sampling errors means the presence of malignancy cannot be ruled out.

Intestinal intussusception is the introduction of a proximal segment of the intestine into a more distal segment; it represents only 1–5% of intestinal obstructions and can be caused by malignancy (lymphoma, adenocarcinoma) or have a benign cause, such as intraluminal lipomas. The diagnosis of intussusception is confirmed by imaging tests, with CT being the most sensitive and specific (83–100%). The characteristic finding is the presence of colon within colon or ileum within colon, as was found in the case we present here. CT will also show the existence of proximal occlusion and any distension of intestinal loops.[3,4]

Due to their benign nature, most colon lipomas do not require treatment, except when there is uncertainty about the diagnosis, the patient has symptoms or they are more than 2 cm in size. Endoscopic resection assisted by endoloops or endoclips can be a treatment option in experienced hands. A prior endoscopic ultrasound is advisable to identify the size, borders, vascularisation, layer of origin and extension of the serosa or muscle within the peduncle and to minimise the risk of perforation.[1,2] Surgical resection is the most widely used treatment for colon lipomas: it is indicated in cases of giant, sessile lipomas, suspected malignancy, serious complications (obstruction, intestinal intussusception, perforation or haemorrhage) or muscle or serous layer involvement (in which endoscopic resection is contraindicated). These days, segmental resections of the colon are most common, using a laparoscopic or open approach, with the rate of complications being low.[2,5]

We are able to conclude that giant lipomas of the colon are uncommon findings in routine colonoscopies and that the coexistence of two complications in the same patient, in addition to endoscopic characteristics indistinguishable from a neoplastic lesion, is very rare. Therefore, when we detect a giant lipoma, particular attention must be paid to its endoscopic characteristics, using endoscopic ultrasound to assess its resectability, as the likelihood of future complications is high and they can potentially be serious.

Conflicts of interest

None of the authors have conflicts of interest to declare.

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Abscess secondary to complicated peptic ulcer managed by endoscopic ultrasound-guided drainage with a lumen-apposing metal stent☆

Absceso secundario a úlcera péptica complicada resuelto mediante drenaje guiado por ecoendoscopia con prótesis de aposición luminal

We present the case of a 67-year-old female patient with no relevant medical history or history of smoking or alcohol or substance abuse. She was admitted to Gastroenterology with a six-day history of epigastric pain, for which she had already visited the Accident and Emergency Department five days earlier, but had been discharged home as investigations were normal (lab tests, abdominal ultrasound) and good pain control was achieved with analgesia. On this occasion, analyses showed slight elevation of liver enzymes (AST 64 U/l, ALT 104 U/l, GGT 143 U/l, alkaline phosphatase 187 U/l) and elevation of acute phase reactants (c-reactive protein >350 mg/l, fibrinogen 1000 mg/dl), but abdominal ultrasound was normal once again. During her stay in hospital, good pain control was achieved, the patient's general condition remained good and to complete the tests, an abdominal computed tomography (CT) scan was requested, which she had on day four. The CT scan showed an intra-abdominal collection with a high air-fluid level (12 × 14 cm) in contact with the left lobe of the liver and gastric antrum (Fig. 1A–B).

A gastroscopy was performed to make a differential diagnosis between abscess of biliary or gastroduodenal origin. In addition to an image of extrinsic compression of

☆ Please cite this article as: Hijos G, Abad D, Laredo V, Alfaro E, Cañamares P, García S, et al. Absceso secundario a úlcera péptica complicada resuelto mediante drenaje guiado por ecoendoscopia con prótesis de aposición luminal. Gastroenterol Hepatol. 2021;44:128–130.

