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Contents

Thrice Monthly Volume 10 Number 30 October 26, 2022

REVIEW

- 10823** New insights into the interplay between intestinal flora and bile acids in inflammatory bowel disease
Zheng L
- 10840** Role of visfatin in obesity-induced insulin resistance
Abdalla MMI

MINIREVIEWS

- 10852** Hyperthermic intraperitoneal chemotherapy and colorectal cancer: From physiology to surgery
Ammerata G, Filippo R, Laface C, Memeo R, Solaini L, Cavaliere D, Navarra G, Ranieri G, Currò G, Ammendola M
- 10862** New-onset diabetes secondary to acute pancreatitis: An update
Yu XQ, Zhu Q
- 10867** Ketosis-prone diabetes mellitus: A phenotype that hospitalists need to understand
Boike S, Mir M, Rauf I, Jama AB, Sunesara S, Mushtaq H, Khedr A, Nitesh J, Surani S, Khan SA
- 10873** 2022 Monkeypox outbreak: Why is it a public health emergency of international concern? What can we do to control it?
Ren SY, Li J, Gao RD

ORIGINAL ARTICLE

Retrospective Cohort Study

- 10882** Clinical characteristics and prognosis of non-small cell lung cancer patients with liver metastasis: A population-based study
Wang JF, Lu HD, Wang Y, Zhang R, Li X, Wang S

Retrospective Study

- 10896** Prevalence and risk factors for *Candida* esophagitis among human immunodeficiency virus-negative individuals
Chen YH, Jao TM, Shiue YL, Feng IJ, Hsu PI
- 10906** Prognostic impact of number of examined lymph nodes on survival of patients with appendiceal neuroendocrine tumors
Du R, Xiao JW

Observational Study

- 10921** Clinical and epidemiological features of ulcerative colitis patients in Sardinia, Italy: Results from a multicenter study
Magri S, Demurtas M, Onidi MF, Picchio M, Elisei W, Marzo M, Miculan F, Manca R, Dore MP, Quarta Colosso BM, Cicu A, Cugia L, Carta M, Binaghi L, Usai P, Lai M, Chicco F, Fantini MC, Armuzzi A, Mocci G

- 10931** Clinical observation of laparoscopic cholecystectomy combined with endoscopic retrograde cholangiopancreatography or common bile duct lithotripsy

Niu H, Liu F, Tian YB

Prospective Study

- 10939** Patient reported outcome measures in anterior cruciate ligament rupture and reconstruction: The significance of outcome score prediction

Al-Dadah O, Shepstone L, Donell ST

SYSTEMATIC REVIEWS

- 10956** Body mass index and outcomes of patients with cardiogenic shock: A systematic review and meta-analysis

Tao WX, Qian GY, Li HD, Su F, Wang Z

META-ANALYSIS

- 10967** Impact of being underweight on peri-operative and post-operative outcomes of total knee or hip arthroplasty: A meta-analysis

Ma YP, Shen Q

- 10984** Branched-chain amino acids supplementation has beneficial effects on the progression of liver cirrhosis: A meta-analysis

Du JY, Shu L, Zhou YT, Zhang L

CASE REPORT

- 10997** Wells' syndrome possibly caused by hematologic malignancy, influenza vaccination or ibrutinib: A case report

Šajin M, Luzar B, Zver S

- 11004** Giant cutaneous squamous cell carcinoma of the popliteal fossa skin: A case report

Wang K, Li Z, Chao SW, Wu XW

- 11010** Right time to detect urine iodine during papillary thyroid carcinoma diagnosis and treatment: A case report

Zhang SC, Yan CJ, Li YF, Cui T, Shen MP, Zhang JX

- 11016** Two novel mutations in the *VPS33B* gene in a Chinese patient with arthrogryposis, renal dysfunction and cholestasis syndrome 1: A case report

Yang H, Lin SZ, Guan SH, Wang WQ, Li JY, Yang GD, Zhang SL

- 11023** Effect of electroacupuncture for Pisa syndrome in Parkinson's disease: A case report

Lu WJ, Fan JQ, Yan MY, Mukaeda K, Zhuang LX, Wang LL

- 11031** Neonatal Cri du chat syndrome with atypical facial appearance: A case report

Bai MM, Li W, Meng L, Sang YF, Cui YJ, Feng HY, Zong ZT, Zhang HB

- 11037** Complete colonic duplication presenting as hip fistula in an adult with pelvic malformation: A case report

