lidia Campos Gonzaga
Hospital of Jerez de la Frontera. Cadiz.
lidiacamposgonzaga@hotmail.com

Campos Gonzaga L, Aguilar Martínez JC, Moreno García A.
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EGD, which showed impassable oesophageal stricture 30 cms from the dental arch.

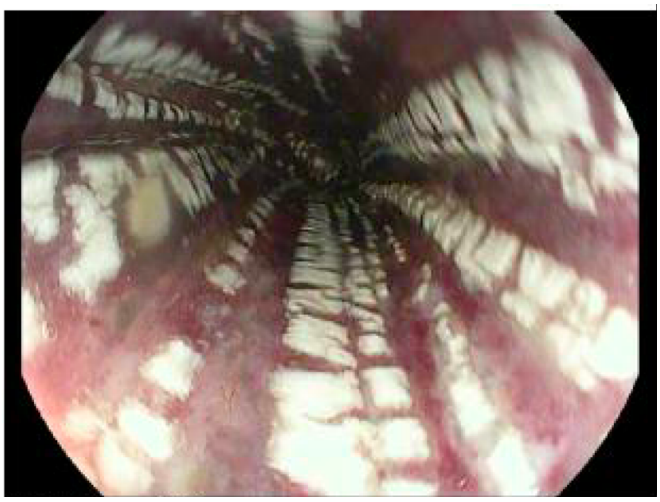

Figure 1. ***From the cervical oesophagus to the middle oesophagus, the mucosa shows oedema, with superficial fibrinous ulcerations with diffuse exudate occupying the entire oesophageal circumference. The lesions become more intense in the distal oesophagus, with the oesophagus acquiring a blackish-ischaemic appearance, with deep ulcerations with a dirty bottom that occupy the entire oesophageal circumference.***

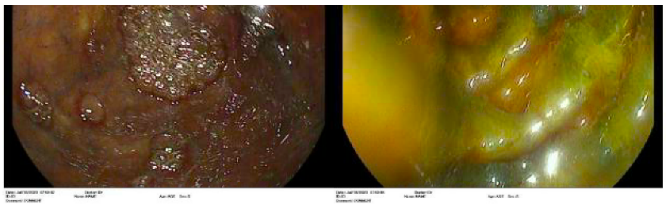

Figure 2. ***Gastric cavity with black mucosa with diffuse mucous exudate, with more expressive lesions in the antral region with deep ulcers with a dirty bottom. The mucosa of the duodenal bulb and second portion shows large diffuse ulcerations, confluent at some points.***

Discussion

The management of patients with caustic ingestion lesions is complex, posing a real therapeutic challenge, not only in the acute phase but mainly in the late phase. Strictures usually appear from the second to third week, and may manifest themselves clinically after months or years, and the risk of developing squamous cell carcinoma is increased.

Endoscopic dilatation or prosthesis placement can be considered in localised and short strictures, but in cases such as our patient's, coordination between the surgical and medical teams is required to obtain the best results.[1,2].

