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

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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.
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3° Bibliography: According to the specifications established in the group of common standards (See common standards and other supporting documents).
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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.
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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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- 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.*
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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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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:

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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.
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,

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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 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.

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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.
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The journal has no fees of any kind.

ORIGINAL

TREATMENT OF ZENKER'S DIVERTICULUM USING Z-POEM: SHORT-TERM AND LONG-TERM RESULTS.

Boyero Moreno P[1], Muñoz García-Borruel M[1], Rosón Rodríguez PJ[2], Jiménez García VA[1], Rodríguez Téllez M[1]

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Abstract

Introduction: Zenker's diverticulum (ZD) is a condition with a low incidence, typically asymptomatic, and when symptoms are present, the most common are food regurgitation and dysphagia. Therapeutic strategies include surgical and endoscopic techniques. Endoscopic techniques are usually preferred, with flexible endoscopic septotomy (FES) being the most common. Peroral endoscopic myotomy (Z-POEM) offers advantages over previous techniques by providing a more controlled and complete myotomy, reducing the risk of complications and recurrence rates.

Material and methods: This is a unicentric retrospective study including patients treated with Z-POEM between January 2022 and July 2024, with a mean follow-up of 1 year. Baseline clinical variables, treatment response, techniques, and safety were analyzed.

Results: A total of 8 patients were included, with a mean age of 69.35 ± 10.11 years. The average diverticulum size was 3.62 ± 1.4 cm. The technical success rate was 100%, the clinical success rate was 87.5% at 3 months, and 42.86% at 12 months. Three patients required reintervention endoscopically. One case of intraprocedural bleeding was recorded, which was resolved endoscopically, and one patient experienced self-limited dysphonia.

Conclusions: Z-POEM may be an effective and safe therapeutic option for the treatment of ZD.In the case of endoscopic reintervention, another Z-POEM or an alternative technique (FES) can be considered.

Keywords: Zenker's diverticulum, Z-POEM, miotomy, endoscopy.

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Boyero Moreno P, Muñoz García-Borruel M, Rosón Rodríguez PJ, Jiménez García VA, Rodríguez Téllez M. Treatment of Zenker's diverticulum using Z-POEM: short-term and long-term results. RAPD 2025;48(6):210-214. DOI: 10.37352/2025486.1

List of abbreviations

ZD: Zenker's diverticulum, FES: flexible endoscopic septotomy, Z-POEM: Zenker's diverticulum peroral endoscopic myotomy.

Introduction

Zenker's diverticulum (ZD) is a herniation of the posterior pharyngeal wall that occurs in an area of weakness of the inferior pharyngeal constrictor muscle. The orientation of the muscle fibers creates a triangle, known as Killian's triangle, where the diverticulum forms[1]. The incidence is around 0.01-0.11% and is more common in elderly male patients[2]. ZDs are usually asymptomatic, and if they do present clinically, the most common symptoms are regurgitation of undigested food and dysphagia, as well as chronic cough, nausea and vomiting, recurrent pneumonia and bronchoaspiration, and weight loss.

Treatment is indicated when symptoms are present, and therapeutic strategies include surgical and endoscopic techniques. Surgical techniques are performed by transcervical surgery, are more invasive, and have higher complication rates; therefore, endoscopic techniques are usually the treatment of choice.

Endoscopic techniques can be performed with a rigid endoscope or a flexible endoscope. Rigid endoscopic septostomy requires the patient's neck to be placed in hyperextension, requires general anesthesia, and is usually performed by otolaryngologists. Flexible endoscopic septostomy (FES) is the most common technique and usually has fewer complications compared to rigid endoscopy[3].

Flexible endoscopic septotomy (FES) is performed with the aid of a diverticuloscope, which is an over-tube with a longer portion at one end that is positioned in the esophagus and a shorter portion that is placed toward the diverticulum, increasing the stability of the position, exposing the septum, and protecting the diverticular and esophageal walls. Once properly positioned, septotomy is performed using kneedle knives or scissor-type scalpels, and the mucosal defect is closed with clips.

Peroral endoscopic myotomy on Zenker's diverticulum, called Z-POEM, is a third-space technique derived from esophageal POEM, and the materials required are similar to those used in that procedure. It consists of performing a mucosotomy on the septum after creating a submucosal wheal with saline solution or other colloidal substances and subsequent submucosal tunneling on both sides of the septum (diverticular and esophageal). Once the cricopharyngeal muscle is fully exposed, the myotomy is performed, extending up to 2-3 cm distal to the bottom of the diverticulum. The mucosotomy is then closed with clips, and it is recommended to dissect the mucosal flap in large diverticula.

FES offers technical success rates of around 90% and clinical success rates of between 56% and 90%, with recurrence rates of 10-30% and adverse effects of 11%[4]. Z-POEM has been reported to have technical success rates of 90-100%, clinical success rates of around 90%, and recurrence rates of 0-14.7% with complications occurring in 6.7-11% of cases[4]. This latter technique offers advantages over the previous ones as it allows for a more controlled and complete myotomy, reduces the risk of perforation and mediastinitis by preserving the mucosa, and has lower recurrence rates[5].

The most common complications are emphysema and perforation. However, pneumoperitoneum, pneumomediastinum, aspiration pneumonia, fever, and bleeding may also occur[5].

According to the classification proposed by Kaminski *et al.*[6] the size of the diverticulum could guide the choice of the most appropriate therapeutic strategy. In cases of small diverticula, which are those less than 2 cm in size, because they tend to have a short, thick septum with a shallow diverticulum that compromises maneuverability and prevents or hinders the use of the diverticuloscope, the literature suggests that Z-POEM is usually the preferred option. In diverticula between 2 and 5 cm, which are more common and usually have a septum of intermediate thickness, it is suggested that both therapies, Z-POEM and FES, can be considered valid. In large diverticula (greater than 5 cm), which usually have thin and long septa, it is suggested that Z-POEM be performed with an intentional incision (mucosal resection) of the redundant mucosal flap to reduce the remaining mucosal septum and avoid symptoms after treatment.

The objective of our study was to evaluate the efficacy and safety of Z-POEM as an endoscopic treatment for Zenker's diverticulum.

Materials and methods

This is a single-center retrospective study that includes patients treated with Z-POEM between January 2022 and July 2024, with a mean follow-up of 1 year. Baseline clinical variables, treatment response variables, technical variables, and safety variables were analyzed.

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Results

A total of 8 patients with Zenker's diverticulum treated with Z-POEM were included, with a mean age of 69.35 ± 10.11 years, 62.5% of whom were women. The mean size of the diverticulum was 3.62 ± 1.4 cm. Seven patients had never received treatment, and one had previously been treated with FES with Ligasure and SB-Knife.