Cai X, Bi JT, Zheng ZX, Liu YQ

- 11044** Autoimmune encephalitis with posterior reversible encephalopathy syndrome: A case report
Dai SJ, Yu QJ, Zhu XY, Shang QZ, Qu JB, Ai QL
- 11049** Hypophysitis induced by anti-programmed cell death protein 1 immunotherapy in non-small cell lung cancer: Three case reports
Zheng Y, Zhu CY, Lin J, Chen WS, Wang YJ, Fu HY, Zhao Q
- 11059** Different intraoperative decisions for undiagnosed paraganglioma: Two case reports
Kang D, Kim BE, Hong M, Kim J, Jeong S, Lee S
- 11066** Hepatic steatosis with mass effect: A case report
Hu N, Su SJ, Li JY, Zhao H, Liu SF, Wang LS, Gong RZ, Li CT
- 11074** Bone marrow metastatic neuroendocrine carcinoma with unknown primary site: A case report and review of the literature
Shi XB, Deng WX, Jin FX
- 11082** Child with adenylosuccinate lyase deficiency caused by a novel complex heterozygous mutation in the ADSL gene: A case report
Wang XC, Wang T, Liu RH, Jiang Y, Chen DD, Wang XY, Kong QX
- 11090** Recovery of brachial plexus injury after bronchopleural fistula closure surgery based on electrodiagnostic study: A case report and review of literature
Go YI, Kim DS, Kim GW, Won YH, Park SH, Ko MH, Seo JH
- 11101** Severe *Klebsiella pneumoniae* pneumonia complicated by acute intra-abdominal multiple arterial thrombosis and bacterial embolism: A case report
Bao XL, Tang N, Wang YZ
- 11111** Spontaneous bilateral femur neck fracture secondary to grand mal seizure: A case report
Senocak E
- 11116** Favorable response after radiation therapy for intraductal papillary mucinous neoplasms manifesting as acute recurrent pancreatitis: A case report
Harigai A, Kume K, Takahashi N, Omata S, Umezawa R, Jingu K, Masamune A
- 11122** Acute respiratory distress syndrome following multiple wasp stings treated with extracorporeal membrane oxygenation: A case report
Cai ZY, Xu BP, Zhang WH, Peng HW, Xu Q, Yu HB, Chu QG, Zhou SS
- 11128** Morphological and electrophysiological changes of retina after different light damage in three patients: Three case reports
Zhang X, Luo T, Mou YR, Jiang W, Wu Y, Liu H, Ren YM, Long P, Han F
- 11139** Perirectal epidermoid cyst in a patient with sacroccygeal scoliosis and anal sinus: A case report
Ji ZX, Yan S, Gao XC, Lin LF, Li Q, Yao Q, Wang D

- 11146** Synchronous gastric cancer complicated with chronic myeloid leukemia (multiple primary cancers): A case report
Zhao YX, Yang Z, Ma LB, Dang JY, Wang HY
- 11155** Giant struma ovarii with pseudo-Meigs' syndrome and raised cancer antigen-125 levels: A case report
Liu Y, Tang GY, Liu L, Sun HM, Zhu HY
- 11162** Longest survival with primary intracranial malignant melanoma: A case report and literature review
Wong TF, Chen YS, Zhang XH, Hu WM, Zhang XS, Lv YC, Huang DC, Deng ML, Chen ZP
- 11172** Spontaneous remission of hepatic myelopathy in a patient with alcoholic cirrhosis: A case report
Chang CY, Liu C, Duan FF, Zhai H, Song SS, Yang S
- 11178** Cauda equina syndrome caused by the application of DuraSeal™ in a microlaminectomy surgery: A case report
Yeh KL, Wu SH, Fuh CS, Huang YH, Chen CS, Wu SS
- 11185** Bioceramics utilization for the repair of internal resorption of the root: A case report
Riyahi AM
- 11190** Fibrous hamartoma of infancy with bone destruction of the tibia: A case report
Qiao YJ, Yang WB, Chang YF, Zhang HQ, Yu XY, Zhou SH, Yang YY, Zhang LD
- 11198** Accidental esophageal intubation *via* a large type C congenital tracheoesophageal fistula: A case report
Hwang SM, Kim MJ, Kim S, Kim S
- 11204** Ventral hernia after high-intensity focused ultrasound ablation for uterine fibroids treatment: A case report
Park JW, Choi HY