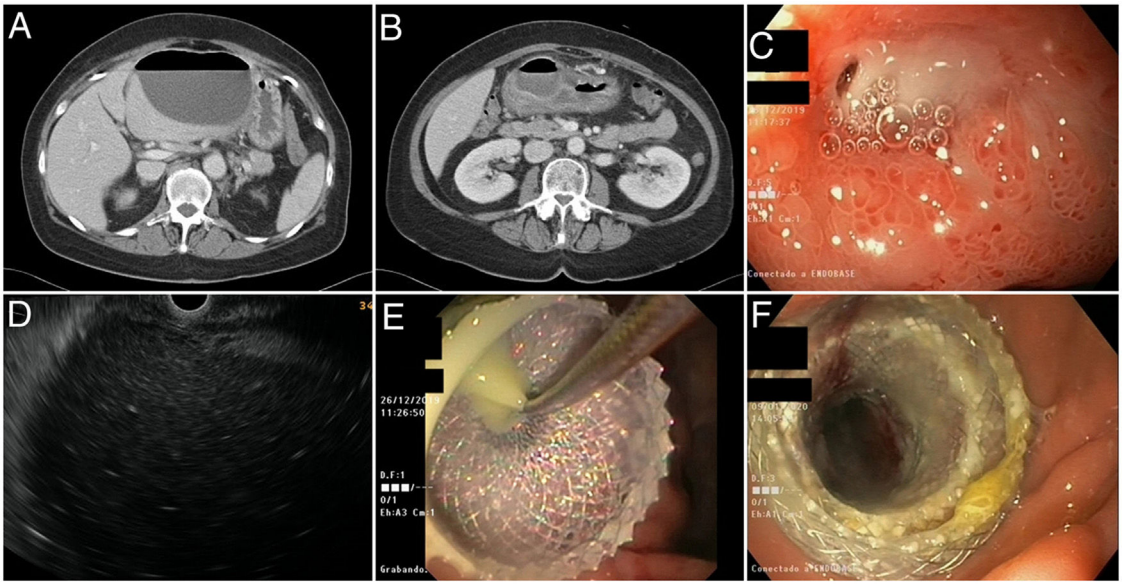

Figure 1 A-B) Abdominal CT images showing a large hypodense collection with an air-fluid level compatible with abscess, showing contact with the left lobe of the liver and with the gastric antrum. C) First gastroscopy. Duodenal bulb ulcer with a hole in its interior suggestive of perforation. D) Endoscopic ultrasound image of the abdominal collection from the gastric antrum. E) Moment of placement of the Hot-Axios® lumen-apposing stent with drainage of purulent material. F) Check-up after one week; open stent allowing access to a cavity now free of purulent material.

the gastric antrum, the duodenal bulb was found to have oedema and inflammation and, on its anterior surface, a small 5-mm ulcer covered with fibrin with spontaneous drainage of purulent content through a 2-mm hole in the interior, suggestive of perforation (Fig. 1C). As the patient was virtually asymptomatic and there were no signs of alarm, we opted for non-surgical management and endoscopic ultrasound was performed, again visualising the collection (Fig. 1D) and placing a Hot-Axios® 10×20 mm lumen-apposing stent at the level of the antrum which enabled drainage of abundant purulent material (Fig. 1E). Due to its large size, easy access, and low output from the orifice of the fistula, we decided to drain the collection, as we considered that conservative management would not resolve the problem and would substantially prolong hospital admission. A repeat gastroscopy was performed a week later, showing a collection containing no purulent material (Fig. 1F), covered with granulation tissue. Two weeks later, the stent was removed after complete resolution of the condition. As regards the aetiology of the ulcer, biopsies taken to rule out *H. pylori* came back negative, and it was assumed that the ulcer was related to the patient taking non-steroidal anti-inflammatory drugs (NSAID) prescribed for joint pain weeks prior to admission. The patient had been started on treatment with proton pump inhibitors (PPI) at diagnosis, with subsequent follow-up endoscopies showing the ulcer to have completely healed.

Endoscopic ultrasound-guided drainage, less invasive than percutaneous or surgical, is a procedure increasingly used in a range of indications. Lumen-apposing stents are shorter than conventional metal stents and have wider ends, which reduces the risk of migration. They are currently one of the most widely used stents for endoscopic ultrasound-guided drainage of infected encapsulated pancreatic necrosis, with data suggesting that they may be superior to drainage with plastic stents, although as yet there is a lack of solid evidence. These stents have a big enough diameter to facilitate adequate drainage and even perform endoscopic necrosectomy through them.[1] They have also been used successfully for endoscopic drainage of the bile duct (choledochoduodenostomy), treatment of acute cholecystitis in patients with high surgical risk (cholecystogastrostomy) and to perform gastroenteroanastomosis in patients with gastric outflow tract obstruction or other indications (enable endoscopic retrograde cholangiopancreatography [ERCP] in patients with Roux-en-Y anatomy).[2]