All procedures were performed under orotracheal intubation and with prophylactic antibiotic therapy in the operating room and a short course after the procedure.

With regard to the technique, a Hybrid-knife® type T scalpel was used in all cases except one, which was type I. The diathermy source used was VIO3 (ERBE), with Endocut I 2-2 and Precise Sect 4-4.5 modes. The myotomy extended 2 to 3 cm below the diverticular base, and the mucosotomy was closed with 11 mm hemoclips in all cases, requiring an average of 5 clips.

As immediate complications, there was one case of bleeding during the esophageal submucosal tunnel, which was resolved endoscopically with hemostatic forceps. A case of self-limiting dysphonia was described as a late complication.

Technical success was 100%. Clinical success, assessed as the complete disappearance of symptoms, was 87.5% at 3 months, 75% at 6 months, and 42.86% at 12 months. Three patients required endoscopic reintervention, one of them with a new Z-POEM and the other two with SB-Knife; one of the patients treated with SB-Knife and the other treated with the second Z-POEM responded clinically.

Discussion

The results obtained in our study show a technical success rate of 100%, which is consistent with the high effectiveness of the Z-POEM technique reported in the literature. However, the clinical success observed in our series was lower than that described in previous studies, with complete resolution of symptoms in 87.5% of patients at three months, but with a decrease in this percentage at six and twelve months (75% and 42.86%, respectively). It is important to note that the definition of clinical success varies considerably between different studies. In many studies, clinical success is measured using dysphagia scales and assessing symptom improvement, whereas in our research we defined it as the total absence of symptoms, which is a stricter criterion and may therefore have influenced the results observed.

In addition, the small sample size of our study may have influenced the generalizability of the results. Although clinical efficacy in terms of complete resolution of symptoms is slightly lower than reported in other studies, the Z-POEM technique proved to be safe and effective for the treatment of Zenker's diverticulum, with only one case of bleeding during the procedure and one case of self-limiting dysphonia as a late complication.

According to current literature, Z-POEM is described as a more controlled, less invasive option with results that are not inferior to FES, positioning it as an excellent alternative for the treatment of this pathology. Although ZD is rare, when it presents symptoms, it can significantly affect patients' quality of life, highlighting the importance of effective and safe techniques such as Z-POEM.

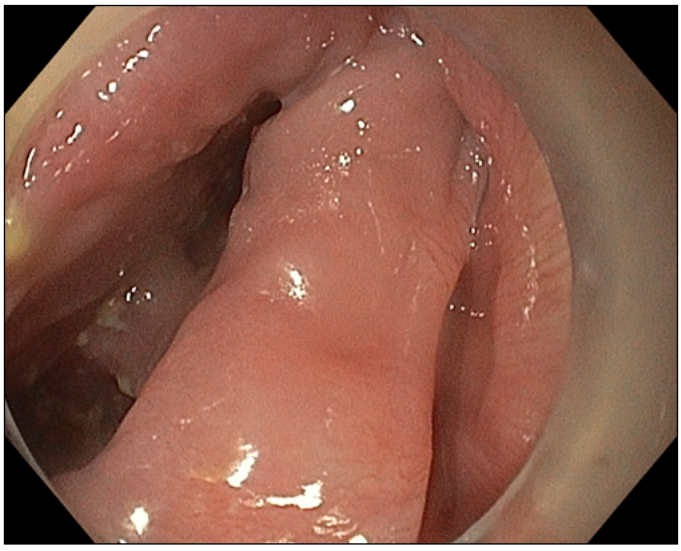

Figure 1. ***Diverticular septum.***

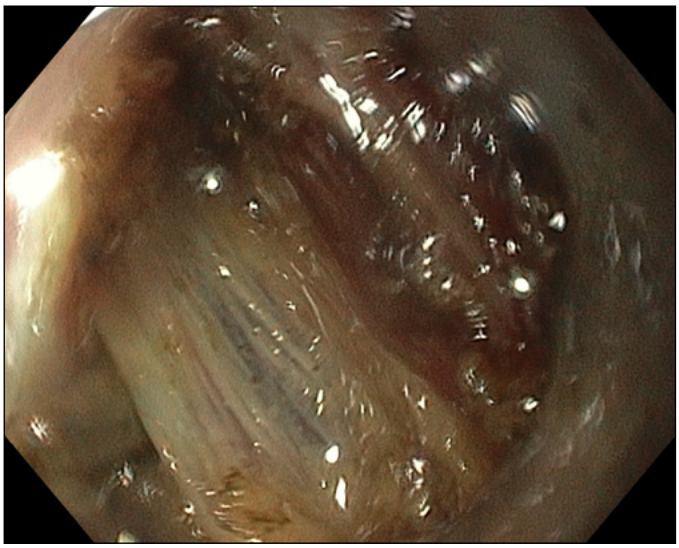

Figure 2. ***Z-POEM: myotomy.***

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In our sample, less than 50% of patients required endoscopic reintervention, suggesting that the technique, although effective, does not guarantee a permanent solution

