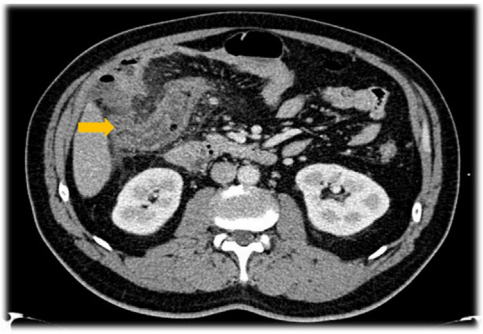

Fig. 2 – Diverticulitis in right and transverse colon, with mural thickening.

a risk factor (more common in Asians), it can also occur in Western populations (all our patients were European Caucasians). Its presentation may mimic other common conditions such as acute appendicitis with right lower quadrant abdominal pain in young people, so imaging techniques are usually mandatory for diagnosis. This cohort study highlights the importance of an uncommon condition that should be considered in the differential diagnosis of patients with right-sided abdominal pain[6] and should be known to all surgeons working in the emergency department.[7]

Funding

This study received no funding.

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http://dx.doi.org/10.1016/j.cireng.2022.06.036
2173-5077/

Influence of carotid anatomy anomaly in rescue surgery due to relapse of papillary thyroid cancer☆

Influencia de la presencia de anomalía anatómica carotídea en la cirugía de rescate por recidiva de carcinoma papilar de tiroides

A vascular kinking is a malformation, typically arterial, whose most likely origin is embryonic,[1] derived from an excessive length of the vessel, which gives it a Z-shape and has been shown to be an independent cardiovascular risk factor.[2] Due to its high surface area in contact with the surrounding structures, which it can even totally or

☆ Please cite this article as: Botella Casas G, Cassinello Fernández N, Pérez Santiago L, Alfonso Ballester R, Ortega Serrano J. Influencia de la presencia de anomalía anatómica carotídea en la cirugía de rescate por recidiva de carcinoma papilar de tiroides. Cir Esp. 2022;100:657–659.

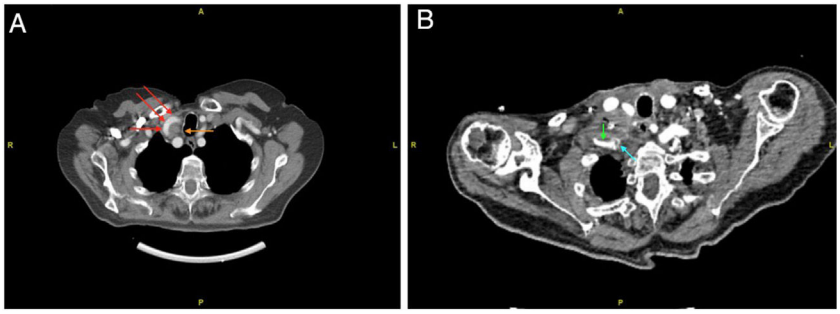

Fig. 1 – (A) CT scan of the abdomen and pelvis showing the gastric tube within the intestinal lumen (straight arrow). (B) Four long perforations at the proximal jejunum.

partially envelop, it poses a surgical difficulty with a risk of injury.

We present the case of an 89-year-old woman with a history of papillary thyroid carcinoma treated by total thyroidectomy and I^{131} 30 years earlier. During follow-up, a TgB elevation of 16 ng/mL was detected in one year, associated with a single palpable lymphadenopathy at the level of the right IV region measuring 27 × 22 × 18 mm confirmed by PET-CT. Because of the high surgical risk due to age and previous surgery, it was decided to treat initially by alcoholisation. The control CT scan (Fig. 1A) showed persistent lymphadenopathy in the cervical level IV on the right side, with no infiltration of vascular structures. As an incidental finding, there was bilateral kinking of the common carotid artery at its proximal origin in the vicinity of the beginning of the subclavian artery, closely related to the suspected lymphadenopathy.

Given the failure of alcoholisation, surgical intervention was decided. During excision of the adenopathy, intense vascular calcification was observed, which made dissection more difficult and led to a partial section of the right subclavian artery (Fig. 2) due to surgical manipulation, which was reconstructed with a subclavian by-pass with an expanded polytetrafluoroethylene (ePTFE) prosthesis (Fig. 1B). On the third postoperative day she was diagnosed with a thrombosis at the level of the right humeral artery. Despite the perceived symptoms, she refused surgical reperfusion and was managed exclusively with anticoagulation therapy. On the seventh day, complete recovery of vascularisation and disappearance of symptoms was observed and the patient was discharged. The patient refused treatment with con I^{131} and one year later her TgB levels were on the rise, and there was a suspicion of tumour recurrence in the same location detected by CT scan. There are no vascular problems related to the carotid or subclavian territories.

