

Conclusión

El dolor abdominal tanto crónico como agudo, en la fosa ilíaca derecha en un paciente con antecedentes de apendicectomía, debe hacernos pensar en la apendicitis del muñón, independientemente de que se presente de forma aguda o crónica, y con pruebas radiológicas no concluyentes debemos considerar la laparoscopia exploradora como prueba diagnóstica definitiva que, además, nos permitirá llevar a cabo el tratamiento quirúrgico en el mismo acto operatorio. Este, consiste en la resección del remanente apendicular¹.

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Endoscopic band ligation – A valid option in colonic diverticular bleeding



Ligadura con bandas elásticas - una opción válida en el sangrado diverticular

Clinical case

Diverticular bleeding (DB) is a common cause for lower gastrointestinal bleeding. Its incidence is increasing due to the aging of population, as colonic diverticula are more frequent in the elderly.¹ The pathogenesis of DB is related to proliferation and weakening of the associated vas rectum of the diverticula conditioned by colonic luminal factors.¹ Hypertension, arteriosclerotic disease and regular use of nonsteroidal anti-inflammatory drugs are associated with higher risk of DB.¹ In the majority of the patients DB stops spontaneously and the bleeding diverticulum is not identified in colonoscopy. However, in about 10–20% of the cases, bleeding reoccurs.² This can be a serious condition, particularly in old patients with comorbidities. Proposed therapeutic options for DB encompass endoscopic hemostasis, embolization and surgery. Endoscopic hemostatic methods may include clipping and endoscopic band ligation (EBL). In a series of 100 patients, EBL was superior to endoscopic clipping (EC) in the treatment of colonic DB.³ We present a case of major colonic DB controlled with EBL.

A 69-year-old male patient with coronary disease under clopidogrel, was admitted to our emergency room with bright red blood hematochezia and syncope. On admission, he was pale, hypotensive and tachycardic. Abdominal examination was unremarkable and nasogastric aspirate was bilious, without blood. Laboratory revealed acute normocytic anemia of 6.1 g/dl (previous value 13 g/dl) and no elevated markers of acute ischemic heart disease. He was stabilized with fluids and blood transfusion, and an urgent upper endoscopy was performed, showing no alterations, namely blood or the cause of bleeding. Bowel preparation was started and a total colonoscopy was performed, within the first 24 h after admission; it showed no blood and multiple non bleeding left sided colonic diverticula. In the next 24 h, the patient presented again with hemodynamic instability and was admitted to our ICU. He was submitted to a second colonoscopy (after fast intestinal preparation) which showed fresh blood along the left colon and colonic diverticula. It was possible to identify the bleeding diverticula, with pulsatile hemorrhage in the sigmoid colon (Fig. 1a). Adrenaline (dilution 1:1000) was injected around the bleeding diverticula, conditioning mucosal elevation in the diverticular area (Fig. 1b); the bleeding was temporarily controlled. After that, endoscopic tattooing was performed to allow identification of the bleeding diverticula (Fig. 1c). Upper variceal band ligation kit was prepared and a conventional gastroscope was introduced; the marked diverticula was easily identified and a rubber ligation band was placed, surrounding and everting the diverticula (Fig. 1d). No active bleeding was seen by the end of the procedure. In the next 2 days, the patient remained stable, without blood loss

