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Contents

Thrice Monthly Volume 9 Number 10 April 6, 2021

MINIREVIEWS

2160 Tertiary peritonitis: A disease that should not be ignored Marques HS, Araújo GRL, da Silva FAF, de Brito BB, Versiani PVD, Caires JS, Milet TC, de Melo FF

2170 SARS-CoV-2, surgeons and surgical masks

Khalil MI, Banik GR, Mansoor S, Alqahtani AS, Rashid H

ORIGINAL ARTICLE

Case Control Study

2181 Iguratimod promotes transformation of mononuclear macrophages in elderly patients with rheumatoid arthritis by nuclear factor-KB pathway

Liu S, Song LP, Li RB, Feng LH, Zhu H

Retrospective Study

2192 Factors associated with overall survival in early gastric cancer patients who underwent additional surgery after endoscopic submucosal dissection

Zheng Z, Bu FD, Chen H, Yin J, Xu R, Cai J, Zhang J, Yao HW, Zhang ZT

- 2205 Epidemiological and clinical characteristics of 65 hospitalized patients with COVID-19 in Liaoning, China Zhang W, Ban Y, Wu YH, Liu JY, Li XH, Wu H, Li H, Chen R, Yu XX, Zheng R
- 2218 Comprehensive clinicopathologic characteristics of intraabdominal neurogenic tumors: Single institution experience

Simsek C, Uner M, Ozkara F, Akman O, Akyol A, Kav T, Sokmensuer C, Gedikoglu G

2228 Distribution and drug resistance of pathogens in burn patients in China from 2006 to 2019 Chen H, Yang L, Cheng L, Hu XH, Shen YM

Observational Study

2238 Impact of simethicone on bowel cleansing during colonoscopy in Chinese patients Zhang H, Liu J, Ma SL, Huang ML, Fan Y, Song M, Yang J, Zhang XX, Song QL, Gong J, Huang PX, Zhang H

Prospective Study

Effect of suspension training on neuromuscular function, postural control, and knee kinematics in anterior 2247 cruciate ligament reconstruction patients

Huang DD, Chen LH, Yu Z, Chen QJ, Lai JN, Li HH, Liu G

CASE REPORT

2259 Turner syndrome with positive SRY gene and non-classical congenital adrenal hyperplasia: A case report He MN, Zhao SC, Li JM, Tong LL, Fan XZ, Xue YM, Lin XH, Cao Y



