Perianal tumour simulating an abscess☆

Tumoración perianal que simulaba ser un absceso

The schwannoma is a rare neoplasm with an incidence of 0.6 cases per 100,000 inhabitants.[1] It has a plethora of synonyms (neurinoma, neurilemmoma, perineural fibroblastoma, peripheral nerve glioma, etc.). This has made it difficult to record in the medical literature. It was first reported by Verocay in 1910.[2] Masson named this type of tumour a ''schwannoma'' in 1932,[3] and Stout coined the term ''neurilemmoma'' to refer to the same lesion in 1935.[4]

We present the case of a 36-year-old patient who visited the emergency department due to a painful right gluteal tumour, which, according to him, had developed a week earlier. He had no clear signs of infection and his laboratory tests were unremarkable. An ultrasound was performed in the consultation and revealed a gluteal tumour with heterogeneous contents, of approximately 5 cm (Fig. 1). A perianal collection of material (probable abscess) was suspected on ultrasound. Consequently, despite the inconsistency between the patient's signs and symptoms and the ultrasound image, it was decided to perform an emergency anal examination under anaesthesia.

The mass was punctured in the operating theatre in several areas, without obtaining purulent contents. Anoscopy revealed no bulges in the anal canal. Subsequently, the perianal and gluteal skin was opened using a longitudinal incision over the mass. This revealed a gelatinous ovoid tumour, which was not consistent with the initial suspicion of a perianal abscess. It was approximately 10 × 5 cm in size, with an elastic consistency and a smooth, bright surface (Fig. 2). The tumour was easily dissected and could be removed *en bloc* without problems as it was far from the sphincter plane. The patient was discharged after 48 h, given that his clinical course was good. There were no recurrences.

The pathology of the specimen was a benign peripheral nerve tumour (schwannoma, neurilemmoma) with a positive S100 marker. All other markers used—c-kit, CD34, EMA, actin and desmin—were negative. The S100 family of proteins is essentially used as a set of tumour markers, since a marked deregulation of S100 proteins has been seen in various tumours such as breast cancer, melanomas and nervous system tumours. These proteins are associated with tumour progression.[4,5]

Schwannomas represent a type of benign neoplasm of the nerve sheath that originate from Schwann cells and lack axonal fibres. In most cases, they develop at the expense of cranial nerves (especially the vestibular nerve) or posterior roots of spinal nerves. They affect both sexes equally, and usually occur in adulthood (30–50 years of age). They are encapsulated tumours that cause symptoms of compression when they expand inside and outside of the spine. They are not invasive and rarely become malignant. Schwannomas are rarely located in the skin or organs. Solitary skin schwannomas tend to appear in the hypodermis, along the path of a peripheral nerve. They are slow-growing tumours with few symptoms, although they may cause pain and paraesthesia when compressed.[6] They are generally located in the laterocervical region or the flexures of the limbs. They have a higher incidence in the upper limbs compared to the lower limbs, in a 2:1 ratio.[7] Some syndromes, such as neurofibromatosis type 1, are characterised by the onset of multiple skin schwannomas. This phenomenon is known as ''schwannomatosis'' or ''neurilemomatosis''.

Schwannoma is a tumour encapsulated in a perineural sheath that should be distinguished from other neoplasms of the nerve sheath, especially neurofibroma, which is not encapsulated and has a mucoid component. Its diagnosis is suspected based on its typical appearance on magnetic resonance imaging and confirmed by a histology and immunohistochemistry study. FNAB of these lesions does not usually provide diagnostic certainty due to the

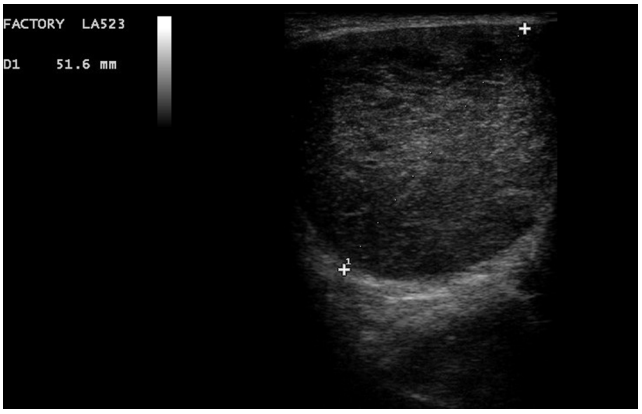

Figure 1 Ultrasound shows a lesion with a heterogeneous appearance.

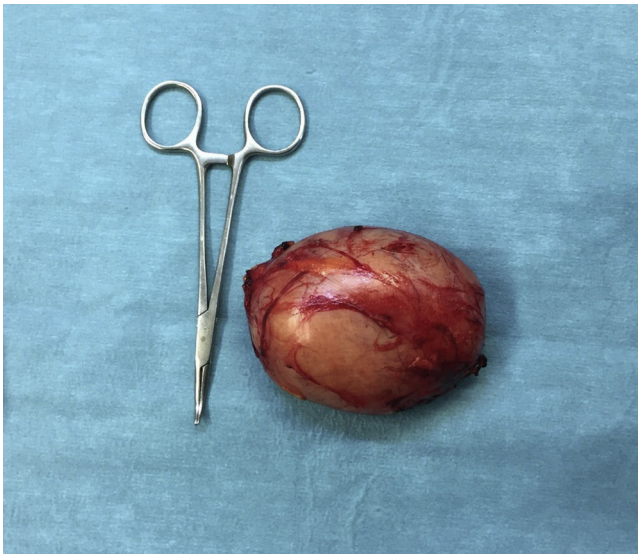

Figure 2 Encapsulated tumour with an elastic consistency.

