

Debemos tener en cuenta que estas técnicas están descritas en su mayor parte en lipomas situados en el colon, mientras que en nuestro caso el lipoma estaba situado en el íleon terminal, lo que dificultaba aún más el abordaje endoscópico. Dicho esto, se han descrito casos de resecciones de lipomas ileales tras llevarlo a la luz colónica mediante aspiración⁸ o mediante la colocación de un capuchón en la punta del endoscopio⁹.

Pese al avance de las técnicas endoscópicas, el tratamiento quirúrgico es de vital importancia en caso de lipomas sésiles de amplia base de implantación, en caso de diagnóstico incierto, en casos de lipomas que ocasionan intususcepciones u obstrucción, y en caso de afectación de las capas muscular propia y/o serosa¹⁰.

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Pancreatic tail schwannoma



Schwannoma de la cola del páncreas

A 75-year-old woman with a history of hypertension, osteoporosis, and cholecystectomy presented with intermittent abdominal pain unrelated to meals and weight loss of 6 kg over the past four months. Physical examination and all laboratory investigations were normal. Upper endoscopy was normal, whereas an abdominal ultrasound revealed a 6-cm, irregular, solid mass in the tail of the pancreas. Computed tomography (CT) scan (Fig. 1A) showed a 7 × 5 cm diameter, encapsulated, solid heterogeneous tumor, without any cystic component. There were no other intra-abdominal lesions or pathologic lymphadenopathy noted. Magnetic resonance cholangiopancreatography showed normal caliber of the biliary tree and pancreatic duct. CT-guided fine-needle aspiration exhibited cellular spindle cell neoplasm with mild atypia (Fig. 1B). On immunohistochemistry, the spindle cells were strongly positive for S-100 protein (Fig. 1C) and negative for pan-cytokeratin, CD-34, CD-117, smooth muscle actin and Melan A, consistent with the diagnosis of a pancreatic schwannoma. Distal pancreatectomy with splenectomy was performed and the patient recovered uneventfully, without relapsing disease after a 2-yr follow-up.

Schwannomas (also called neurilemmomas) are encapsulated tumors made entirely of benign neoplastic Schwann

cells, which represent the most common peripheral nerve tumors. They grow eccentrically from peripheral nerves or nerve roots with the nerve itself usually incorporated into the capsule. The most frequent locations for schwannomas are lower and upper limbs, head and neck, retroperitoneum, mediastinum, and pelvis.¹ Symptoms and signs are caused by direct nerve invasion, involvement of surrounding tissues, or mass effect. Benign pancreatic schwannoma is a rare entity, with around 50 cases reported in the English literature in 2016.² We have only found two previous reports of pancreatic schwannomas in Spain.^{3,4} Malignant transformation has been seldom reported in literature. The pancreatic head is the most common location (40%), followed by the body (20%), being tail and uncinate process the least common locations. The most common symptom is abdominal pain and jaundice with proximal tumors, but these lesions can also be found incidentally. As for CT findings, tumors that are predominantly or exclusively composed of Antoni A areas (cellular component) show inhomogeneous, hypodense, solid masses with contrast enhancement, whereas tumors predominantly composed of Antoni B areas (loose myxoid) may exhibit homogeneous cystic masses without significant contrast enhancement.⁵ Immunohistochemically, pancreatic schwannomas are positive for S100, Vimentin and CD 56. Conversely, spindle cells in pancreatic schwannomas stain negative for cytokeratin, CD117, desmin, CD34, AE1/AE3, alpha smooth muscle actin, and smooth muscle

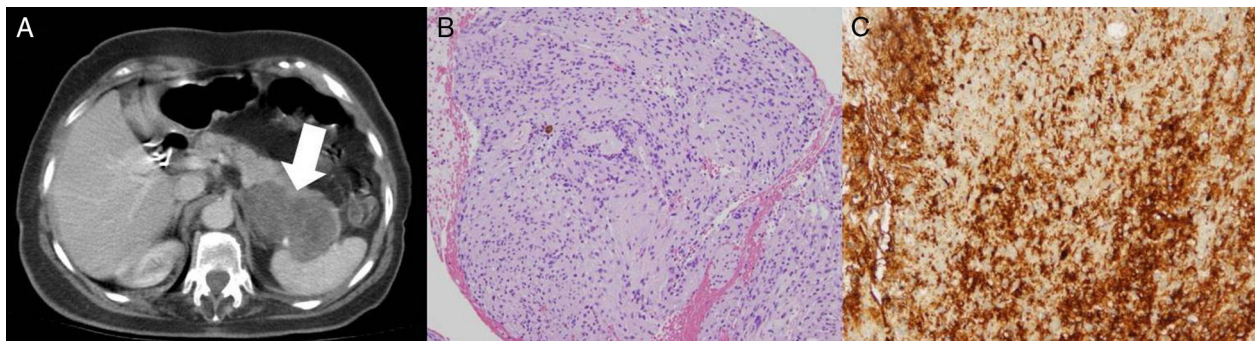


Figure 1 (A) Abdominal computed tomography (CT) scan showing a 7 × 5 cm solid heterogeneous mass in the pancreatic tail. (B) Spindle cell neoplasm on tissue obtained with CT-guided fine needle aspiration. (C) Strong positivity of spindle cells for S100 on immuno-staining, consistent with schwannoma.

myosin. The management of pancreatic schwannomas should be strictly guided by symptoms and histologic results. With most of the tumors having a benign histology, tumor enucleation is the most common surgical procedure performed for symptomatic lesions. In cases where the tumor shows a malignant behavior (infiltration of tissue or close proximity to important vessels), margin negative resection is recommended. Malignant transformation of pancreatic schwannomas has been seldom reported in literature.⁶

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Cirrosis biliar secundaria a obstrucción de la vía biliar por pólipos hamartomatosos en una paciente con síndrome de Peutz-Jeghers. Reporte de Caso



Biliary cirrhosis secondary to bile duct obstruction by hamartomatous polyps in a patient with Peutz-Jeghers syndrome. Case Report

El síndrome de Peutz-Jeghers (SPJ) se caracteriza por la presencia de pólipos hamartomatosos en el tracto gastrointestinal y melanosis mucocutánea^{1,2}. Su incidencia está entre 8.300-29.000 nacidos vivos. Para su diagnóstico se requiere de la presencia de antecedentes familiares³. La

cirrosis biliar secundaria es causada por la interrupción crónica del flujo biliar⁴, que termina por lesionar de forma irreversible el parénquima hepático.

Se presenta el caso de una paciente diagnosticada con SPJ a los 8 meses de edad, con antecedente del padre, hermano y tío paterno con el mismo diagnóstico. Acude por dolor abdominal y manifestaciones de hepatopatía crónica; se diagnostica cirrosis biliar secundaria a obstrucción de la vía biliar.

Mujer de 11 años de edad con cuadro de 3 días de evolución: náuseas, vómito gástrico, distensión abdominal, sin canalizar gases, imposibilidad al evacuar y dolor abdominal. Estudio contrastado previo a su ingreso: defectos de llenado en estómago, duodeno y yeyuno (fig. 1A). *Exploración física*: ictericia en conjuntivas y piel; melano-plaqui-perioral, mucosa oral y extremidades superiores; cardiopulmonar sin compromiso, ascitis, red venosa colateral, dolor generalizado a la palpación abdominal, signo de rebote