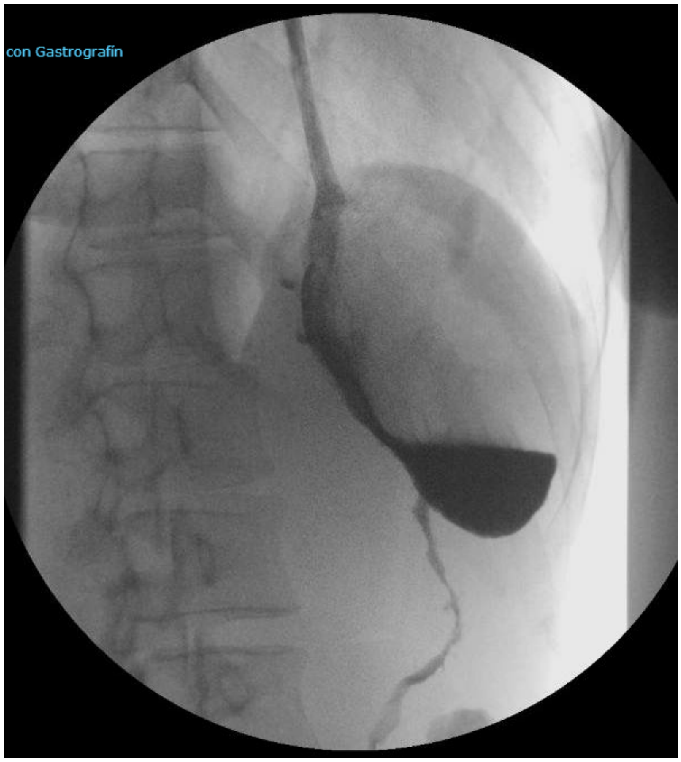

Figure 3. ***Oesophageal stricture with a marked decrease in diameter, with a luminal diameter of 4 mm. There is extensive and marked stenosis of the body, gastric antrum and duodenal bulb, with filiform passage of contrast, with marked irregularity of the contour, compatible with marked thickening of folds and ulcerations. Scarce passage of contrast into the duodenal frame.***

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CHRONIC ISCHEMIC GASTROPATHY AS AN UNUSUAL CAUSE OF ABDOMINAL PAIN

Fernández Carrasco M, Plaza Fernández A, Navarro Moreno E, Anguita Montes F, Gálvez Miras A
TORRECÁRDENAS UNIVERSITY HOSPITAL, ALMERIA.

Abstract

Ischaemic gastropathy is a rare condition with a highly variable clinical spectrum. Its presentation varies from chronic abdominal pain to fatal cases of fulminant gastric ischaemia if it develops abruptly[1]. There are several aetiologies of abdominal pain, however, early diagnosis of this pathology will allow a targeted therapeutic approach, which may improve prognosis and avoid fatal consequences.

Keywords: ischemic gastropathy, cardiovascular risk factors, revascularization.

Clinical case

We present the case of a 57-year-old male smoker with a history of arterial hypertension, dyslipidaemia and revascularised ischaemic heart disease, who was admitted for abdominal pain in the mesogastrium that intensified after eating, of two months' duration, associated with anaemia and weight loss.

We present the case of a 57-year-old male smoker with a history of arterial hypertension, dyslipidaemia and revascularised ischaemic heart disease, who was admitted for abdominal pain in the mesogastrium that intensified after eating, of two months' duration, associated with anaemia and weight loss. Upper gastrointestinal endoscopy was performed with findings of linear fibrinous ulcers in the antrum, with a change in the colour of the gastric mucosa after insufflation, showing whitish areas suggestive of areas of hypoperfusion (Figure 1). The study was completed with computed tomography angiography showing evidence of calcified atheromatous disease leading to severe stenosis at the origins of the celiac trunk and superior mesenteric artery (Figures 2 and 3).

The patient underwent surgery to recanalise the celiac trunk and implant a stent in the superior mesenteric artery, with resolution of the clinical condition that precipitated admission.

Marta Fernández Carrasco
Torrecárdenas University Hospital, Almeria.
mfcarrasco16@gmail.com

Fernández Carrasco M, Plaza Fernández A, Navarro Moreno E, Anguita Montes F, Gálvez Miras A
Chronic ischemic gastropathy as an unusual cause of abdominal pain
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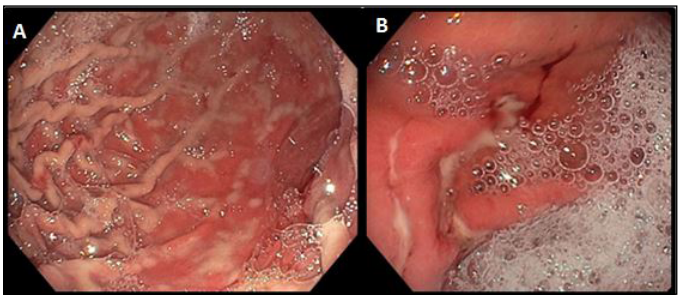

Figure 1. ***Upper endoscopic images of: gastric chamber at maximum insufflation with pale gastric fold mucosa (A) and fibrinous linear ulcers (B).***