The incidence of admissions for peptic ulcer is declining. The most common complication is gastrointestinal bleeding. Perforation is less common; it usually manifests as an acute abdomen with a CT finding of pneumoperitoneum and requires urgent surgery in most cases. Less often, if the perforation is contained by neighbouring organs or if concomitant treatments interfere with its clinical course, it can present in a more latent form, giving rise to an intra-abdominal abscess.[3] We have presented a case of intra-abdominal abscess secondary to a perforated duodenal ulcer with an atypical clinical presentation, which we were able to completely resolve by inserting a lumen-apposing stent. There is very little evidence on the use of this technique for the drainage of non-pancreatic intra-abdominal collections. It has mainly been used for post-surgical collections, with good outcomes.[4] A Spanish series of 18 intra-abdominal abscesses, which were neither pancreatic nor postoperative, recently reported high technical and clinical success rates (both 88.9%) for endoscopic ultrasound drainage, including eight lumen-apposing stents and ten conventional metal or

plastic stents.[5] Although controlled studies are required, using our case as illustration, we believe this technique could be useful for the management of intra-abdominal abscesses.

Conflicts of interest

The authors declare that they have no conflicts of interest.

Funding

This study has received no specific funding from public, private or non-profit organisations.

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Familial adenomatous polyposis associated with pancreatic neuroendocrine tumour☆

Poliposis adenomatosa familiar asociada a tumor neuroendocrino de páncreas

A high percentage of patients with familial adenomatous polyposis (FAP) have extraintestinal manifestations. However, FAP associated with pancreatic cancer, such as in the case described below, is uncommon.

We present the case of a 65-year-old male former smoker with a history of Arnold-Chiari type I malformation, partial ulcer-related gastrectomy and FAP who, in his youth, had undergone total proctocolectomy and ileoanal anastomosis with ileal pouch and endoscopic resection of duodenal adenomas. He had stopped attending his medical check-ups in recent years due to depression. The patient consulted with epigastric pain and vomiting. On examination, a hard mass was palpable in the epigastrium, and ultrasound confirmed the presence of a solid, heterogeneous tumour adjacent to the pancreas. The CT scan showed a voluminous, hypervascularised 9 × 8 cm mass, with an area of central necrosis, at the head of the pancreas compressing the duodenum and neighbouring vascular structures (Fig. 1). No liver metastases were detected. Chromogranin levels were found to be elevated (209.4 ng/ml). Octreotide scintigraphy identified intense activity in the region of the pancreatic tumour, but no uptake of the marker in other locations. Ultrasound-guided percutaneous biopsy of the lesion confirmed a well differentiated, chromogranin- and synaptophysin-positive, intermediate-grade (WHO G2) neuroendocrine tumour, with a Ki-67 index of less than 20%. The multidisciplinary team decided to operate on the lesion, but during surgery it was discovered to be unresectable. The patient was started on chemotherapy (streptozocin/5-fluorouracil), but died a few months later as a result of pneumonia with sepsis.

FAP is the most common inherited polyposis syndrome. Even so, it only affects one in every 10,000–20,000 people. It is characterised by multiple adenomatous polyps in the colon, from tens to thousands in number. FAP occurs due to a germline mutation in the APC gene, and is transmitted with an autosomal dominant inheritance pattern. Up to 70% of individuals with FAP develop extraintestinal manifestations, which include desmoid tumours, osteomas, epidermoid cysts, dental abnormalities, congenital hypertrophy of the retinal epithelium, duodenal and periampullary adenomas, papillary thyroid carcinoma and hepatoblastoma. It is known that the location of the mutation within the APC gene determines the clinical phenotype, the severity, the risk of cancer and the likelihood of certain extraintestinal manifestations, depending on the codons affected.

Pancreatic tumours are uncommon in individuals with FAP. However, there are reports in the medical literature of cases of FAP and pancreatic tumours of different types (exocrine, endocrine and stromal). Nevertheless, whether or not there is a common genetic association responsible for both conditions remains the subject of debate. Patients with FAP are estimated to have a four-fold higher risk of pancreatic carcinoma than the general population, with the total risk being around 2% over their lifetime.[1] Available data are

☆ Please cite this article as: Pardillos Tomé A, Bajador Andreu E, Comín Orce A, Marcilla Córdoba F. Poliposis adenomatosa familiar asociada a tumor neuroendocrino de páncreas. Gastroenterol Hepatol. 2021;44:130–131.