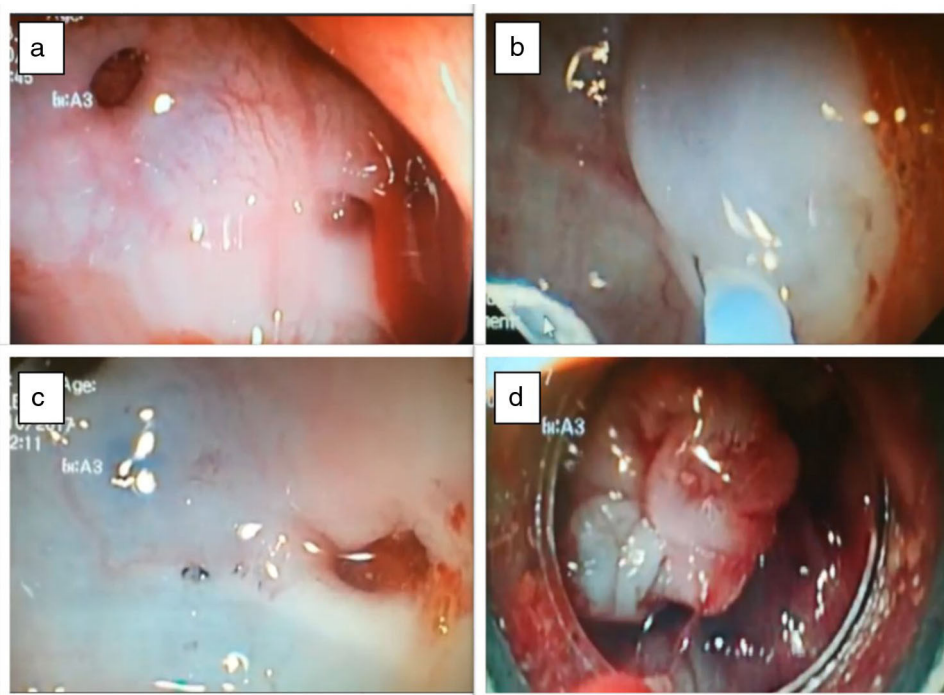


Figure 1 (a) Bleeding diverticula in the sigmoid colon; (b) Adrenaline injection around the bleeding diverticula, conditioning mucosal elevation in the diverticular area; (c) endoscopic tattooing was performed to allow the identification of the bleeding diverticula; (d) EBL of the bleeding diverticula.

despite reintroduction of clopidogrel. He was discharged 5 days after the admission, asymptomatic. One year after hospitalization, the patient remains asymptomatic and no rebleeding events or complication have occurred.

DB is mostly intermittent and resolves spontaneously; endoscopic diagnosis is usually presumptive, as the bleeding diverticula is not usually identified.² Early colonoscopy (within 18h after the final hematochezia) was proved to significantly increase the detection rate of identifiable bleeding diverticula (40.5% versus 10.5%, $p < 0.01$).⁴ Moreover, Mizuki et al. found higher detection rates of colonoscopy with preparation with polyethylene glycol compared to no preparation, though not statistically significant (28.2% versus 12.0%, $p = 0.11$).⁴ Most series report higher rebleeding rates with endoscopic clipping when compared to EBL and therefore the latter should be used as a first choice for endoscopic hemostasis.³ In most of the reported series, EBL is a safe procedure without important associated complications.³⁻⁵ Nagata et al. recently published a series of 108 patients comparing EC versus EBL in colonic diverticular bleeding and found that the risk of rebleeding after 1 year was higher in the EC group (11.5% with EBL versus 37.0% in the clipping group – $P = 0.018$) and, for EBL, more likely to occur if the diverticula was located in the left colon; also no cases of perforation or need for surgery were registered, although one patient experienced diverticulitis one day after EBL.⁶ In our case, one year after endoscopic band ligation, the patient remains asymptomatic, without record of rebleeding events or complications like diverticulitis or perforation. Also, in a series of 95 patients, Shimamura et al. concluded that EBL can be safely and effectively performed by non-expert endoscopists.⁵ It is of notice that,

in our case, the endoscopist that performed the EBL had never done this procedure before, in the context of colonic DB. In this case, we believe that tattooing the bleeding area was important to identify the correct diverticulum, once the EBL kit was placed. Furthermore, the injection of adrenaline and mucosal elevation in the diverticular area might have facilitated following suction, rubber band placement and eversion of the bleeding diverticula.

In conclusion, this case illustrates that EBL can be an effective and safe procedure to control colonic DB, particularly in patients with comorbidities, avoiding surgery.

Conflicts of interest

None declared.