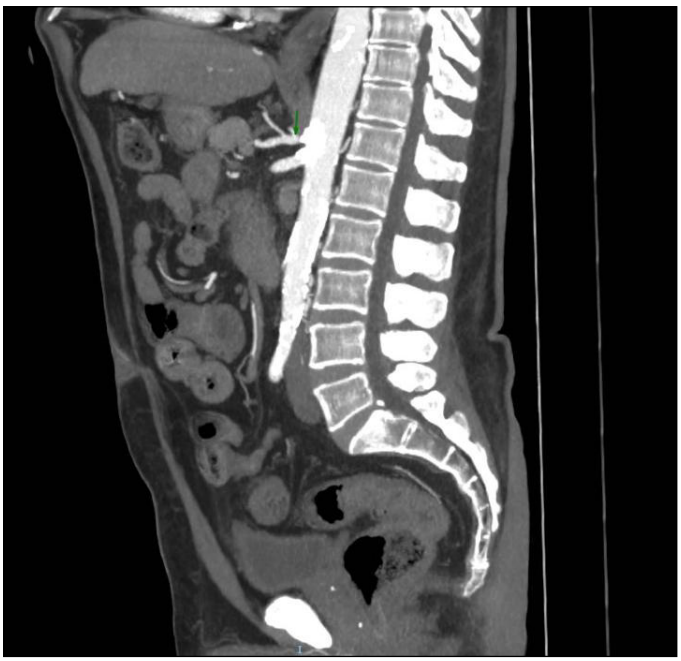

Figure 2. ***Computed tomography angiography showing aortic calcified plaque at the exit of the celiac trunk and superior mesenteric artery.***

Discussion

Due to the rich collateral circulation from the branches of the celiac trunk and the superior mesenteric artery, gastric ischaemic pathology is rare. The aetiology is in almost all cases atheroembolic[2], which has led to an increase in its incidence in recent decades, due to the ageing of the population and the rise of cardiovascular diseases.

Clinical manifestations may occur in a larval form in chronic cases, in which postprandial pain is the predominant symptom, and may be accompanied by anaemia due to gastrointestinal bleeding and weight loss due to fear of ingestion. However, in acute cases of abrupt occlusion of one of the main branches, fulminant gastric ischaemia occurs with a fatal short-term prognosis and high mortality[1,4].

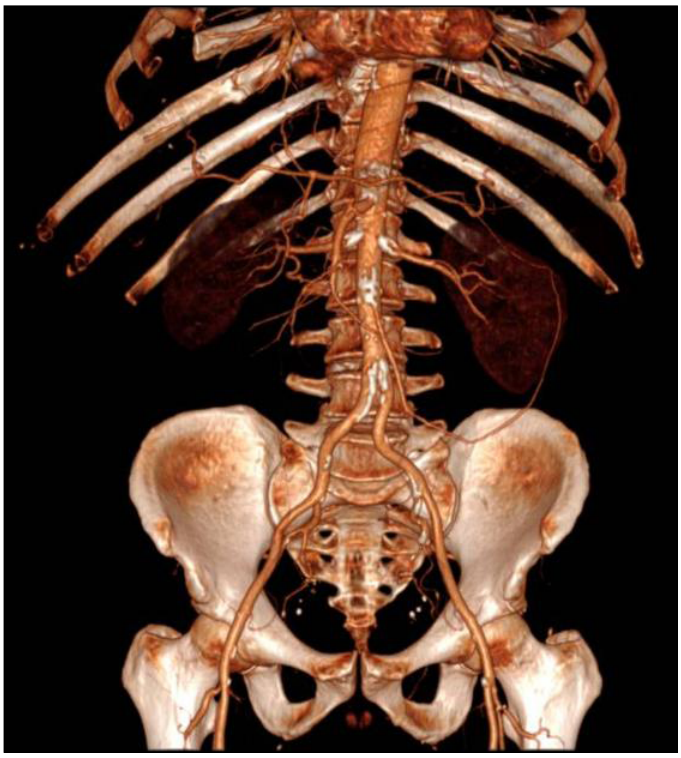

Figure 3. ***Three-dimensional reconstruction of vascular alterations described in angiotomography.***

Treatment, whenever possible, is early revascularisation, preferably percutaneous endovascular angioplasty with stent placement to prevent restenosis of the same segment[5].

