



Scientific letter

Gallbladder metastasis from squamous cell carcinoma of the head and neck: Atypical presentation of airway metastasis[☆]

Metástasis en vesícula biliar de carcinoma epidermoide de cabeza y cuello: presentación atípica de metástasis de vía aérea

Of all the malignant neoplasms of the digestive tract, gallbladder cancer ranks fifth in order of frequency¹. More than 95% of these are primary neoplasms, and metastases from other carcinomas are extremely rare².

We present the case of a 69-year-old male smoker and drinker. His medical history included a T4N2M1 oral cavity squamous cell carcinoma at the age of 55 that had been treated with hemiglossectomy, functional cervical dissection and forearm flap, although follow-up in the outpatient consultation had been inadequate due to lack of patient compliance. Ten years later, he presented recurrence at the cervical and pulmonary level and was treated with immunotherapy and chemotherapy (C19D1 MK-3475-048 maintenance with pembrolizumab) with a sustained partial response. Months later, he underwent left cervical dissection, and several areas were identified of intracapsular metastasis of squamous cell carcinoma. Two months after this surgery, a PET/CT scan showed no evidence of local tumor recurrence of the pharyngeal neoplasm, but a hypermetabolic lesion was identified in the fundus of the gallbladder (Fig. 1), and he was therefore referred to us for surgery. Abdominal MRI demonstrated focal thickening of the gallbladder wall that was 7 mm thick and 27 mm in maximum diameter, with indeterminate enhancement, meaning that the malignant nature of the lesion could not be ruled out (Fig. 1). Tumor markers were negative. With suspected metastasis of the oral squamous cell carcinoma, the digestive tumor committee decided on a surgical approach that included surgical resection and radical cholecystectomy, with laparoscopic resection of 2-3 cm of the liver parenchyma. A combination of the electroscalpel and the laparoscopic ultrasonic surgical aspirator (CUSA®) was implemented for the dissection of the

liver parenchyma with cirrhotic characteristics. There were no incidents during surgery, and the patient was discharged from hospital on the fifth postoperative day, without complications. The pathological anatomy study identified the lesion as squamous cell carcinoma, with positive immunohistochemistry for squamous tumor markers CK 5-6 and p63 (Fig. 2), poorly differentiated, with a solid pattern, no glandular component, and images of lymphovascular and perineural invasion; positive presence of human papillomavirus (HPV) DNA was detected by polymerase chain reaction (PCR) technique. No lymph node involvement was found, and margins were free.

Almost all distant metastases of head and neck squamous cell carcinomas (HNSCC) occur in the lungs (77%), bones (19%), mediastinum/other lymph nodes (4%), as well as the brain, liver and skin. The appearance of metastases of HNSCC in other locations is extremely rare³. In turn, metastases from other neoplasms that are deposited in the gallbladder are very rare, and these patients have a very short survival after diagnosis (8.4 months on average)⁴. Within this group of gallbladder metastases, the most common primary malignant tumors are melanoma^{5,6} and gastric cancer⁷. There are no reports of gallbladder metastasis from airway carcinomas in the literature. The patient in this case report presented advanced-stage squamous cell neoplasm of the airway (T4N2M1) with histologically confirmed cervical recurrence and a lesion in the gallbladder that was purely squamous. This poses the differential diagnosis with a squamous cell carcinoma of the gallbladder, which is very rare and has an incidence of 4% among gallbladder tumors⁸. In this case, the presence of a primary airway neoplasm and the confirmed presence of HPV DNA in the resected lesion (knowing that HPV