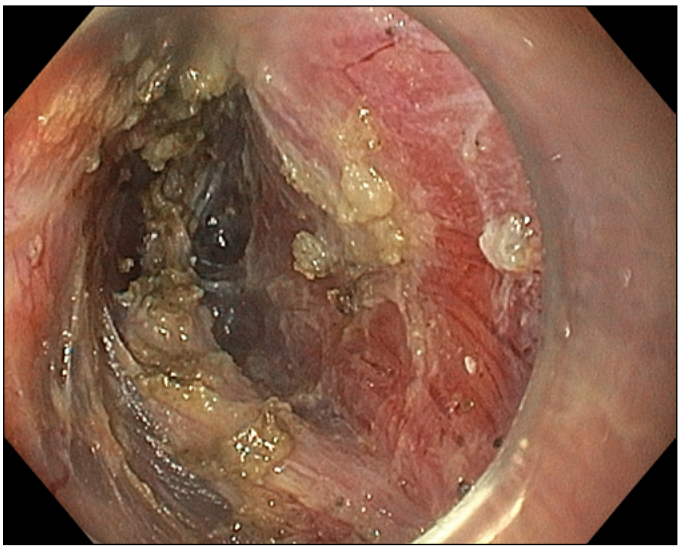

Figure 3. ***Z-POEM: complete myotomy.***

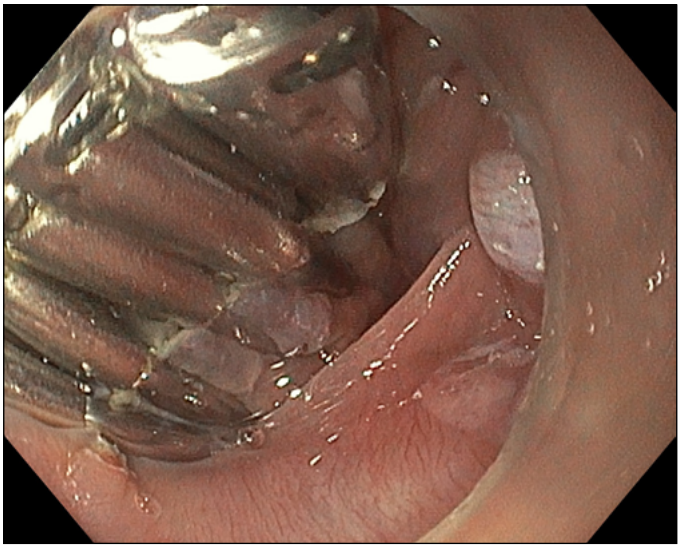

Figure 4. ***Z-POEM: closure of mucosotomy with clips.***

in all cases. This need for reintervention could be related to the nature of the pathology, the variability in the size and characteristics of the diverticulum, factors that do not always allow for a definitive solution in a single procedure. Currently, our group has slightly modified the technique, performing longer tunneling and myotomies, as well as final dissection of the mucosal flap, obtaining more satisfactory results. However, further studies with a larger sample size and long-term follow-up are required to evaluate the durability of the results and

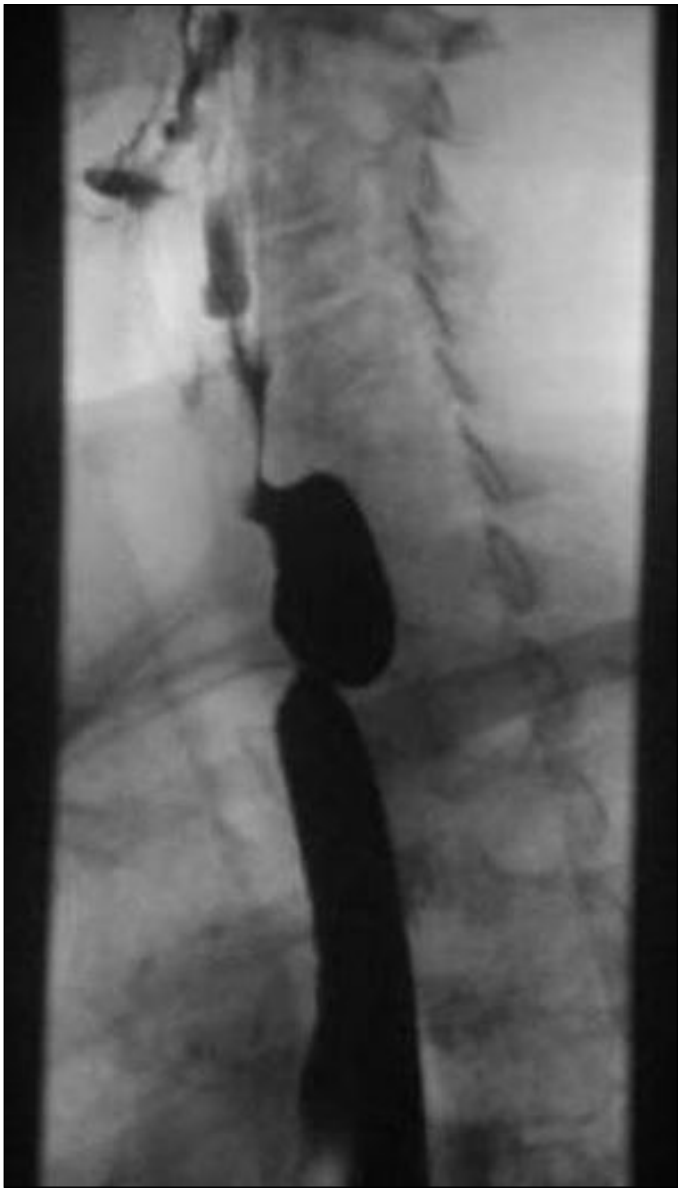

Figure 5. ***Barium esophagram, lateral view, prior to Z-POEM.***

determine predictive factors that may influence the success of the treatment.

Conclusions

Z-POEM may be an effective and safe therapeutic option for the treatment of Zenker's diverticulum.

In the event of endoscopic reoperation, another Z-POEM or an alternative technique (FES) may be performed.

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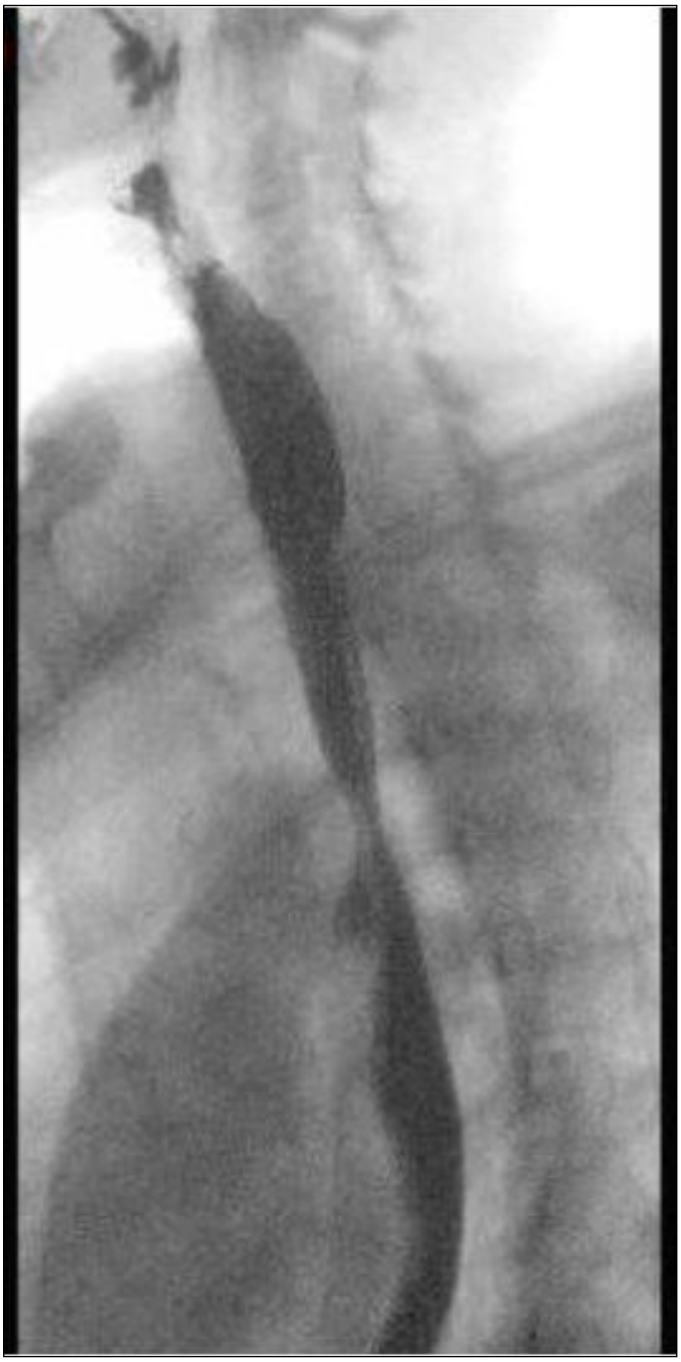