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Leiomiomatosis peritoneal diseminada, un reto diagnóstico

Disseminated peritoneal leiomyomatosis, a diagnostic challenge



La leiomiomatosis peritoneal diseminada es una enfermedad benigna e infrecuente, de la que existen unos 150 casos descritos en la literatura¹. Se caracteriza por múltiples nódulos constituidos por músculo liso en la cavidad abdominopélvica. Normalmente aparece en mujeres premenopáusicas^{2,3}, y en algunos casos se ha descrito relación con estados de hiperactividad hormonal como la toma de anticonceptivos orales, neoplasia de ovario, etc.^{1,4,5}. En la mayoría de casos son asintomáticas, aunque la clínica dependerá de número y tamaño de las lesiones, así como un crecimiento rápido. Su diagnóstico suele ser un hallazgo casual en un estudio radiológico o en el transcurso de una intervención quirúrgica^{1,5}. El mayor problema es establecer el diagnóstico diferencial con la carcinomatosis peritoneal^{3,5}, siendo su diagnóstico definitivo histológico².

El tratamiento debe individualizarse, dependiendo de las características y la sintomatología de la paciente.

Presentamos el caso de una mujer de 42 años con antecedentes de HTA, poliquistosis renal en seguimiento por nefrología, y en tratamiento con ACO desde hace 2 años. Intervenido en 2013 mediante laparoscopia por mioma ute-

rino con diagnóstico anatomopatológico de leiomioma. Fue remitida a consultas ante el hallazgo causal en la TC de control por poliquistosis renal de 2 masas de 6,3 y de 3,1 cm localizadas en espacio de Morrison y en mesosigma, sin poder descartar implantes peritoneales. La paciente se encontraba asintomática, y la exploración abdominal era normal. Se realizó PAAF de ambas lesiones, informando de neoplasia mesenquimal de bajo índice de proliferación, que expresaban receptores estrogénicos, Bcl-2 y vimentina, compatible con leiomioma entre otros diagnósticos, siendo imprescindible su exéresis para una correcta filiación. Se completó estudio con PET/TC (fig. 1 A) que mostraba una intensa captación de ambas lesiones, con SUV máximo de 26,4 y 24,8, además de un útero aumentado de tamaño de aspecto miomatoso.

La paciente fue intervenida quirúrgicamente mediante una laparotomía media, identificando las lesiones y realizando resección completa de ambas (fig. 1 B). La anatomía patológica informaba de neoplasias mesenquimales de bajo potencial maligno (Ki-67 al 2%, <1 mitosis/10 CGA) con inmunofenotipo de músculo liso y receptores estrogénicos positivos, compatibles con leiomiomas. Se compararon los resultados, tanto de hematoxilina-eosina como de inmunohistoquímica, con la miomectomía previa realizada en 2013, siendo muy similares ambas lesiones, con la diferencia que las actuales presentaban una mayor vascularización y una menor positividad para desmina. Ante estos resultados, llamaba la atención la discrepancia entre los altos valores del SUV del PET/TC y el aspecto de bajo grado histológico (escasez de mitosis y ausencia de signos de malignidad como pleomorfismo y necrosis), por lo que se remitió

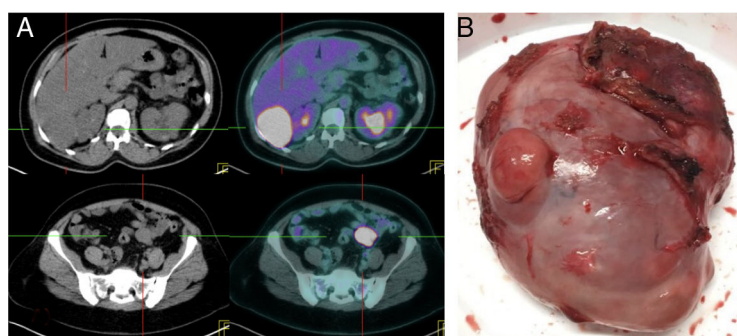


Figura 1 A) PET/TC mostrando 2 focos de captación a nivel de las lesiones en espacio de Morrison y mesosigma con SUV máximo de 26,4 y 24,8, respectivamente. B) Pieza quirúrgica de la lesión localizada en espacio de Morrison.