This is therefore a case that highlights the importance of the differential diagnosis of abdominal pain, with clinical suspicion of this entity being essential in patients with suggestive symptoms and established cardiovascular risk factors, as it has been shown that early revascularisation significantly improves survival rates[6].

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LETTER TO EDITOR

SPLENIC INFARCTION WITHOUT THROMBOSIS SECONDARY TO SEVERE ACUTE PANCREATITIS

Aguirre-Sánchez Cambronero JA, Rodríguez Fernández S, Pérez Villafáñez A, Arias Ortega M, Legaz Huidobro ML, González Carro P

MANCHA CENTER GENERAL HOSPITAL. CIUDAD REAL.

Abstract

Introduction: Acute pancreatitis is a common disease that is usually mild, although in some cases it may present complications, among which are vascular ones such as splenic infarction.

Clinical case: A 71 years old woman was admitted for acute pancreatitis, who presented a torpid evolution throughout the first admission with associated acute cholecystitis and an encapsulated necrotic collection that required endoscopic drainage using a luminal apposition prosthesis and endoscopic necrosectomy. A month and a half later, the patient was readmitted for abdominal pain, with abdominal CT scan showing a very thinned splenic vein and patent artery without identifying thrombosis (with 700,000 platelets/mm3), associated splenic infarction as well as worsening of the inflammation of pancreatitis. Given these findings, we were decided to start anticoagulation with enoxaparin at prophylactic doses for splenic vascular stenosis, achieving resolution of the thrombocytosis (410,000 platelets/mm3), disappearance of the splenic necrotic area and improvement of the pancreatic inflammatory component confirmed by CT scan.

Conclusion: When splenic infarction is associated with severe pancreatitis with splenic thrombosis, anticoagulation is indicated. However, when there is no splenic thrombosis and the splenic infarction occurs in the context of critical vascular stenosis with high thrombocytosis, the indication for anticoagulation is controversial, with no consensus in the literature. Furthermore, at present it is not establish the active ingredient to be used or its dose, and highlights the need to carry out clinical trials in order to establish clinical or consensus guidelines.

Keywords: splenic infarction; severe acute pancreatitis.

Introduction

Acute pancreatitis is a disease with a high and increasing incidence in our environment and is a frequent cause of hospitalisations[1]. Vascular complications are an infrequent complication of severe pancreatitis[1], including splenic infarction, which is increasingly being described in association with inflammatory processes of the pancreas, justified by the close relationship between the pancreas and the splenic hilum[2].

Clinical case

A 71-year-old woman was admitted for acute pancreatitis with a torpid evolution throughout the first admission. Two

José Antonio Aguirre Sánchez-Cambronero
Mancha Center General Hospital. Ciudad Real.
jaguirresanchez@gmail.com

Aguirre-Sánchez Cambronero JA, Rodríguez Fernández S, Pérez Villafáñez A, Arias Ortega M, Legaz Huidobro ML, González Carro P. Splenic infarction without thrombosis secondary to severe acute pancreatitis. RAPD 2024;47(5):195-197. DOI: 10.37352/2024475.6

weeks later, she presented clinical and analytical worsening due to acute cholecystitis, which was detected in imaging tests and treated with empirical antibiotic therapy. One month after admission, he presented a new clinical and analytical worsening, and an echoendoscopy was performed, visualising a small collection of 4cm in the pancreatic body with a permeable splenic axis and another collection suggestive of an infected encapsulated necrotic collection measuring 6x6x8cm adjacent to the compressing gastric body, and transmural drainage was performed using a Hot-Axios luminal apposition metal prosthesis, draining abundant pus. On successive days, endoscopic necrosectomy was performed through the prosthesis, which was finally removed and a 7Frx10cm pig-tail plastic prosthesis was placed, with radiological improvement prior to discharge. In addition, enzyme replacement treatment with Kreon 50000 was started after each main meal.