Figure 6. ***Barium esophagram, lateral view, after Z-POEM.***

Bibliography

1. *Norton B, Siggens K, Papaefthymiou A, Telese A, Duku M, Murino A, et al.. The safety and efficacy of endoscopic approaches for the management of Zenker's diverticulum: a multicentre retrospective study. Surg Endosc. 2024 Oct;38(10):5842-5850. doi: 10.1007/s00464-024-11164-4.*

2. *Murat Buyruk A, Erdoğan Ç. Efficacy and Safety of Peroral Endoscopic Myotomy in the Treatment of Zenker's Diverticulum: A Single-Center Experience. Turk J Gastroenterol. 2024 Feb;35(2):119-124. doi: 10.5152/tjg.2024.23402.*

3. *Al Ghamdi S.S., Farha J., Moran R.A., Pioche M., Moll F., Yang D.J., et al. Zenker's peroral endoscopic myotomy, or flexible or rigid septotomy for Zenker's diverticulum: A multicenter retrospective comparison. Endoscopy. 2022;54:345–351. doi: 10.1055/a-1518-7223.*

4. *Dell'Anna G, Fasulo E, Fanizza J, Barà R, Vespa E, Barchi A, et al. The Endoscopic Management of Zenker's Diverticulum: A Comprehensive Review. Diagnostics (Basel). 2024 Sep 27;14(19):2155. doi: 10.3390/diagnostics14192155.*

5. *Mandarino FV, Vespa E, Barchi A, Fasulo E, Sinagra E, Azzolini F, Danese S. Precision Endoscopy in Peroral Myotomies for Motility Disorders of the Upper Gastrointestinal Tract: Current Insights and Prospective Avenues-A Comprehensive Review. Life (Basel). 2023 Oct 31;13(11):2143. doi: 10.3390/life13112143.*

6. *Kaminski MF, Budnicka A, Przybysz A, Pilonis ND. Traditional septotomy or Z-POEM for Zenker's diverticulum. Best Pract Res Clin Gastroenterol. 2024 Aug;71:101943. doi: 10.1016/j.bpg.2024.101943.*

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CLINICAL CASE

BEYOND HELICOBACTER PYLORI: GASTRIC T-CELL LYMPHOMA AS AN UNUSUAL CAUSE OF GASTROINTESTINAL BLEEDING.

Plaza Fernández A, Fernández Carrasco M, Rodríguez Mateu A

Abstract

Primary gastric T-cell lymphoma is a rare and aggressive neoplasm with nonspecific clinical presentation. We report the case of a 75-year-old patient who presented with upper gastrointestinal bleeding secondary to a gastric mass, with histological analysis confirming a high-grade T-cell lymphoma. This case highlights the importance of considering this entity in the differential diagnosis of hemorrhagic gastric lesions.

Keywords: gastric T-cell lymphoma, gastrointestinal bleeding.

Introduction

Primary gastric lymphomas represent a small percentage of gastric neoplasms, and among them, B-cell lymphomas, such as MALT lymphoma and diffuse large B-cell lymphoma, are the most common. In contrast, primary gastric T-cell lymphoma is extremely rare and poses a diagnostic challenge due to its nonspecific clinical presentation. We present a clinical case that presented initially as gastrointestinal bleeding.

Clinical case

A 75-year-old patient with a history of Helicobacter pylori infection eradicated years ago and resected urothelial carcinoma currently in remission. The patient had no known autoimmune diseases or viral infections. In the months prior to admission, the patient reported progressive asthenia and weight loss of approximately 6 kg, with no other relevant digestive symptoms. He went to the emergency department due to an episode of hematemesis associated with syncope. Laboratory tests revealed anemia in the transfusion range, and an urgent gastroscopy was performed, which revealed a large ulcerated infiltrative mass in the gastric body at the level of the greater curvature, with irregular and friable edges and active bleeding. Hemostatic control was achieved by sclerotherapy with adrenaline and the application of hemostatic powders. Subsequently, the patient presented a new episode of hematemesis with hemodynamic instability, so a computed tomography (CT) angiogram was performed, which revealed active bleeding from the gastric lesion. Given the instability, urgent surgery was indicated, and a partial gastrectomy was performed with control of the hemorrhagic focus using

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hemostatic sutures. Subsequently, during admission, review of the previous CT images revealed infiltration of the tail of the pancreas and splenic artery, as well as perigastric and retroperitoneal lymphadenopathy, with no distant involvement (Figures 1 and 2). Histological analysis showed diffuse high-grade T-cell lymphoid proliferation, with positivity for CD3 and CD7 and negativity for B markers, confirming the diagnosis of gastric T-cell lymphoma. The patient was referred to Hematology and started treatment with systemic chemotherapy (modified CHOP). The initial course was favorable, with a good clinical response and no new bleeding episodes during short-term follow-up.

Figure 1. ***CT image showing gastric neoplasm with transmural extension and loss of the fatty separation plane with the tail of the pancreas and splenic artery due to infiltration of the same.***

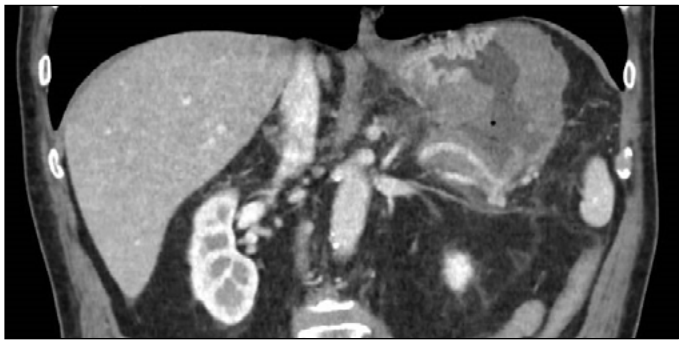

Figure 2. ***Abdominal CT (coronal section) showing the gastric neoplasm in close contact with the splenic artery and the tail of the pancreas.***

Discussion

Primary gastric T-cell lymphoma is an extremely rare neoplasm, with a very low incidence compared to B-cell lymphomas, among which MALT lymphoma is the most common subtype[1,2]. Unlike these, its association with Helicobacter pylori is not well established, although it has been linked to viral infections such as HTLV-1, HBV, HCV, or HIV, and to autoimmune diseases[2,3].

