Ganglioneuroma como causa infrecuente de tumor suprarrenal

Ganglioneuroma (Gn) es un tumor benigno del sistema nervioso simpático que puede ocurrir a lo largo del tronco simpático, a partir del cuello hasta el pélvico, y de manera ocasional en la médula suprarrenal. El Gn es tratado mediante resección quirúrgica y tiene un pronóstico excelente. Se reportan dos pacientes con Gn diagnosticados en nuestro hospital.

**Case 1.** Este fue un paciente femenino de 28 años que acudió por síntomas no específicos de abdomen. Se informó la presencia de una masa suprarrenal incidental en un estudio de imagen solicitado para otra razón. A pesar de su naturaleza benigna, la转化a maligna del schwannoma ha sido documentada en algunos casos, y se ha asociado con tumores como la pheochromocitoma. Se diagnosticó Gn y se realizó una adenectomía laparoscópica. El paciente fue dado de alta 24 h sin complicaciones postoperatorias, y se prognoza una mejora clínica.

**Case 2.** Este fue un paciente de 28 años que acudió por episodios recurrentes de gastroenteritis y dolor abdominal no específico. La ultrasonografía y la tomografía computarizada (TC) mostraron una masa suprarrenal no funcional. Se realizó una adenectomía laparoscópica y se informó la presencia de una masa suprarrenal en el examen de la pieza quirúrgica.
Emission Tomography (PET) has recently been incorporated to complement both tests in Gn diagnosis and, above all, to rule out malignant adrenal neoplastic conditions. Final diagnosis is made after histopathological analysis of the surgical specimen. The characteristic microscopic appearance is a uniform image with a stroma consisting of irregularly intertwined transversely and longitudinally oriented Schwann cells. Fat may occasionally be found. Relatively mature neurons with little Nissl substance and forming small groups or nests are found scattered throughout this Schwannian background. A bulky eosinophilic cytoplasm and one to three nuclei with mild to moderate atypia are typically seen (Fig. 2). The use of fine needle aspiration is limited by the possibility that the lesion is malignant (adrenal carcinoma or metastasis) or cystic in nature and by the difficulty in differentiating adenoma from carcinoma.

The indication of surgery for incidental, non-functioning adrenal tumors is not clearly defined and will depend on lesion size and radiographic characteristics. However, surgery should be performed on symptomatic tumors greater than 6 cm in diameter (an increased incidence of carcinoma has been seen in these lesions) or showing radiographic characteristics of malignancy. Clinical and radiographic monitoring is usually done for lesions less than 4 cm in size, although some authors advise surgical excision in young patients because of the very long follow-up that would be required and the anxiety this may cause. Treatment for lesions ranging from 4 and 6 cm in size is controversial, and both surgical excision and monitoring have been recommended. Surgery should be considered if the tumor grows or radiographic signs of malignancy occur.

Laparoscopy has become the procedure of choice for all adrenal pathology, including incidental, on-functioning masses, and is increasingly less limited by size. There is no current agreement about the maximum tumor size amenable to laparoscopic surgery. The traditionally accepted limit is 6 cm, but there are many series reporting surgery for greater tumors, up to 13 cm in size. A transperitoneal approach is usually used, but a retroperitoneal approach is preferred by some groups. Today, the presence of an invasive malignant tumor or venous thrombosis associated with the renal or suprarenal veins is an absolute contraindication. The prognosis of AGn after surgical resection is excellent, even when complete excision is not possible. Tumor recurrence is rare, and should be considered to result from an incomplete initial surgery (and should therefore be called "persistence" instead).

References
Acute hallucinatory psychosis secondary to oral glucocorticoid treatment in a patient diagnosed with Sheehan’s syndrome

Psicosis alucinatoria aguda secundaria a tratamiento con glucocorticoides orales en una paciente diagnosticada de síndrome de Sheehan

Patients with untreated chronic adrenal insufficiency, high-dose glucocorticoid treatment, and Cushing’s syndrome are known to frequently experience psychiatric changes. However, psychiatric changes, occurring after glucocorticoid replacement therapy that has been started following the diagnosis of adrenal insufficiency, are less well known.

We report the case of a 53-year-old female patient with a personal history of a complicated delivery in 1981 (28 years ago) requiring several transfusions of packed red cells for severe bleeding and hypotension. After delivery, the patient experienced agalactia, early menopause (amenorrhea since delivery) and hepatitis C virus (HCV) infection. She was on follow-up at the gastrointestinal clinic, but had not returned there for 8 years, and had been diagnosed with liver disease with Child C stage cirrhosis induced by HCV. The patient was admitted to hospital on December 2009 for obnubilation, bradypsychia, impaired speech, and temporal and spatial disorientation secondary to hyponatremia and hypoglycemia. She also reported significant fatigue, a depressive mood, and weight loss over several years. Examination revealed eyebrow alopecia, absence of pubic and axillary hair, pallor, and thinness. Table 1 shows laboratory and imaging data.

Based on these clinical and laboratory findings, the patient was diagnosed with hypopituitarism due to Sheehan’s syndrome. Replacement therapy was started with levothyroxine (25 µg/day) and hydrocortisone (60 mg/day in three divided doses). Her clinical condition improved after the start of treatment, with normalization of blood glucose levels and correction of hyponatremia, but three days later the patient experienced anxiety, euphoria, and lack of inhibition. This condition progressed in two days to a hallucinatory psychosis with visual hallucinations with no delusional interpretation and partial subsequent recall. As there was no personal or family history of psychiatric disease or use of toxic substances, and after ruling out an infectious etiology to account for the condition, a “steroid psychotic crisis” was diagnosed, and treatment was started with tiapride and haloperidol. Glucocorticoid doses were decreased to 10 mg/day.

The patient experienced a gradual improvement in the five days following the start of treatment. The psychotic symptoms disappeared, and treatment with psychodrugs was discontinued at two weeks and has not been needed since then. After 6 days of treatment with hydrocortisone 10 mg/day, the dose was increased to 30 mg/day. The patient then experienced a mild exacerbation of the psychotic conditions which required a dose reduction to 10 mg/day again. This dose was subsequently increased very slowly and gradually.

The patient is currently being treated with hydrocortisone 20 mg/day and levothyroxine 75 µg/day.

Sheehan’s syndrome, currently uncommon thanks to improved obstetric procedures, is caused by pituitary infarction after severe bleeding during or after delivery. Clinical signs vary, depending on the severity of the condition and range from acute severe panhypopituitarism to less severe forms including agalactia, lack of resumption of the menstrual cycle after delivery, and a clinical picture of indolent hypopituitarism. In such cases, prolactin, gonadotropin, and growth hormone deficiency occur in 90–100% of patients, while ACTH and TSH deficiency is a little less common (60–75% of patients). Diabetes insipidus rarely occurs. The most common water and electrolyte change in Sheehan’s syndrome is hyponatremia (occurring in 35–65% of patients), resulting from cortisol deficiency, hypothryoidism, and a potentially impaired vasopressin secretion. These patients often experience psychiatric changes such as depression, impaired memory, and difficulty in concentration, caused by untreated, long-standing hypothyroidism and chronic adrenal insufficiency. These changes are resolved when replacement therapy is started.

As regards psychiatric pathology and glucocorticoids, psychiatric changes are common in patients with untreated, long-standing hypocortisolism, as previously discussed. Psychiatric changes caused by the administration of high glucocorticoid doses, which usually occur early after the...