LETTER TO THE EDITOR

- 11210** C-Reactive protein role in assessing COVID-19 deceased geriatrics and survivors of severe and critical illness
Nori W

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Giant cutaneous squamous cell carcinoma of the popliteal fossa skin: A case report

Ke Wang, Zhen Li, Sheng-Wu Chao, Xiao-Wei Wu

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Abstract

BACKGROUND

Cutaneous squamous cell carcinoma (cSCC) is a common malignant hyperplasia of the skin epithelium. However, cSCC progressing to giant squamous cell carcinoma of the popliteal fossa skin has not been reported. We used full-thickness skin graft from the lower left quadrant of the abdomen to reconstruct the popliteal fossa skin defect in our patient.

CASE SUMMARY

A 64-year-old woman presented with a 3-year history of a progressively enlarged integumentary tumor located on her left popliteal fossa, which was surgically treated. The resultant defect (15 cm × 25 cm) was repaired using full-thickness skin graft from the lower left quadrant of the abdomen.

CONCLUSION

Full-thickness skin graft is a good choice to repair popliteal fossa defect.

Key Words: Giant cutaneous squamous cell carcinoma; Popliteal fossa skin; Case report

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Core Tip: We report an exceedingly rare case of giant cutaneous squamous cell carcinoma (maximum diameter > 5 cm), which presented as skin invasion of the popliteal fossa that was excised with optimal clinical result.

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INTRODUCTION

Cutaneous squamous cell carcinoma (cSCC) is a non-melanoma skin and keratinocyte cancer, accounting for 20% of all skin cancers, and it is the second most common cancer worldwide[1]. Unfortunately, cSCC is not included in the national cancer registry in the United States, which makes it difficult for us to know the exact morbidity and mortality in China. European data show that the age-standardized incidence of cSCC is 9 to 96 cases per 100000 male residents and 5 to 68 cases per 100000 female residents (2002-2007 estimate)[2-4].

Although cSCC is mostly a benign tumor, it can locally infiltrate and metastasize. The 10-year survival rate of patients with cSCC is over 90%, but when metastasis occurs, the survival rate drops sharply[5]. The frequency of lymph node metastasis is about 4%, and the mortality is close to 2%. Because of the high incidence of cSCC, it has a significant impact on the overall mortality[6]. Furthermore, most cSCCs can be completely removed by surgery. cSCC of the popliteal fossa skin, which is a very rare site, is closely related to the knee joint and important neurovascular system, posing a surgical challenge for reconstruction. Herein, we report an exceedingly rare case of giant cSCC (maximum diameter > 5 cm), which presented as skin invasion of the popliteal fossa that was excised with optimal clinical result.

CASE PRESENTATION

Chief complaints

Three-year history of pain and mobility problems due to a progressively enlarged integumentary tumor located on the left popliteal fossa.

History of present illness

In June 2020, a 64-year-old woman presented with a 3-year history of pain and mobility problems due to a progressively enlarged integumentary tumor located on her left popliteal fossa.

History of past illness

This patient had no history of chronic diseases, such as hypertension, hyperuricemia, hyperlipidemia, and coronary heart disease.

Personal and family history

The patient was a non-smoker and had no family history of cSCC.

