Table 1 – Percentage of esophagitis and Barrett's esophagus after sleeve gastrectomy, according to different studies.

Groups	Esophagitis (%)	Barrett's esophagus (%)
Braghetto and Csendes[2]	15.5	1.2
Genco et al.[1]	—	17.2
Sebastianelli et al.[5]	41	18.8
Lim et al.[8]	44.4	—
Soricelli et al.[6]	59.8	13.1
Yeung et al.[7] (meta-analysis)	28	8

trated areas of Barrett's esophagus close to the resection area. Two cycles of radiofrequency ablation were performed. Two months later, a new endoscopic follow-up study was done and biopsies taken, but there were no pathological findings.

In October 2019, the patient underwent laparoscopic conversion of the sleeve gastrectomy to gastric bypass.

As shown in the case above, we feel it is important to monitor these patients in order to detect and treat Barrett's esophagus and dysplasia in time, despite not being a frequent finding, before they degenerate into adenocarcinoma. This is especially important when considering that lack of symptoms does not completely rule out the disease.

To conclude, we suggest that routine endoscopies should be included in the follow-up testing of all patients who have undergone sleeve gastrectomy. More studies are needed to determine the magnitude of the problem and to adjust the indications for sleeve gastrectomy for the treatment of morbid obesity.

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Thymic cysts: A rare entity in adults☆

Quiste tímico: una entidad rara en el adulto

The appearance of cervical tumors in adults is frequent, mainly due to the growth of thyroid nodules in the context of multinodular goiter. In some cases, these masses do not depend on the thyroid, so the differential diagnosis

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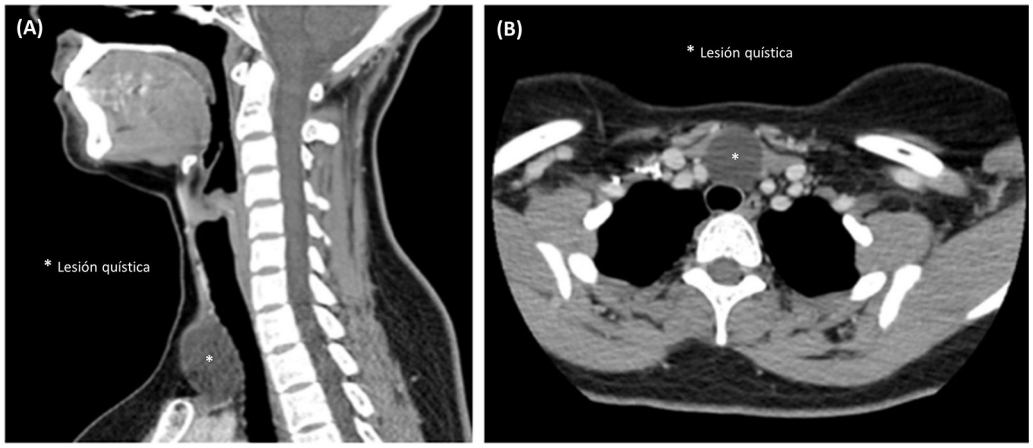

Fig. 1 – Computed tomography scan: A) sagittal view showing a cystic lesion below the thyroid gland; B) axial view showing that the cystic lesion does not invade the neighboring structures.

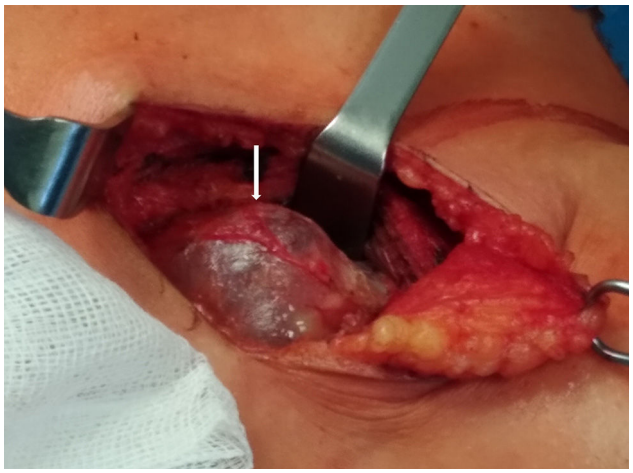

Fig. 2 – Intraoperative image of the cystic lesion (arrow) in the anterior cervical region, not adhered to adjacent structures.

should include other types of rare lesions, including thymic cysts.

