bilidad de que nos hallemos ante otra entidad clínica. Esto es de especial importancia cuando se valora el uso de tratamiento inmunosupresor o tratamientos biológicos ya que expondremos al paciente de forma no justificada a tratamientos con efectos secundarios graves además de realizar una gestión inadecuada de los recursos sanitarios.

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Bouveret's syndrome

Síndrome de bouveret

Gallstone ileus is an unusual complication of cholelithiasis, occurring in <0.5%. It is responsible for 1–4% of cases of mechanical obstruction.[1] Bouveret's syndrome is an uncommon form of gallstone ileus, first described in 1896 by Leon Bouveret,[2] comprising 1–3% of cases.[3]

A 90-year-old man presented with a 2-day history of abdominal pain and postprandial vomiting. Laboratory investigations revealed leukocytes 18.7×10^3 μL, reactive c protein 14 mg/dL, bilirubin 2.61 mg/dL, aspartate aminotransferase 96 U/L, alanine aminotransferase 96 U/L, alkaline phosphatase 310 U/L and gamma-glutamyl transferase 528 U/L. Abdominal ultrasound showed pneumobilia, dilated common bile duct (CBD) and scleroatrophic gallbladder with cholelithiasis.

He presented a high likelihood of choledocholithiasis based on clinical predictors and was referred to endoscopic retrograde cholangiopancreatography (ERCP), which was unsuccessful due to gastric stasis bulky, not identifying the pylorus. To exclude gastroduodenal obstruction, he performed an upper gastrointestinal endoscopy revealing an impacted gallstone at pylorus that was successfully treated with endoscopic extraction combined with mechanical lithotripsy. A fistulous stoma was visualized on the duodenal bulb (Fig. 1). ERCP demonstrated a dilated CBD filled with multiple gallstones and confirmed cholecystoduodenal fistula (Fig. 2). Endoscopic sphincterotomy was performed being the CBD explored with biliary balloon and Dormia basket. Following the procedure CBD had no residual stones, presenting good drainage of contrast. The planned conservative treatment was successful and the patient was discharged 15 days later.

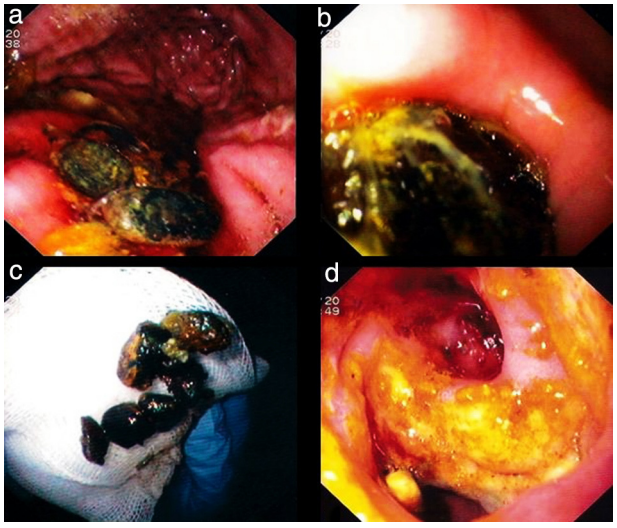

Figure 1 Upper gastrointestinal endoscopy showing gallstones in the gastric corpus (image a) and an impacted gallstone at pylorus (image b). Retrieved gallstones after mechanical lithotripsy with snare and Dormia basket (image c). Endoscopic view of the duodenal bulb: fistulous stoma with surrounding duodenal bulb mucosa extensively ulcerated (image d).

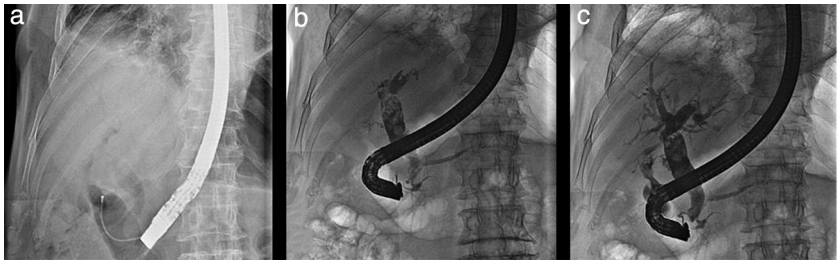

Figure 2 Endoscopic retrograde cholangiopancreatography. Plain abdominal radiograph before contrast injection showing pneumobilia and air route from gallbladder to duodenum topography, suggestive of biliary enteric fistula (image a). A 14 mm dilated CBD filled with multiple gallstones, a scleroatrophic gallbladder with cholelithiasis and a patent cystic duct (image b and c). Cholecystoduodenal fistula was confirmed after contrast injection (image c).

Bouveret's syndrome is defined as gastric outlet obstruction secondary to an impacted gallstone in the duodenum or pylorus, which enter into the bowel through a biliary enteric fistula. Endoscopy made the diagnosis in nearly all cases, identifying the obstructing gallstone in 69%. Endoscopic treatment should be considered a first-line option, because of low morbidity and negligible mortality.[4] Fistula repair is considered unnecessary due to spontaneous closure, especially when the cystic duct is patent.[5]

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Comienzo de hepatitis aguda grave autoinmune refractaria a tratamiento convencional, rescatada con infliximab

Onset of severe acute autoimmune hepatitis refractory to conventional treatment, rescued with infliximab

La hepatitis autoinmune (HAI) es una enfermedad cuya etiología es desconocida. Su diagnóstico se basa en la conjunción de parámetros clínicos, analíticos e histológicos aplicándose para ello un *Score* internacional (*Score* simplificado de la IAIHG) que permite establecer el diagnóstico como probable o definitivo. El tratamiento clásico se basa en prednisona y azatioprina, consiguiéndose remisión mantenida en más del 75% de los casos. En los casos en los que no se consigue dicha remisión, el pronóstico empeora sustancialmente. Por este motivo, es necesario establecer nuevas pautas de tratamiento de rescate para los pacientes que no responden al tratamiento habitual. Presentamos el caso de una paciente con hepatitis autoinmune que comienza de forma grave, tratada con infliximab de forma satisfactoria.

Caso clínico

Mujer de 36 años, con antecedentes personales de hipotiroidismo primario a tratamiento sustitutivo, laparotomía exploradora hacía 3 años por dificultades para quedarse embarazada y embarazo a término hacía 2 meses. Es remitida por su médico de atención primaria al servicio de urgencias por hallazgo analítico de hiperbilirrubinemia e hipertransaminasemia (bilirrubina total 8,6 mg/dl, fracción directa 7 mg/dl, AST 1.085 U/l, ALT 1.746 U/L, GGT 261 U/l, FA 397 U/l), tras 10 días de clínica seudogripal y 48 h de ictericia y coluria. No había tomado ningún otro tratamiento, no había realizado viajes en los meses previos, requerido transfusiones de hemoderivados ni tenía ningún tatuaje o *piercing*. Asimismo, no refería hábitos tóxicos y bebía agua embotellada. A su llegada a urgencias, la paciente se encontraba afebril y estable hemodinámicamente, presentando una exploración física y neurológica normal salvo por ictericia mucocutánea, prurito y malestar general. Ingresa en el servicio de aparato digestivo con la hipótesis diagnóstica de hepatitis aguda de etiología indeterminada. En la analítica realizada al ingreso se detecta empeoramiento franco de la función hepatocelular en forma de coagulopatía (INR: 1,56), hipoalbuminemia (2,8 g/dl), incremento de la hiperbilirrubi-