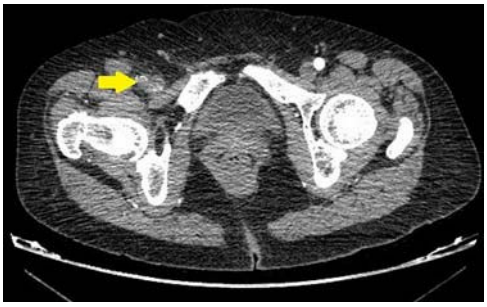

Fig. 1 – Transversal image of computed tomography angiogram (CT-angiogram) demonstrating a thrombus in the right external iliac artery, impeding the passage of contrast.

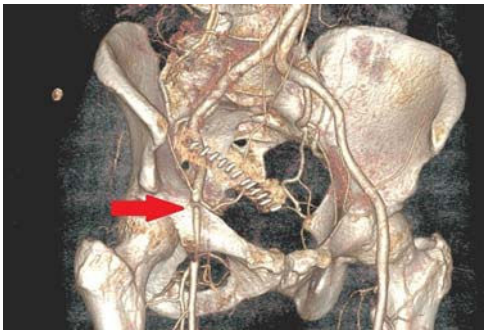

Fig. 2 – 3-D reconstruction showing stenosis at the right iliofemoral transition.

delaying diagnosis for up to 3 days, which initially led to a neurological sequela despite optimal limb revascularization.

Clinical suspicion should guide the correct diagnosis and treatment of these lesions. The loss of pulses or the weakness of the femoral pulse compared to the contralateral limb after inguinal surgery should lead to suspicion of a possible arterial lesion, and symptoms of sudden claudication with coldness and paresthesia are highly suggestive of ischemia.[2]

Urgent evaluation by a vascular surgeon will avoid potential neuromotor sequelae or even loss of the limb.

In the event of bleeding due to direct injury to the artery, randomly applied hemostatic stitches should be avoided. It is recommended to dissect and correctly expose the artery in order to reliably identify the point of injury and make the repair properly under direct vision, using non-stenosing vascular sutures or patch angioplasty depending on the size of the defect.

Arterial injury after surgery for femoral hernia is a rare but serious complication. It is important to explore the diagnosis of ischemia in patients after recent femoral hernia repair who present absence of pulses in association with coldness, paleness, paresthesia or motor dysfunction of the ipsilateral limb. Proper diagnosis and treatment of a vascular injury minimizes the subsequent consequences of ischemia.[1]

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2173-5077/

Porocarcinoma located in the breast: A case report☆

Porocarcinoma de localización mamaria, a propósito de un caso

Eccrine porocarcinoma is a rare cutaneous neoplasm that arises from the intraepidermal portion of the eccrine sweat glands.[1] Its incidence varies between 0.005 and 0.01% of all skin tumors, and it is more common in women over 60 years of age,[2,3] although cases have been reported in children and young adults.[4]

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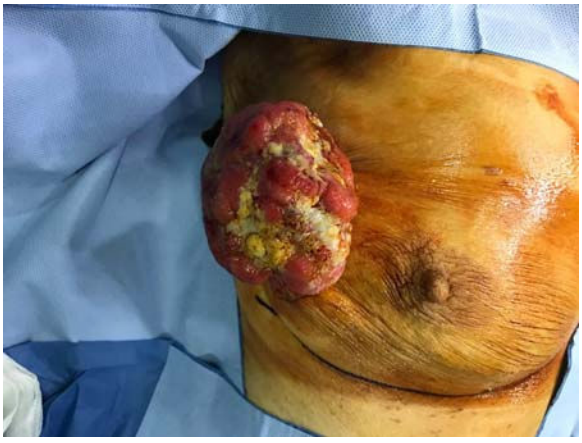

Fig. 1 – Indurated and ulcerated exophytic mass, measuring some 5 × 6 cm in the right breast.

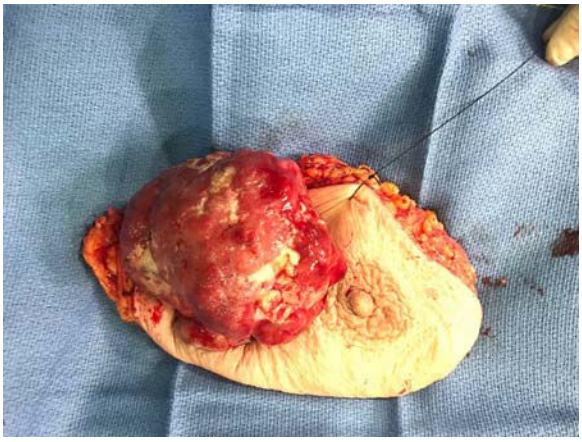

Fig. 2 – Exophytic mass, with no signs of infection.