The clinical presentation is usually nonspecific, with symptoms such as abdominal pain, weight loss, and asthenia predominating. Gastrointestinal bleeding, as in our case, is an unusual form of onset[4]. Endoscopically, these lymphomas can take many forms: infiltrating masses, ulcers, or thickening of folds[5].

Diagnosis requires biopsy with immunohistochemical study, with the CD3+ and CD20– phenotype being characteristic. Echoendoscopy allows assessment of transmural involvement and locoregional lymphadenopathy, while CT is essential for assessing distant disease. Treatment is usually based on chemotherapy, with regimens such as CHOP, although the course is often aggressive and the prognosis is poor[2,4].

In conclusion, primary gastric T-cell lymphoma is a rare entity with a complex diagnosis. Its atypical presentation, such as gastrointestinal bleeding, requires a high index of suspicion for timely diagnosis and treatment.

Bibliography

1. *Juárez-Salcedo LM, Sokol L, Chavez JC, Dalia S. Primary gastric lymphoma: epidemiology, clinical diagnosis, and treatment. Cancer Control. 2018 Jan-Mar;25(1):1073274818778256. doi:10.1177/1073274818778256.*

2. *Zhang M, Xiao F, Lin M, Chen M, Hou J, Huang H. The epidemiology and prognosis of patients with primary gastric T-cell lymphoma in the SEER program. Cancer Med. 2023 Jan;12(1):84-98. doi:10.1002/cam4.4936.*

3. *Riveros Anglas ME, Del Castillo Glenny R, Cerrillo G. Linfoma gástrico primario a células T, no asociado a HTLV1, con presentación inicial de fractura patológica. Reporte de caso. Acta Med Peruna. 2023 Jul-Sep;40(3):256-261. doi:10.35663/amp.2023.403.2583.*

4. *Ghimire P, Wu GY, Zhu L. Primary gastrointestinal lymphoma. World J Gastroenterol. 2011 Feb 14;17(6):697-707. doi:10.3748/wjg.v17.i6.697.*

5. *Iwamizu-Watanabe S, Yamashita Y, Yatabe Y, Nakamura S, Mori N. Frequent expression of CD30 antigen in the primary gastric non-B, non-Hodgkin lymphomas. Pathol Int. 2004 Jul;54(7):503-509. doi:10.1111/j.1440-1827.2004.01657.x.*

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CLINICAL CASE

ESOPHAGITIS DISSECANS SUPERFICIALIS IN AN HIV PATIENT WITH A HISTORY OF SUBSTANCE ABUSE

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Abstract

Esophagitis dissecans superficialis is a rare and often underdiagnosed entity, whose diagnosis relies on characteristic endoscopic findings.

We present the case of a 58-year-old man with stage C3 human immunodeficiency virus (HIV) infection and a history of daily inhaled cannabis, cocaine, and heroin use. He was admitted with pneumococcal pneumonia, oropharyngeal candidiasis, and cachexia. Chest CT revealed thickening of the distal esophageal wall. Endoscopy demonstrated a circumferential desquamative and friable lesion consistent with superficial esophageal dissecans. Biopsies ruled out malignancy and viral infection.

The compatible diagnosis was esophagitis dissecans superficialis, most likely secondary to chronic toxic substance use.

Keywords: esophagitis dissecans superficialis, immunosuppression, toxic substances.

Introduction

Esophagitis dissecans superficialis (EDS) is characterised by circumferential desquamation of the oesophageal mucosa, causing striking lesions that usually have a benign course. We present the case of a patient with HIV infection and substance abuse.

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León Sanjuan GF, García Martínez A, Benavente Oyega MA. Esophagitis dissecans superficialis in an HIV patient with a history of substance abuse. RAPD 2025;48(6):217-218. DOI: 10.37352/2025486.3

Clinical case

A 58-year-old male, daily user of cannabis, cocaine, and inhaled heroin. Diagnosed in 2004 with human immunodeficiency virus (HIV) infection, currently stage C3, with regular adherence to treatment for years. History of hepatitis C virus infection, treated and cured with direct-acting antivirals.

He was admitted to the Infectious Diseases Unit for asthenia, pneumococcal pneumonia, oropharyngeal candidiasis, and cachexia. In this context, a chest CT scan was performed, showing evidence of thickening of the oesophageal wall in the distal third. Therefore, an oral endoscopy was requested, which identified a circumferential area of desquamative mucosa with friability on rubbing, compatible with oesophagitis, approximately 32 cm from the dental arch (Figure 1).

Biopsies were taken from the surrounding mucosa for microbiology and anatomopathological study, with no evidence of malignancy or viral induction, as well as negative immunohistochemistry for cytomegalovirus. No other pathological findings were evident on endoscopy.

Given the clinical context, exposure to multiple toxins, and the endoscopic and histological data, a compatible diagnosis was established: Esophagitis dissecans superficialis probably related to damage to the oesophageal mucosa caused by toxins.

Discussion

Superficial dissecting oesophagitis is a rare and often underdiagnosed condition. Its diagnosis is based on the finding of characteristic endoscopic lesions such as diffuse mucosal desquamation and the presence of 'whitish membranes', given that it can often be asymptomatic and histological examination is not specific in this condition[1,2].

Although the available literature on this subject is limited, this condition has been associated with factors such as physical and chemical trauma, smoking, autoimmune bullous dermatoses, consumption of toxic substances, and certain drugs such as bisphosphonates, NSAIDs, doxycycline, and apixaban.

Despite its striking endoscopic appearance, it has a benign course, achieving complete healing after removal of the causative agent, if it is a drug or toxin, or through control of the underlying disease[3].