Physical examination

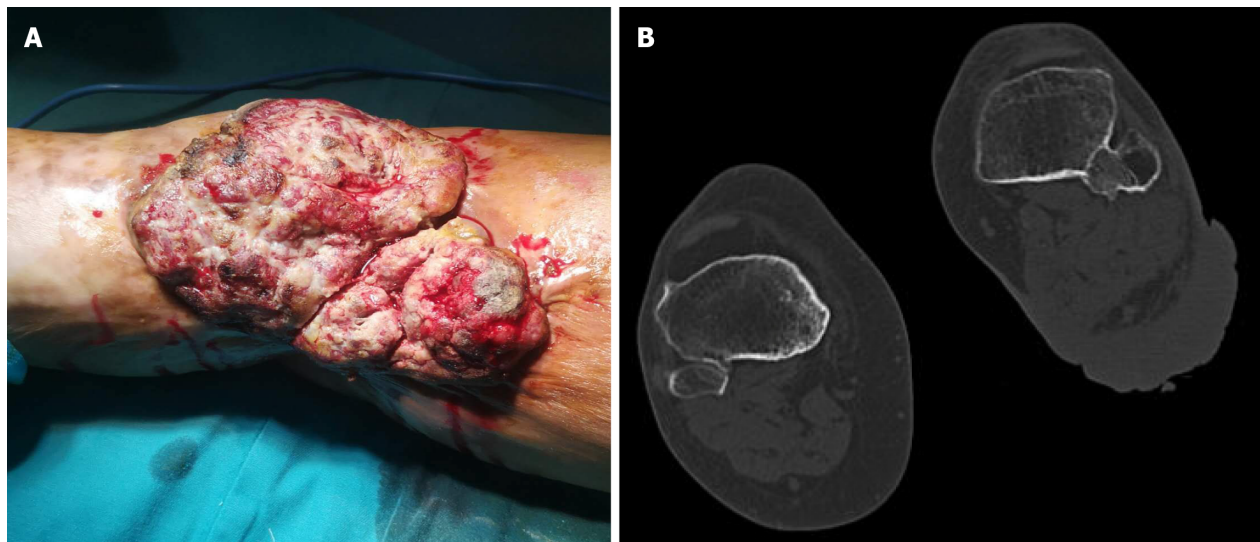
Physical examination showed an erythematous, nodular, protruding, ulcerative, mainly necrotic, foul smelling, cauliflower-like, firm skin tumor measuring 15 cm × 20 cm on the left popliteal fossa (Figure 1A). However, no significant lymph node or distant metastases were identified.

Laboratory examinations

The laboratory results revealed that the level of squamous cell carcinoma antigen was 20 ng/mL, the C-reactive protein level was 15.5 mg/L, and the erythrocyte sedimentation rate was 42 mm/h. Other laboratory results were within the normal range.

Imaging examinations

Computed tomography showed that the tumor had infiltrated deep into the muscular layer of the left popliteal fossa, but not the skeletal layer (Figure 1B).



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Figure 1 Before the surgery. A: A huge erythematous nodular ulcerative skin tumor, measuring approximately 15 cm × 20 cm, was located on the left popliteal fossa; B: Computed tomography scan of the popliteal fossa.

FINAL DIAGNOSIS

Giant cSCC of the popliteal fossa skin.

TREATMENT

After popliteal fossa tumor excision and skin grafting, the tumor was totally excised. The tumor infiltrated the muscular layer and a 4 cm margin of muscular tissue was excised with the tumor. The final surgical defect measured 15 cm × 25 cm (Figure 2A and B). The surgical defect was repaired with a full-thickness skin graft from the lower left quadrant of the abdomen.