The incidence of lymph node metastases in the lateral cervical compartment in patients with papillary thyroid cancer can be as high as 20.9%,[3] with cervical level III being affected more frequently than the others (62,6%).[4] Levels III and IV, in addition to being the most frequently affected, are also the most anatomically related to the cervical vascular bundle as they are located along the sternocleidomastoid and are in close contact with the carotid sheath and, in the case of level IV, also with the proximal portion of the subclavian artery. This proximity may imply a high risk of intraoperative vascular injury, especially in patients with aberrant or less common distributions.

In terms of arterial malformations, kinking is the most frequent of all,[5] being present in 10%–25% of the population.[6] There is currently no clear indication for surgical treatment of kinking if it remains asymptomatic. However, in symptomatic kinking cases, symptom reduction due to decreased blood flow through the kinking has been observed[7] and endarterectomy is effective in preventing ipsilateral ischaemic cardiovascular eventss[8] without a statistically significant risk of vascular complications from revascularisation surgery.[9]

Although cervical arterial vascular malformations are infrequent, their presence, especially in older patients, may condition the surgical technique and/or approach, so we believe that the participation of multidisciplinary teams including vascular surgery is beneficial in patients with this preoperative diagnosis. As this is an isolated case, it is difficult to draw conclusions or recommendations, but we believe that it could provide useful information for the treatment of future patients who may find themselves in a similar situation.

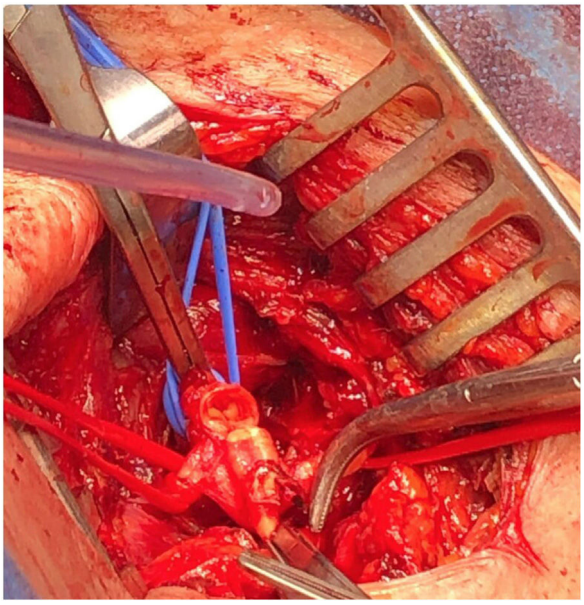

Fig. 2 – Intraoperative view of the lesion at the level of the proximal subclavian artery, marked with blue vessel-loop; carotid artery marked with red vessel-loop.

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http://dx.doi.org/10.1016/j.cireng.2022.06.035
2173-5077/

Unusual gastric band migration causing multiple perforations on the jejunum

Migración de banda gástrica causando múltiples perforaciones en el yeyuno

Laparoscopic adjustable gastric banding (LAGB) is one of the three most common procedures performed worldwide for treating morbid obesity, with a global reported incidence of 12.1% of all bariatric procedures. However, incidence of different techniques are variable among countries[1] LAGB has the advantage of being the least invasive, with the fastest insertion, adjustable restriction, reversibility, and anatomy preservation.[2] However, extensive studies on LAGB have reported a complication rate of up to 30–40%, including slippage, port dysfunction, band erosion, food intolerance, bowel obstruction, and band migration to the gastrointestinal tract, with or without perforation, being this last one, extremely rare with only a few cases reported in the literature.[3] The objective of this letter is to present a female patient who presented with a gastric band migration into the jejunum.

A 50-year-old female patient was admitted to the hospital with abdominal pain in the epigastric region, nausea, and vomiting after a one-month history of colicky abdominal pain in the same region. The patient had a medical history of LAGB insertion 19 years ago, with the last follow-up 10 years ago. Her body mass index (BMI) at the moment of the bland placement was 55 kg/m^2. Her current BMI is 40 kg/m^2. The patient lost 45 kg of body weight, for a total weight loss of 31%. The patient was hemodynamically stable and afebrile. Physical examination showed abdominal distension with reduced bowel movements to auscultation accompanied by diffuse abdominal tenderness to superficial and deep palpation, with a tympanic colonic margin to percussion.

CT was performed, revealing an obstruction of the small bowel due to an intra-jejunal location of the LAGB, and no free