☆ Please cite this article as: González Plo D, García Pavía A, León Gámez CL, Pueyo Rabanal A, Sánchez Turrión V. Tumoración perianal que simulaba ser un absceso. Gastroenterol Hepatol. 2017;40:398–399.

cellular pleomorphism particular to these tumours, which may sometimes confuse the pathologist.[8]

The treatment of choice is complete surgical removal with preservation of the nerve fascicles. It is indicated when they cause discomfort or aesthetic problems.[6] These tumours have a good prognosis, since they rarely become malignant (less than 0.001% in isolated schwannomas). In most cases, the malignant component exhibits an epithelioid morphology.[9] In neurofibromatosis type 1, the rate at which the lesion becomes malignant increases to 18%.[10]

References

1. Gorgan M, Sandu AM, Bucur N, Neacsu A, Pruna V, Voina A, et al. Sciatic nerve schwannoma-case report. Romanian Neurosurg. 2009;15:27–31.
2. Verocay J. Zur kenntnis der Neurofibrome. Beitr Pathol Anat Allg Pathol. 1910;48:1–5.
3. Masson AP. Experimental and spontaneous schwannomas (peripheral gliomas): Part I. Am J Pathol. 1932;8:367–70.
4. Stout AP. The peripheral manifestations of the specific nerve sheath tumor (neurilemmoma). Am J Cancer. 1935;24:51–5.
5. Ortiz-Muñoz B, Menéndez-López A, Yayá-Tur R, Arribas-Alpuente L, Maíquez Richart J, Bordes-Monmeneu M. Proteína S100 en tumores del sistema nervioso central. Rev Neurol. 2003;36:1011–5.
6. Rodriguez Acar M, Alcalá Pérez D, González González M, Novales Santa Coloma J, Flores Castellanos M, de Alba Alcántara L, et al. Tumores cutáneos de origen neural. Rev Cent Dermatol Pascua. 2012;21:109–15.
7. Enríquez Merino J, Villaseñor Camacho P, Ramos Garibay A. Neurilemoma: comunicación de un caso. Rev Cent Dermatol Pascua. 2007;16:89–92.
8. Requena Caballero L, Herrera Ceballos E, Moreno Carazo A, Rodríguez Peralto JL. Dermopatología: Correlación clínico-patológica. Badalona: Grupo Menarini; 2013.
9. Barrera M, Spelta G, Moya J, Gavazza S, Barbarulo A, Fontana MI, et al. Schwannoma. A propósito de un caso. Arch Argent Dermatol. 2008;58:153–6.
10. Traistaru R, Enachescu V, Manuc D, Gruia C, Ghilusi M. Multiple right schwannoma. Rom J Morphol Embryol. 2008;49:235–9.

Daniel González Plo*, Arturo García Pavía, Carmen Lucero León Gámez, Alberto Pueyo Rabanal, Víctor Sánchez Turrión

Servicio de Cirugía General y Aparato Digestivo, Hospital Universitario Puerta de Hierro-Majadahonda, Majadahonda, Madrid, Spain

* Corresponding author.
E-mail address: danigonzalezplo@gmail.com (D. González Plo).

2444-3824/

Jejunal diverticulosis: A rare cause of intestinal obstruction☆

Diverticulosis yeyunal: una causa rara de obstrucción intestinal

Diverticula of the jejunum and ileum, together with diverticula of the stomach, occupy last place in terms of frequency of gastrointestinal diverticula. They account for approximately 0.9–1% of all diverticular disease. They mainly occur in older adults and are not normally suspected in differential diagnoses of abdominal pain. This leads to a delay in their suitable management.

Clinically, they are usually asymptomatic or have non-specific symptoms. Acute complications, such as perforation, haemorrhage and intestinal obstruction sometimes arise, and usually require emergency surgical treatment.

We present the case of an 86-year-old male patient with a personal history of transurethral resection due to bladder carcinoma in 2013 and cholecystectomy. He sought care as the colicky abdominal pain in his right flank that he had been experiencing for the last month had worsened in the last 24 h and was accompanied by vomiting. His physical examination revealed a poor general condition, with tachycardia and a tendency towards hypotension. His abdomen was distended and his right flank was painful on palpation, with voluntary defence and signs of peritoneal irritation.

An abdominal X-ray showed small bowel loops with some air-fluid levels (Fig. 1A). His laboratory tests showed leukocytosis with left shift. Given the clinical context of the patient (advanced age and deterioration of general condition), an emergency abdominal computed tomography scan was ordered to complete the diagnosis, in view of the possible need for a surgical procedure. The scan reported distended small bowel loops, but could not identify the cause of obstruction (Fig. 1B).

With a diagnosis of intestinal obstruction, he underwent surgery, which found small bowel volvulus secondary to an adhesion. This involved a segment of jejunum with multiple large diverticula and signs of ischaemia (Fig. 2). Resection of the segment involved and anastomosis were performed. He had no diverticula in other locations.

After surgery, he developed acute pulmonary oedema and died on day 3 of the postoperative period.

Diverticular disease of the jejunum and ileum, excluding Meckel's diverticulum, is a rare, usually asymptomatic disease. It may be chronic or acute; this renders it difficult to make a suitable diagnosis. In addition, due to a lack of awareness of the disease, it is rarely considered as part of the differential diagnosis of gastrointestinal diseases. The first reports of jejunal diverticulosis were made by Sommervit in 1794, Voigtel in 1804 and Sir Astley Cooper in 1807.[1] Since then, several articles reporting clinical complications of this disease have been published.

☆ Please cite this article as: Romera-Barba E, Gálvez Pastor S, Navarro García MI, Torregrosa Pérez NM, Sánchez Pérez A, Vazquez-Rojas JL. Diverticulosis yeyunal: una causa rara de obstrucción intestinal. Gastroenterol Hepatol. 2017;40:399–401.