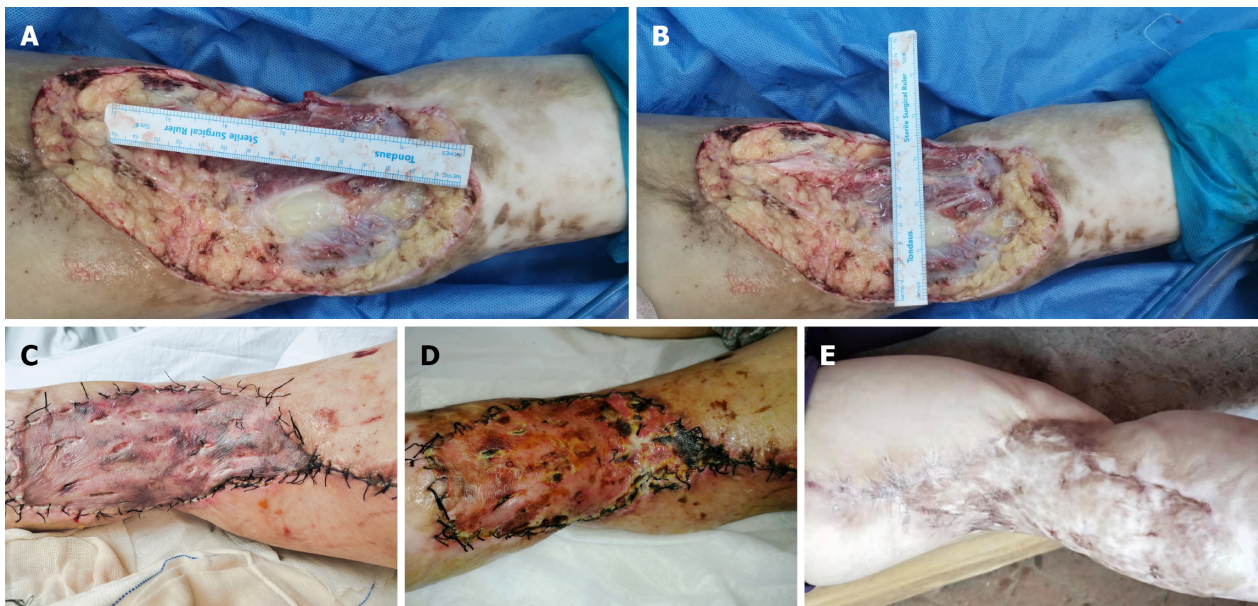
OUTCOME AND FOLLOW-UP

After surgery, the patient's condition significantly improved (Figure 2C and D). Hematoxylin and eosin-stained section of the surgical specimen revealed an invasive, infiltrative well-differentiated cSCC (Figure 3). The patient was discharged 1 mo after operation, and had no recurrence and good wound healing after surgery. The patient was followed for one year after surgery (Figure 2E), without recurrent symptoms.

DISCUSSION

Although most cSCC cases have a good prognosis after surgical resection[7], 3.7%-5.2% of patients have lymph node metastasis, and 1.5%-2.1% of patients die of cSCC[8]. Although these incidences are relatively low compared with those of many other malignant tumors, the absolute number of cSCC patients with lymph node metastasis is estimated to be 5604 to 12572 in the United States alone[9]. In addition, the estimated number of cSCC-related deaths per year is between 3932 and 8791, and its upper limit is close to the number of melanoma-related deaths per year. Thus, it is important to identify such aggressive cSCC cases in time, which can guide additional testing and treatment to improve the prognosis[7].

Old age, fair skin, long-term sun exposure, long-term immunosuppression, and previous skin cancer diagnosis are all important risk factors for cSCC[10]. In addition, long-term skin inflammation seems to contribute to the development of cSCC, such as chronic wound, ulcer, sinus tract, burn, or scar[11]. This patient developed cSCC mainly due to repeated skin ulceration, leading to local chronic inflammation and popliteal squamous cell carcinoma, which not only affects the functional recovery of knee joint but also increases the probability of malignant degeneration and the difficulty of popliteal defect reconstruction.



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Figure 2 After extirpating the tumor, the final surgical defect on the left popliteal fossa measured 25 cm × 15 cm. A: The surgical defect in the left popliteal fossa was 25 cm long; B: The surgical defect in the left popliteal fossa was 15 cm wide; C: As seen on day 4 after reconstruction, the surgical defect on the left popliteal fossa was repaired by full-thickness skin grafting; D: Appearance of the full-thickness skin repair of the left popliteal fossa on day 15 after reconstruction; E: Appearance of the full-thickness skin repair of the left popliteal fossa at the 1-year follow-up.