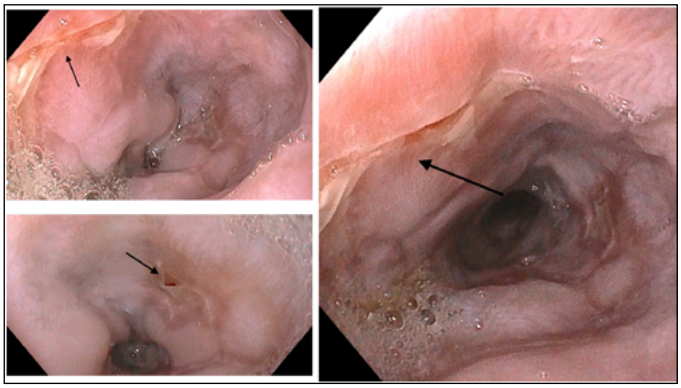

Figure 1. ***Oesophageal endoscopic image showing areas of desquamated oesophageal mucosa, with the appearance of a partially detached membrane, without ulceration or active bleeding, findings consistent with esophagitis dissecans superficialis.***

In the case we present, the findings are consistent with esophagitis dissecans superficialis associated with the consumption of toxic substances such as cocaine and heroin, in the context of possible mucosal fragility due to HIV.

Bibliography

1. *Zaher E A, Patel P, Zaher D. Esophagitis Dissecans Superficialis: A Case Report. Cureus 2023;15: e44372. DOI 10.7759/cureus.44372.*

2. *Ahmed A, King W, Middleton CE IV, Sharma A. Esophagitis dissecans superficialis after thermal injury. ACG Case Rep J. 2024;11:e01445. doi:10.14309/crj.0000000000001445.*

3. *Escobar Ortiz J, Pérez Pérez J, Barceló López M, et al. Esophagitis dissecans superficialis: an unusual desquamative disorder. Rev Esp Enferm Dig. 2025;117(3):233–234. doi:10.17235/reed.2025.10991/2024.*

DOI: 10.37352/2025486.3

CLINICAL CASE

GASTROINTESTINAL MANIFESTATIONS OF BLUE RUBBER BLEB NEVUS SYNDROME: A CASE REPORT AND LITERATURE REVIEW.

Lorente Martínez MA, Baute Trujillo EA, Moreno Barrueco M, Martín Navas MA, Candel Erenas JM

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Abstract

Blue Rubber Bleb Nevus Syndrome (BRBNS) is a rare disorder characterized by multiple vascular nodules affecting the skin and gastrointestinal tract. Gastrointestinal involvement is highly variable, ranging from chronic anemia and iron deficiency to episodes of acute gastrointestinal bleeding. Endoscopic techniques play a key role in diagnosis, evaluation of disease extent, and therapeutic management of vascular lesions.

Keywords: Blue Rubber Bleb Nevus syndrome, gastrointestinal hemorrhage, vascular malformation.

Introduction

Blue Rubber Bleb Nevus Syndrome (BRBNS) is a rare condition characterized by the development of multiple vascular nodules on the skin and in the gastrointestinal tract. Although congenital forms exist, most cases are secondary to somatic mutations of genes involved in the regulation of angiogenesis, mainly the TEK gene that encodes the angiopoietin-1 receptor. Its mutation causes permanent activation of the receptor, independent of its ligand, and triggers the uncontrolled proliferation of endothelial cells, responsible for the development of multiple venous malformations[1].

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Lorente Martínez MA, Baute Trujillo EA, Moreno Barrueco M, Martín Navas MA, Candel Erenas JM. Gastrointestinal manifestations of blue rubber bleb nevus syndrome: a case report and literature review. RAPD 2025;48(6):219-221. DOI: 10.37352/2025486.4

Many patients are diagnosed during childhood, however, they can debut in adulthood in the form of chronic anemia, iron deficiency, or even acute gastrointestinal bleeding.

Clinical case

We present the case of a 40-year-old male with no relevant family history who was being monitored by dermatology due to multiple blue nevi on his skin and was referred to gastroenterology due to a positive fecal occult blood test. The patient described intermittent melena-like stools and occasional episodes of hematemesis. On examination, the abdominal evaluation showed no pathological findings, and the rectal examination was not consistent with melena.

Laboratory tests showed no anemia, iron deficiency, or elevated urea levels. A study was initiated with gastroscopy, colonoscopy (Figure 1), and subsequently capsule endoscopy (Figures 2 and 3) which revealed multiple nevi associated with angiodysplasias throughout the digestive tract.

Figure 1. ***Colonic nevus.***

Given the presence of multiple venous malformations in different areas, the etiological study was completed with genetic analysis (TEK, VHL, etc.), which did not reveal any pathological alterations. The multidisciplinary clinical evaluation ruled out the main diagnostic alternatives (Von Hippel-Lindau syndrome, Osler-Weber-Rendu disease, etc.), establishing the diagnosis of BRBNS.

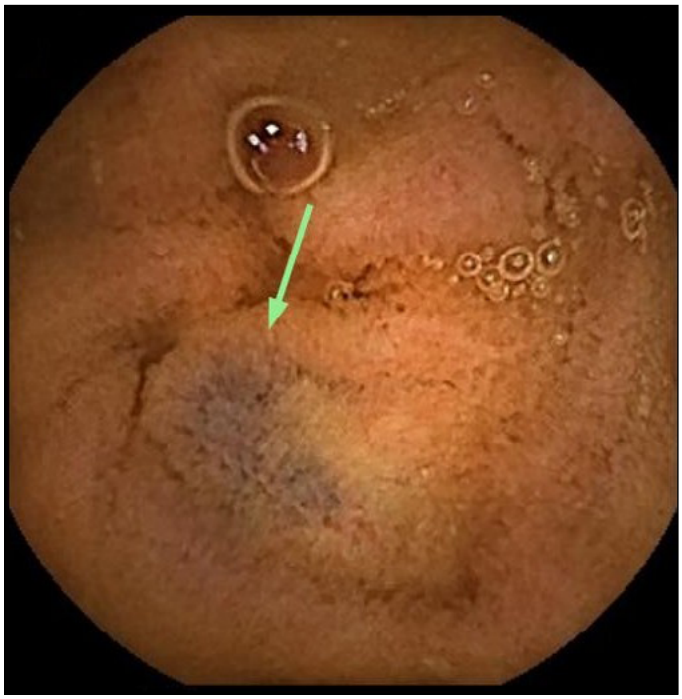

Figure 2. ***7 mm nevus at the level of the jejunum.***

Figure 3. ***10 mm vascular malformation occupying half the circumference, suggestive of a blue nevus.***

The patient is currently under close follow-up by the gastroenterology department, maintaining a wait-and-see approach given the absence of clinical and hematimetric repercussions of the gastrointestinal lesions.

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Discussion

The diagnosis of BRBNS requires the collaboration of different medical specialties, based on clinical evaluation, endoscopic findings, and genetic studies, although the latter are not essential for diagnosis.