Thymic cysts account for 1% of cervical masses and appear mainly in the first decade of life,[1] so they are very rare in adults.[2,3] They tend to present as an asymptomatic cervical mass, and in many cases the diagnosis is made after the lesion is resected, since preoperative imaging tests do not determine the etiology of the cyst.[4] Recurrence after complete excision has not been documented in the literature.[5]

We present the case of a 36-year-old woman with no relevant history who consulted for an asymptomatic left anterior cervical mass that had been developing over several months. Ultrasound detected a 4-cm nodule with a cystic appearance that did not depend on the thyroid. CT scan located the lesion below the thyroid gland, posterior to the infrahyoid muscles and anterior to the trachea, in contact with the right brachiocephalic trunk as well as the origin of the right common carotid artery, but no signs of invasion (Fig. 1). The study was completed with an MRI that demonstrated a cystic image measuring 4 cm with no extension to the thorax, which did not depend on any structure and presented benign characteristics.

The patient was treated surgically, making a transverse cervical incision and observing an anterior cervical cystic-looking lesion that extended to the superior mediastinum, without invading any structure (Fig. 2). It was removed without incident, preserving the recurrent laryngeal nerves and the inferior parathyroid glands, and the patient was discharged 24 h after the intervention.

The histopathological study reported a unilocular thymic cyst with cuboidal epithelium, thymic tissue, and an adjacent ectopic parathyroid gland.

During embryonic development, the thymus arises from the 3rd pair of pharyngeal pouches next to the inferior parathyroid glands. During the 7th week of gestation, the primordium of the thymus migrates from the angle of the mandible to the superior mediastinum, forming the thymopharyngeal duct, which later becomes fibrous.[6]

Thymic cysts are very rare and appear mainly in children, although cases have been described in adults, especially during the 2nd and 3rd decades,[2,5] affecting men more often. They are more frequently located on the left side, although they can appear at any point from the upper edge of the hyoid bone to the antero-superior mediastinum, and their size varies (1-17 cm). Most are asymptomatic, although they can cause dyspnea, dysphagia and voice alterations.[1,5]

Although various classifications have been described, the most widely accepted today divides them into congenital and acquired forms. The former are due to a persistence of the thymopharyngeal duct, while the latter are due to degeneration of the ectopic thymic tissue.[3,5,7,8]

In most cases, the diagnosis is made after analysis of the surgical specimen,[4] as in the case described. Preoperative imaging tests, such as ultrasound, CT and MRI, are useful to characterize the lesion and determine its relationship with neighboring structures, although they hardly provide an etiological diagnosis. Needle aspiration is not useful to determine the origin of cervical cystic lesions in most cases.[4]

The differential diagnosis should be made with other cervical cystic lesions, such as thyroglossal duct cyst, branchial cyst, thyroid cyst, desmoid cyst, lymphangiomas, cystic teratoma, lymphadenopathy with a cystic appearance, metastases, and other causes that are very rare but should be considered in adults, such as parathyroid cysts.[5,9] In the latter case, biochemical

analysis of the cyst fluid is useful, since it will present a high level of PTH.[9] The possibility of malignant degeneration must also be considered, since the presence of a thymic carcinoma within a thymic cyst has been described in the literature.[10]

Thymic cysts can be uni- or multilocular and have an epithelium that can be squamous, cuboidal, or columnar. The histopathological characteristics that determine the diagnosis and are considered pathognomonic are the presence of thymic tissue remnants in the wall and the presence of Hassall's corpuscles, which are eosinophilic structures present in the normal thymic medulla.[1,8] Furthermore, as a consequence of the common embryological origin, it is common to find parathyroid tissue adjacent to the cyst wall, as described in the clinical case we have presented.

Treatment is surgical, with complete excision of the lesion. No recurrences have been described in the literature, so the prognosis is excellent.[5]

In conclusion, thymic cysts are rare in adults but should be included in the differential diagnosis of cervical lesions.

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Cytoreductive surgery in functioning peritoneal pheochromocytomatosis☆

Cirugía citorreductora en feocromocitomatosis peritoneal funcionante

Catecholamine-secreting tumors are rare neoplasms with an annual incidence of 1–2 cases/100,000 inhabitants per year. Only 10% are malignant, with no histological or biochemical differences compared to benign presentations, except for local invasion of surrounding tissues and organs or distant metastasis.[1–4]

Patients with pheochromocytoma experience persistent disease in 3%–13% and recurrence in 6%–23%, both local and

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