One and a half months later, the patient came to the emergency department complaining of severe abdominal pain in the left hypochondrium-flank without fever. Laboratory tests showed elevated acute phase reactants, thrombocytosis, mild coagulopathy and a normal pancreatic profile. An abdominal CT scan was requested, showing radiological worsening with a greater inflammatory component and peripancreatic fluid, very thinned splenic vein with permeable splenic artery and signs compatible with splenic infarction without identifying thrombosis (Figure 1) with associated thrombocytosis (700,000 platelets/mm3). It was decided to anticoagulate the patient with enoxaparin at prophylactic doses due to splenic vascular stenosis. After discharge and review in consultation, resolution of the thrombocytosis (410,000 platelets/mm3) and stenosis was observed due to a decrease in the pancreatic inflammatory component, homogenisation of the spleen and disappearance of the splenic necrotic zone (Figure 2) with no new collections and a decrease in inflammatory changes in the control CT scan; anticoagulation was therefore withdrawn.

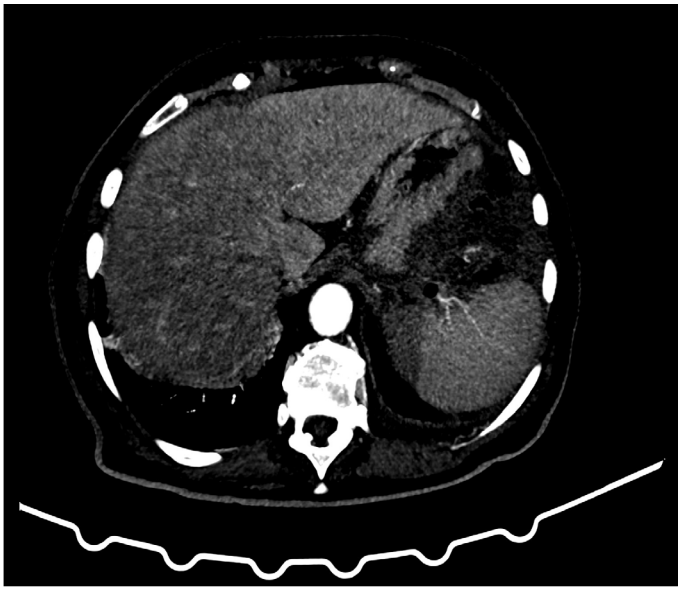

Figure 1. ***The arterial phase shows a thinned splenic artery at the level of the splenic hilum with a hypodense splenic area compatible with splenic infarction.***

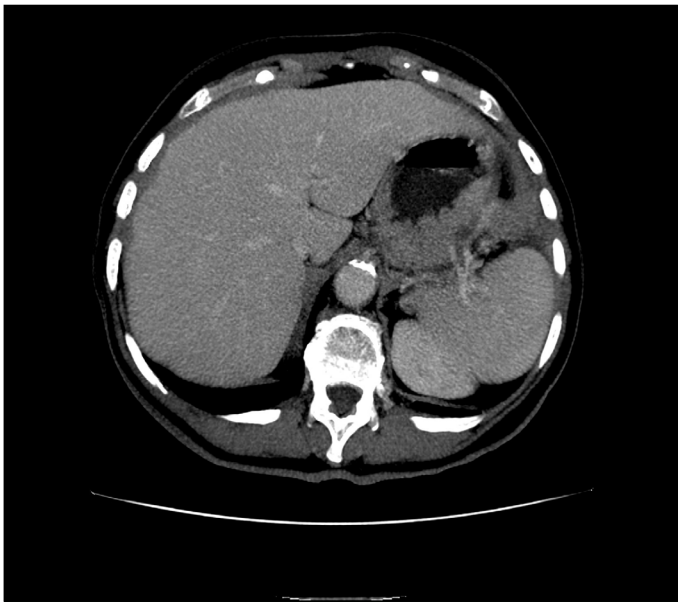

Figure 2. ***In the portal phase, an increase in the calibre of the splenic artery and repermeabilisation of the splenic vein at the level of the hilum with homogenisation of the spleen and disappearance of the splenic infarction are identified.***

Discussion

Splenic infarction is a complication increasingly described in association with inflammatory processes of the pancreas, the incidence of which is increasing. The most frequent symptom is left hypochondrium pain, which may be accompanied by fever, chills, nausea and vomiting, pleuritic pain and left shoulder pain (Kher's sign)[2] as described in our patient.