Endoscopic techniques are essential for diagnosing and assessing the extent of the disease and applying therapeutic measures to vascular lesions.

The current lack of scientific evidence makes therapeutic abstention a valid option in mild cases or cases without active bleeding. In cases of bleeding, current studies suggest prioritizing endoscopic therapy (argon plasma coagulation, polypectomy loop excision)[2] over systemic treatments (sirolimus), which are reserved as a second line due to controversy over their safety and management[3,4].

Bibliography

1. *Kozai L, Nishimura Y. Clinical characteristics of blue rubber bleb nevus syndrome in adults: systematic scoping review. Scand J Gastroenterol. 2023;58(10):1108-1114.*

2. *Rimondi A, Sorge A, Murino A, et al. Treatment options for gastrointestinal bleeding blue rubber bleb nevus syndrome: Systematic review. Dig Endosc. 2024;36(2):162-171.*

3. *Weiss D, Teichler A, Hoeger PH. Long-term sirolimus treatment in blue rubber bleb nevus syndrome: Case report and review of the literature. Pediatr Dermatol. 2021;38(2):464-468.*

4. *Becq A, Bisdorff A, Riccioni ME, Blaise S, Mallet S, Toth E, et al.; iCARE group and FAVA-Multi. Blue rubber bleb nevus syndrome: A European multicenter cohort study. Dig Liver Dis. 2025 Feb;57(2):603–608.*

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CLINICAL CASE

RECURRENT DIGESTIVE HEMORRHAGE DUE TO FUNDIC VARICES SECUNDARY TO LEFT-SIDED PORTAL HYPERTENSION AFTER DISTAL PANCREATECTOMY: SPLENECTOMY AS DEFINITIVE TREATMENT.

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Abstract

Extrahepatic portal hypertension (EPH) is defined as an increase in pressure within the portal venous system without the presence of chronic liver disease. Left-sided portal hypertension (LSPH) is a rare form of extrahepatic portal hypertension, typically associated with pancreatic pathology. The formation of collateral circulation and the development of gastric varices are the main associated findings, which can lead to potentially severe upper gastrointestinal hemorrhages (UGIH)[1].

We present the case of a patient who underwent a distal pancreatectomy and subsequently developed recurrent UGIH due to fundic varices as a consequence of altered splenic circulation.

Keywords: left-sided portal hypertension, gastric varices, splenectomy.

Clinical Case

A 50-year-old woman with a history of distal pancreatectomy for unilocular acinar cell cystadenoma. She consulted for sudden onset of hematemesis, associated with dizziness and arterial hypotension. Initial laboratory

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tests showed anemia (Hb 7.1 g/dL) and normal coagulation parameters. Fluid replacement and red blood cell transfusion were initiated.

Upper gastrointestinal endoscopy (UGE) revealed the presence of variceal conglomerate in the gastric fundus as the source of the symptoms, and endoscopic administration of cyanoacrylate was performed. Computed tomography (CT) was performed, showing post-surgical changes due to corporocoidal pancreatectomy, numerous splenic venous collaterals, and varices in the fundus and lesser curvature of the stomach.

The patient was readmitted one month later due to recurrent bleeding with a new episode of hematemesis and anemia. UGE showed persistent fundic varices. The surgical committee decided to perform a splenectomy as definitive treatment. The patient underwent laparoscopic splenectomy without intraoperative complications. Her progress was favorable, with no new episodes of bleeding during the one-year follow-up period and no increased rate of infections.

Discussion

Segmental extrahepatic portal hypertension can be caused by thrombosis or obstruction of the splenic vein (SV), often due to complications of chronic pancreatitis. Other causes include pancreatic carcinoma, pseudocysts, fibrosis, retroperitoneal tumors, and surgeries such as distal pancreatectomy with spleen preservation, which interrupts splenic venous drainage. Venous obstruction diverts the return from the spleen to vessels with lower pressure, generating collateral circulation and perigastric varices. Ligation of the SV without venous reconstruction increases the risk of increased pressure in this area, with the consequent formation of varices[1].

Symptoms generally do not occur and it is detected incidentally. In some cases (4-17%), it can cause gastrointestinal bleeding due to rupture of gastric varices. Diagnosis is based on endoscopy, ultrasound, and CT, which identifies splenic obstruction, splenomegaly, and collateral circulation[2].

Initial treatment aims to stabilize the patient. Alcohol sclerotherapy, band ligation, and cyanoacrylate are endoscopic options for controlling bleeding. In classic PH, endovascular techniques include transjugular intrahepatic portosystemic shunting (TIPS), which reduces portal pressure, and balloon retrograde transvenous obliteration (BRTO), which is more effective in cardiofundal varices[3].

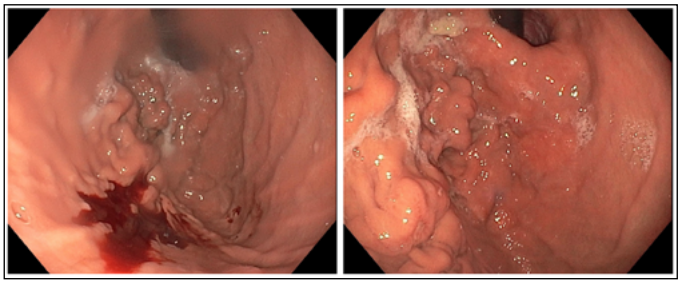

Figure 1. ***Upper gastrointestinal endoscopy image showing active upper gastrointestinal bleeding secondary to variceal cluster in the gastric fundus.***

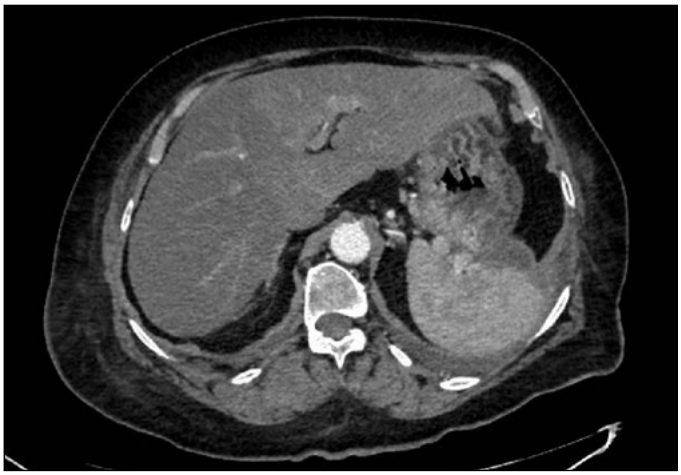

Figure 2. ***Abdominal CT image showing splenic collaterals and fundic varices.***

The non-indication of TIPS in this context is based on the fact that the procedure is not effective in segmental portal hypertension, since the overall portal pressure gradient is not elevated and the cause of gastric varices is localized obstruction of the splenic vein. TIPS diverts the main portal flow to the systemic circulation, but does not resolve the splenic venous congestion or localized hypertension that causes gastric varices in this scenario[15].