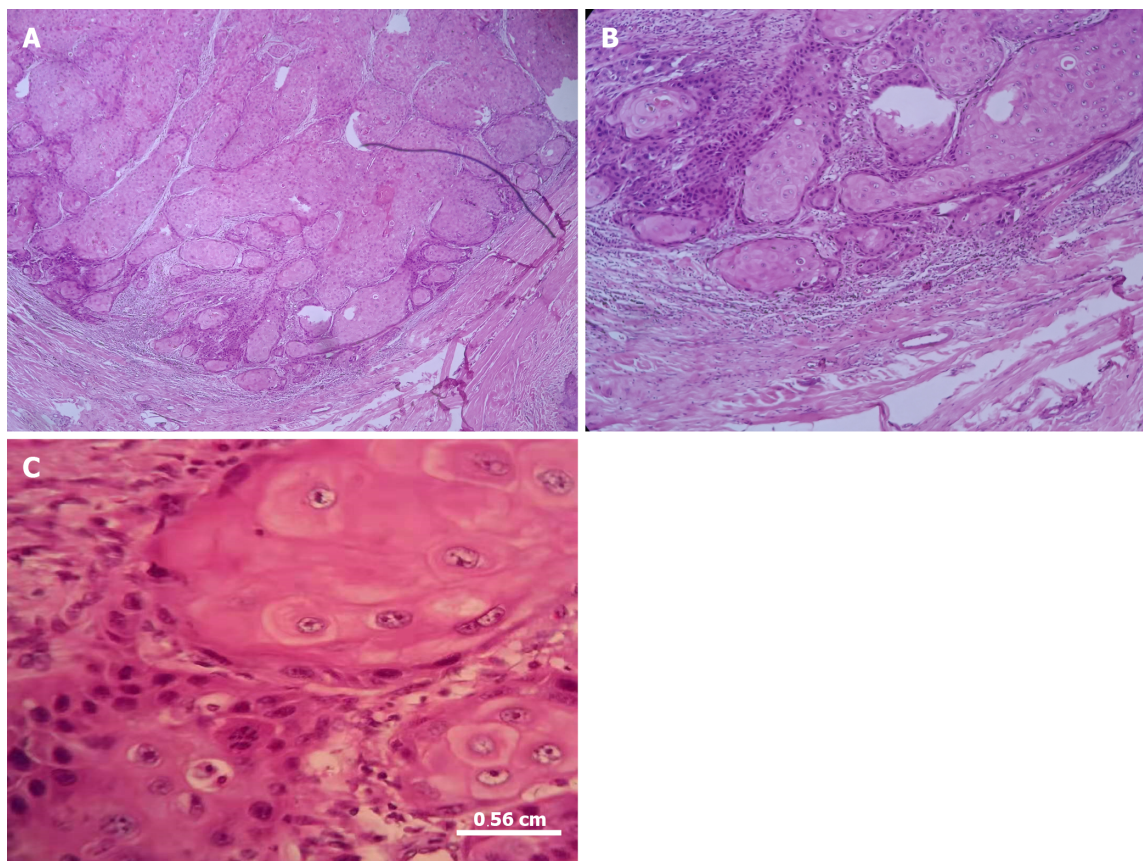
Besides Bowen disease, keratoacanthoma (KA), and invariant cSCC classic variant described above, the pathological tissues of cSCC also have several types, such as fibroproliferative, spindle cell, keratolytic, pseudovascular, verrucous, wedge-shaped epithelioma, adenosquamous cell and neurotrophic cSCC[12]. Disordered maturation of atypical keratinocytes, single cell keratinization, nuclear pleomorphism, atypical mitosis, and multi-nucleated tumor cells appear in all epidermal layers, but the basal layer remains unchanged[13]. KA is a symmetrical keratinocyte hyperplasia with limited proliferation, and its central horn plug and epidermis extend to the tumor. Histologically, invasive cSCC is characterized by atypical and abnormal keratinocytes, hyperchromic and pleomorphic nuclei, and atypical mitotic cells. Well-differentiated cSCC usually has horny pearls and single cell keratinization, while poorly differentiated cSCC usually lacks keratinization, and has many atypical mitoses and mixed inflammatory infiltration.

Pathological examination showed numerous squamous cells with keratosis and mitotic infiltration [13]. Considering that it was invasive cSCC with keratosis and no lymph node metastasis was found in our case, we performed surgery for complete tumor resection and skin grafting, and advised the patient to undergo regular postoperative reexamination.

The resection of cSCC at the popliteal fossa involves joint movement and numerous blood vessels and nerves. Therefore, it is critical to protect the important neurovascular system and prevent secondary scar contraction based on extensive activities of the popliteal fossa, which may be manifested as external aesthetic distortion and popliteal fossa retraction, thus seriously damaging the shape and function[14]. We chose a full-thickness skin graft from the lower left quadrant of the abdomen to repair the popliteal fossa defect. Full-thickness skin graft can survive on fresh sterile wounds or infected granulation wounds due to its characteristics of thin skin and strong vitality[15]. Additionally, the donor area is scar-free and cannot be easily infected[16]. In the present case, the patient could perform normal daily activities, without severe postoperative pain or any complications. Therefore, full-thickness skin repair is suitable for patients with popliteal cSCC who need extensive tumor resection, with fewer complications and faster postoperative recovery.

CONCLUSION

Full-thickness skin graft is a good alternative for the repair of popliteal fossa defects.



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Figure 3 Photomicrographs of the tumor. A: Scattered squamous cells with dyskeratosis and mitotic infiltrates (H&E staining, 40 × magnification); B: Numerous squamous cells with dyskeratosis and mitotic infiltrates (H&E staining, 100 × magnification); C: Squamous cells in the periphery of the tumor (H&E staining, 400 × magnification).

FOOTNOTES

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