In splenic infarction associated with arterial and/or venous thrombosis, the treatment of choice is anticoagulation without specifying the drug used[3]. A recent retrospective cohort study has compared the benefits of initiating anticoagulation with both heparin followed by vitamin K antagonists and the use of direct-acting oral anticoagulants, establishing that there is an improvement in survival without increasing the risk of bleeding[4]. Thrombolysis and/or thrombectomy would be indicated if symptoms persist despite anticoagulation, reserving surgery if complications such as mesenteric ischaemia develop[5].

In splenic infarction associated with severe pancreatitis, the indication for anticoagulation is controversial and there

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is no consensus in the literature. No references have been found on how to proceed in cases of splenic infarction without thrombosis and with critical vascular stenosis in the context of a complication of severe pancreatitis.

In our case, we considered whether or not to anticoagulate the patient because the splenic infarction was associated with marked thrombocytosis without thrombosis. Given her age, we opted to use enoxaparin at prophylactic doses in order to avoid splenic thrombosis until the inflammation in the area improved or resolved, which would secondarily improve the splenic vascular stenosis. Subsequently, months later, after analytical and radiological control, the resolution of thrombocytosis and vascular stenosis was verified, and enoxaparin was discontinued.

In summary, the treatment of splenic infarction without thrombosis secondary to severe acute pancreatitis is a therapeutic challenge. The decision of whether or not to anticoagulate, the active ingredient to use and its dose, is currently undefined and highlights the need for clinical trials in order to establish clinical or consensus guidelines.

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DR. FRANCISCO GALLEGO ROJO

On 29 July 2024 we woke up to the tragic and unexpected news of the passing of Dr. Francisco Javier Gallego Rojo, head of the Digestive Unit at the Poniente Hospital, whose passion and dedication to gastroenterology left an indelible mark on colleagues and patients.

Born in Melilla in 1964, although from Almeria at heart, he graduated in Medicine at the University of Granada and later completed his residency in Digestive Medicine at the Clinical Hospital in that city. Since 1996, practically since its inauguration, he has been uninterruptedly linked to the Poniente hospital to which he dedicated himself body and soul until the last day of his life.

I met Paco Gallego just over 20 years ago, when I was finishing my residency and facing the dreaded world of work. He was a young and enthusiastic specialist whose dream was to develop the Digestive Service and the endoscopy unit at the centre in El Ejido. In almost three decades of tireless work, he managed to create a high level service, developing the most complex endoscopic techniques and turning it into a regional and national reference.

Passionate about his family, endoscopy, the sea and cycling, I have never met a more enthusiastic, energetic and tenacious person than Paco Gallego. Whatever he set his mind to, he achieved. His capacity for work, his passion for learning and sharing knowledge were admirable. His natural vehemence, and in a perfect balance, prudence, were enviable. And his respect for the patient, or as he used to say, the sick person, whom he always kept at the centre of his actions and decisions, a mirror in which to look at himself.

We are not aware, or actually we are, of how lucky we have been to have him in this hospital, his home for 28 years. Paco Gallego was Poniente, and Poniente cannot be understood without him. The patients have lost an exceptional doctor, endoscopy a true master and with his departure we have lost a boss, a mentor and a friend. We will try our best to honour his exceptional legacy as he would have wished.

Farewell Paco. Rest in peace.

Dr. Francisco Gallardo Sánchez
Assistant Physician at the Digestive Unit of Poniente Hospital

Francisco Gallardo Sánchez
Poniente Hospital. Almeria.
fgallardos@yahoo.es

Gallardo Sánchez F.
Dr. Francisco Gallego Rojo.
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