Therefore, splenectomy is considered the definitive treatment, as it eliminates the source of venous congestion and prevents hemorrhagic recurrence in patients with segmental portal hypertension secondary to thrombosis or compression of the splenic vein. In patients at high surgical risk, embolization of the splenic artery may be considered. This latter option is less invasive but carries a risk of complications such as splenic infarction or abscesses[3].

Bibliography

1. Mayer P, Venkatasamy A, Baumert TF, Habersetzer F, Pessaux P, Saviano A, et al. Left-sided portal hypertension: Update and proposition of management algorithm. J Visc Surg. 2024;161(1):21–32.

DOI: 10.37352/2025486.5

2. Patel RK, Tripathy T, Chandel K, Marri UK, Giri S, Nayak HK, et al. Left-sided portal hypertension: what an interventional radiologist can offer? Eur Radiol. 2024.

3. Henry Z, Patel K, Patton H, Saad W. AGA clinical practice update on management of bleeding gastric varices: Expert review. Clin Gastroenterol Hepatol. 2021;19(6):1098-1107.e1.

4. El Kininy W, Kearney L, Hosam N, Broe P, Keeling A. Hemorragia varicosa recurrente tratada con stent en la vena esplénica. Ir J Med Sci. 2017;186(2):323–7.

5. de Franchis R, Bosch J, García-Tsao G, Reiberger T, Ripoll C y Facultad Baveno VII. (2022). Baveno VII - Renovando el consenso en hipertensión portal. Revista de Hepatología , 76 (4), 959–974.

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TYPE IVA CHOLEDOCHAL CYST DIAGNOSED IN ADULTHOOD

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Abstract

Choledochal cysts are congenital dilations of the intrahepatic and extrahepatic bile ducts, most commonly diagnosed during childhood, with adult diagnosis being less frequent. We present a case of a large type IVA choledochal cyst, incidentally diagnosed in adulthood through imaging studies.

Keywords: choledochal cyst, type IVA, Todani.

Clinical Case

We present the case of a 33-year-old woman admitted for pain in the right hypochondrium and fever. Laboratory tests reveal abnormal liver function (cytolysis and dissociated cholestasis).

An abdominal ultrasound is performed, which shows dilation of the intrahepatic and extrahepatic bile ducts, with a common bile duct measuring up to 15 mm. An abdominal CT scan and MR cholangiography were performed, revealing marked cystic dilatation of the common bile duct (90 x 57 x 58 mm), associated with cystic dilatation of the intrahepatic bile duct, predominantly on the left side, findings suggestive of a type IVA common bile duct cyst (Figures 1-2). Clinical improvement was observed after administration of analgesia and empirical antibiotic therapy. It was decided to perform a cephalic duodenopancreatectomy (CDP) due to the intrapancreatic component of the lesion and the potential risk of malignancy, which was carried out without complications. After anatomopathological analysis of the surgical specimen (Figure 3), malignant degeneration of the lesion was ruled out.

Discussion

Choledochal cysts are rare entities consisting of a congenital dilation of the bile duct. They are mostly diagnosed in children, although in recent years there has been an increase in their incidence in the adult population. According to Todani's classification[1], the most common (80-90%) are type I (dilatation of the extrahepatic bile duct), while type IVA cysts involve dilatation of both the extrahepatic and intrahepatic bile ducts

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Figure 1. ***MR cholangiography. Coronal section - Marked cystic dilatation of the common bile duct (90 x 57 x 58 mm) associated with cystic dilatation of the intrahepatic bile duct, predominantly on the left side.***

Figure 2. ***Abdominal CT. Axial section - Cystic dilatation of the common bile duct associated with cystic dilatation of the intrahepatic bile duct, predominantly on the left side, findings suggestive of a type IVA choledochal cyst according to Todani's classification.***

and are extremely rare (1-2%). In 70-80% of cases, they are related to an abnormal pancreatico-biliary junction (AUPJ), predisposing to reflux of pancreatic secretions, with proteolytic activity on the common bile duct[2].

In adults, they manifest as pain in the right hypochondrium, jaundice, pancreatitis, or cholangitis, with diagnosis primarily based on imaging tests, particularly MR cholangiography due to its high sensitivity (90-100%).

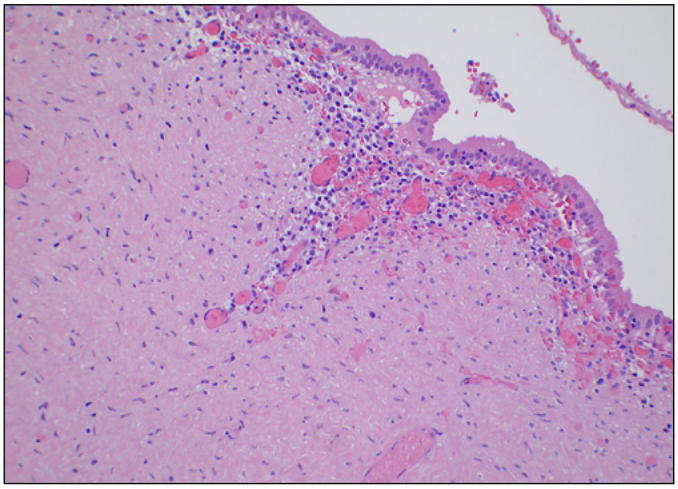

Figure 3. ***Pathological anatomy. Hematoxylin-eosin staining - Columnar-type cyst lining epithelium, with areas of chronic subepithelial inflammation.***

The treatment of choice will always be surgical, with complete removal of the cyst, given its potential risk of malignancy[3].

Bibliography

1. *Todani T, Watanabe Y, Narusue M et al. Congenital bile duct cysts: Classification, operative procedures, and review of thirty-seven cases including cancer arising from choledochal cyst. Am J Surg. 1977 Aug;134(2):263-9.*

2. *Brown ZJ, Baghdadi A, Kamel I et al. Diagnosis and management of choledochal cysts. HPB (Oxford). 2023 Jan;25(1):14-25.*

3. *Torres M, Becerra M, Calderón B et al. Choledochal Cyst. En: Yan Q, Shen H (eds.). Biliary Tract – Review and Recent Progress. Londres: InTechOpen; 2022.*

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