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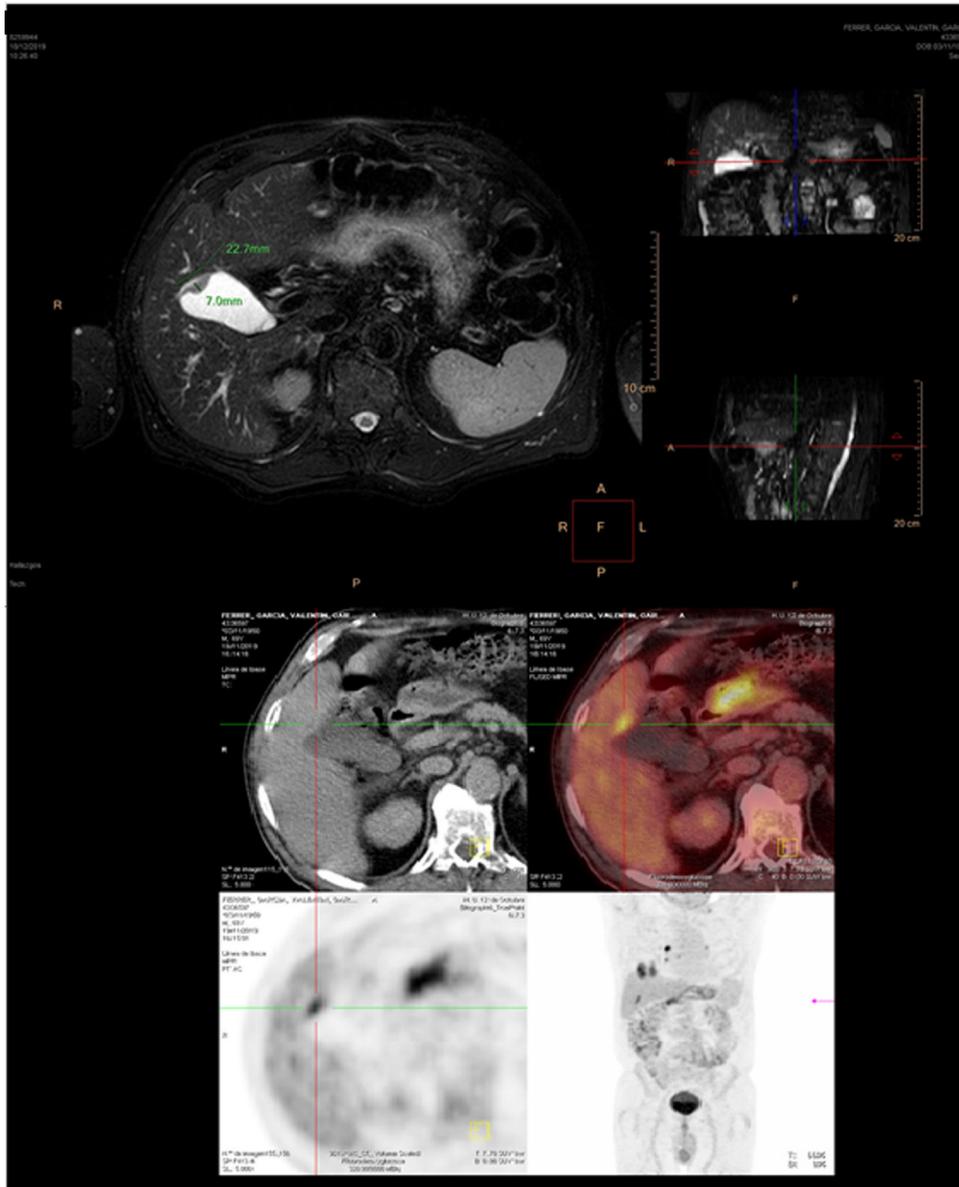
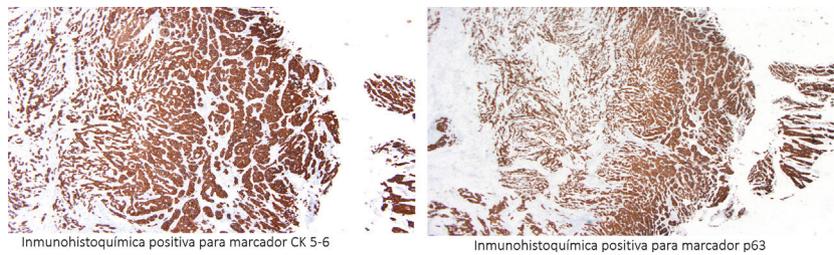


Fig. 1 – MRI and PET/CT prior to surgery.



Imunohistoquímica positiva para marcador CK 5-6

Imunohistoquímica positiva para marcador p63

Fig. 2 – Immunohistochemistry of the surgical piece: A) Positive immunohistochemistry for CK 5-6; B) Positive immunohistochemistry for p63.

is responsible for up to 65% of epidermoid tumors of the oral cavity³), leads us to conclude that it is a metastatic lesion of an airway squamous cell carcinoma, making this one of the first reported cases of this type of metastasis in the gallbladder.

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Refractory hypoxemia in critical trauma patient. Usefulness of extra-corporeal membrane oxygenation[☆]

Hipoxemia refractaria en la enfermedad traumática grave. Utilidad de la ECMO veno-venosa



The use of veno-venous extracorporeal membrane oxygenation devices (VV-ECMO) in severe respiratory failure due to trauma has been controversial and is not completely defined, which is probably due to its underuse in this population. VV-ECMO provides adequate oxygenation until the lungs recover. However, one limiting factor for its generalized use has been the risk of bleeding due to both the trauma as well as the anticoagulation necessary to use this system¹. In this article, we describe a case of trauma-related refractory hypoxemia treated with ECMO without using anticoagulation, which demonstrates that these devices can be considered a rescue measure once previous therapeutic options have been optimized.

We present the case of a 65-year-old woman who had been hit by a car. Upon admission to the Intensive Medicine Unit, she was conscious and showed no focal lesions; BP 90/60, HR 90 bpm, tachypnea RR 20, SatO₂ 90%. Physical examination revealed a hematoma on the left cheekbone, hypoventilation in the base of the right lung, slight abdominal guarding, and pelvic pain on palpation. An imaging study showed a fracture of two unifocal right ribs with bilateral pulmonary contusion (Fig. 1A), lacerated liver, spinal trauma (fracture of five right transverse processes from T12 to L4) and skeletal trauma (fractures in both sacra alae, communicated fracture of the left pubis with fractures of both pubic branches, and right anterior acetabular rim). No intracranial injuries were observed.

During the first few hours of treatment, the patient presented hemorrhagic shock, requiring blood products and vasoactive drugs (massive bleeding protocol was activated). Orotracheal intubation was performed, and the study was completed with arteriography. Several foci of contrast extravasation were identified, suggestive of bleeding from

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