While the etiology of this neoplasm is unknown, it has been related to chronic sun exposure, exposure to chemical agents, and immunosuppression.[1]

The presentation is usually as a verrucous mass or nodule that can ulcerate. It is more frequent in the lower extremities (33.9%) and in the head and neck (39.9%).[1] To date, few cases of porocarcinomas in the breast have been published in the literature.[1,5,6]

The rates of recurrence and locoregional metastatic extension are high, with multiple nodules in the area of the lesion.[2] Distant metastatic extension (31%) usually has a fatal prognosis and develops mainly in lymph nodes (57.7%) and the lungs (12.8%).

The treatment of choice for this type of tumor is surgical resection of the lesion plus locoregional radiotherapy.[1]

Despite complete removal of the lesion, recurrence rates are around 20%, distant metastases are found in 12% of patients, and mortality rates are above 50%.[3]

We present the case of a 92-year-old woman with a history of arterial hypertension, dyslipidemia, polyarthritis and vitamin D deficiency, who came to the emergency department after having suffered traumatic brain injury in the context of a constitutional syndrome with weight loss over several previous months. During physical examination, an indurated, ulcerated, exophytic mass measuring about 5 × 6 cm was observed on the right breast, with no signs of infection, but capillary bleeding when touched (Figs. 1 and 2). The patient reported progressive growth of the lesion over the last 2 years, but had not reported it to her physician.

Lab work detected a hemoglobin level of 8.4 g/dL.

With the suspicion of a mammary neoplasm, and due to the capillary bleeding, we decided to treat the patient surgically with a simple right mastectomy, which was performed without incident. The patient presented good postoperative progress and was discharged 7 days after the intervention.

After the pathology report provided the diagnosis of porocarcinoma, an extension study was ordered, which identified multiple axillary lymphadenopathy clusters on the right side. Given her age, the patient decided not to undergo adjuvant treatment.

Porocarcinoma located in the breast is a very rare entity in the literature. In this case, it was treated surgically, which is the treatment of choice. Although there are no established protocols due to its poor response, in the event of locoregional or distant metastases, treatment can be completed with lymph node resection, radiotherapy and chemotherapy. Our patient herself rejected the treatment due to her advanced age.

In this case, the differential diagnosis included breast carcinoma, and a biopsy would usually have been necessary prior to treatment. However, given that the mastectomy was palliative in this patient, the biopsy would not have changed the therapeutic decision. Early diagnosis is of vital importance in this type of tumors, given their high rates of recurrence and distant disease.

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Bilateral chylothorax and chylous ascites resulting from the spontaneous rupture of a retroperitoneal lymphangioma☆

Quilotórax bilateral y ascitis quilosa como consecuencia de la rotura espontánea de un linfangioma retroperitoneal

Injury to the lymphatic system, either by obstruction or by traumatic disruption, gives rise to leakage of lymphatic fluid that can accumulate in the thoracic and abdominal cavities.[1] Chylothorax is the most common cause of pleural effusion in neonates, although in adults it represents only 3% of cases of pleural effusion. Chylous ascites is even less common, with an incidence of approximately 1 in every 20,000 cases. The simultaneous accumulation of lymph in the serous cavities is very rare. It is usually associated with non-traumatic etiologies[2] and can lead to severe nutritional deficiency as well as immunosuppression that could lead to life-threatening situations for the patient.[3]

We present the case of a 38-year-old patient with no relevant personal history who started with an episode of progressive dyspnea associated with massive left pleural effusion compatible with chylothorax. Initially, he responded to conservative treatment with pleural drainage, *nil pero os*, and total parenteral nutrition. The extension study to determine its origin included a thoracoabdominal computed tomography scan that showed an incidental finding of a lesion in segment V of the liver. Liver segmentectomy was performed, and the pathology study reported benign hepatic adenoma. The immediate postoperative period was uneventful. However, 7 days after hospital discharge, the patient was readmitted due to predominantly left bilateral pleural effusion compatible with bilateral chylothorax. Since the discharge through the left drain was > 500 mL/day and taking into account the anatomical variations of the thoracic duct described in the bibliography,[4] fluorescence-guided left video-assisted thoracoscopy and ligation of the thoracic duct were performed after administration of indocyanine green as a localization method. After surgery, the discharge of the left hemithorax decreased considerably; however, the right side increased to more than one liter a day, so it was decided to surgically address the right side, this time using lateral thoracotomy: the thoracic duct was located and tied at that level. As a result of this last intervention, the collected discharge from both thoracic drains fell significantly (<100 mL/day). Despite this, on the second postoperative day, the patient developed abdominal distension and pain along with oliguria and impaired renal function. Abdominal ultrasound revealed an abundant amount of free fluid that, after aspiration and drainage, again showed the presence of lymph.

Once all the possible secondary medical etiologies potentially causing this condition had been ruled out, magnetic resonance lymphography was performed, which detected an abdominal mass with a craniocaudal diameter of 11 cm that had not been observed on the initial computed tomography scan. The lesion extended from the celiac vessels up to the renal hila surrounding the abdominal aorta in early phases (Fig. 1), with extravasation of the contrast agent into the abdominal cavity in late phases (Fig. 2).

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