 Mechanical thrombectomy for acute occlusion of the posterior inferior cerebellar artery: A case report <i>Zhang HB, Wang P, Wang Y, Wang JH, Li Z, Li R</i> Bilateral retrocorneal hyaline scrolls secondary to asymptomatic congenital syphilis: A case report <i>Jin YQ. Hu YP. Dai Q. Wu SQ</i> Recurrent undifferentiated embryonal sarcoma of the liver in adult patient treated by pembrolizumab: case report <i>Yu XH, Huang J, Ge NJ, Yang YF, Zhao JY</i> Adult onset type 2 familial hemophagocytic lymphohistiocytosis with <i>PRF1</i> c.65delC/c.163C>T compoun heterozygous mutations: A case report <i>Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL</i> Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flat transposition: A case report <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati timuitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Barges AL, Reis-de-Carvalho C, Chordo M, Pereira H, Djokovic D</i> 	World Journal of Clinical Cases		
 <i>Zhung HB, Wang P, Wang Y, Wang JH, Li Z, Li R</i> 2274 Bilateral retrocorneal hyaline scrolls secondary to asymptomatic congenital syphilis: A case report <i>Jin YQ, Hu YP, Dai Q, Wu SQ</i> 2281 Recurrent undifferentiated embryonal sarcoma of the liver in adult patient treated by pembrolizumab: case report <i>Yu XH, Huang J, Ge NJ, Yang YF, Zhao JY</i> 2289 Adult onset type 2 familial hemophagocytic lymphohistiocytosis with <i>PRF1</i> c.65delC/c.163C>T compoun heterozygous mutations: A case report <i>Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL</i> 2296 Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flit <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> 2310 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2300 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati funtitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2316 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie J, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chordo M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and oth media: A case report 	Conter	its Thrice Monthly Volume 9 Number 10 April 6, 2021	
 2274 Bilateral retrocorneal hyaline scrolls secondary to asymptomatic congenital syphilis: A case report <i>Jin YQ. Hu YP. Dai Q. Wu SQ</i> 2281 Recurrent undifferentiated embryonal sarcoma of the liver in adult patient treated by pembrolizumab: case report <i>Yu XH, Huang J. Ge NJ, Yang YF, Zhao JY</i> 2289 Adult onset type 2 familial hemophagocytic lymphohistiocytosis with <i>PRF1</i> c.65delC/c.163C>T compour heterozygous mutations: A case report <i>Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL</i> 2296 Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flat maposition: A case report <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati funtitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2336 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and otimedia: A case report 	2268	Mechanical thrombectomy for acute occlusion of the posterior inferior cerebellar artery: A case report	
 Jin YQ, Hu YP, Dai Q, Wu SQ 2281 Recurrent undifferentiated embryonal sarcoma of the liver in adult patient treated by pembrolizumab: case report Yu XH, Huang J, Ge NJ, Yang YF, Zhao JY 2289 Adult onset type 2 familial hemophagocytic lymphohistiocytosis with <i>PRF1</i> c.65delC/c.163C>T compound heterozygous mutations: A case report Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL 2296 Salvage of vascular graft infections via vacuum sealing drainage and rectus femoris muscle flattransposition: A case report Zhang P, Tao FL, Li QH, Zhou DS, Liu FX 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and ottimedia: A case report 		Zhang HB, Wang P, Wang Y, Wang JH, Li Z, Li R	
 2281 Recurrent undifferentiated embryonal sarcoma of the liver in adult patient treated by pembrolizumab: case report <i>Yu XII, Huang J, Ge NJ, Yang YF, Zhao JY</i> 2289 Adult onset type 2 familial hemophagocytic lymphohistiocytosis with <i>PRF1</i> c.65delC/c.163C>T compound heterozygous mutations: A case report <i>Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL</i> 2296 Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flat transposition: A case report <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and oth media: A case report 	2274	Bilateral retrocorneal hyaline scrolls secondary to asymptomatic congenital syphilis: A case report	
 case report Yu XH, Huang J, Ge NJ, Yang YF, Zhao JY 2289 Adult onset type 2 familial hemophagocytic lymphohistiocytosis with <i>PRF1</i> c.65delC/c.163C>T compoun heterozygous mutations: A case report <i>Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL</i> 2296 Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flat transposition: A case report <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> 2310 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tw case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and oth media: A case report 		Jin YQ, Hu YP, Dai Q, Wu SQ	
 Adult onset type 2 familial hemophagocytic lymphohisticytosis with <i>PRF1</i> c.65delC/c.163C>T compour heterozygous mutations: A case report <i>Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL</i> Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flat transposition: A case report <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and otil media: A case report 	2281	Recurrent undifferentiated embryonal sarcoma of the liver in adult patient treated by pembrolizumab: A case report	
 heterozygous mutations: A case report Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL Salvage of vascular graft infections via vacuum sealing drainage and rectus femoris muscle flattansposition: A case report Zhang P, Tao FL, Li QH, Zhou DS, Liu FX Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC Changes in sleep parameters following biomimetic oral appliance therapy: A case report Singh GD, Kherani S Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tw case reports Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and otil media: A case report 		Yu XH, Huang J, Ge NJ, Yang YF, Zhao JY	
 2296 Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flatransposition: A case report <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and otil media: A case report 	2289	Adult onset type 2 familial hemophagocytic lymphohistiocytosis with <i>PRF1</i> c.65delC/c.163C>T compound heterozygous mutations: A case report	
 transposition: A case report <i>Zhang P, Tao FL, Li QH, Zhou DS, Liu FX</i> 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and oth media: A case report 		Liu XY, Nie YB, Chen XJ, Gao XH, Zhai LJ, Min FL	
 2302 Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection chondrosarcoma in the sternum: A case report Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report Singh GD, Kherani S 2300 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tw case reports Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and other media: A case report 	2296	Salvage of vascular graft infections <i>via</i> vacuum sealing drainage and rectus femoris muscle flap transposition: A case report	
 chondrosarcoma in the sternum: A case report <i>Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC</i> 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and othmedia: A case report 		Zhang P, Tao FL, Li QH, Zhou DS, Liu FX	
 2312 Changes in sleep parameters following biomimetic oral appliance therapy: A case report <i>Singh GD, Kherani S</i> 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tw case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and othmedia: A case report 	2302	Innovative chest wall reconstruction with a locking plate and cement spacer after radical resection of chondrosarcoma in the sternum: A case report	
 Singh GD, Kherani S 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tw case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and otil media: A case report 		Lin CW, Ho TY, Yeh CW, Chen HT, Chiang IP, Fong YC	
 2320 Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsati tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tv case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and other media: A case report 	2312	Changes in sleep parameters following biomimetic oral appliance therapy: A case report	
 tinnitus: A case report <i>Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC</i> 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tw case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and othmedia: A case report 		Singh GD, Kherani S	
 2326 Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Tw case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and other media: A case report 	2320	Bone remodeling in sigmoid sinus diverticulum after stenting for transverse sinus stenosis in pulsatile tinnitus: A case report	
 case reports <i>Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ</i> 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and other media: A case report 		Qiu XY, Zhao PF, Ding HY, Li XS, Lv H, Yang ZH, Gong SS, Jin L, Wang ZC	
 2334 Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review literature <i>Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D</i> 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and other media: A case report 	2326	Prolonged use of bedaquiline in two patients with pulmonary extensively drug-resistant tuberculosis: Two case reports	
 literature Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D 2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and other media: A case report 		Gao JT, Xie L, Ma LP, Shu W, Zhang LJ, Ning YJ, Xie SH, Liu YH, Gao MQ	
2344 Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and othe media: A case report	2334	Low-grade mucinous appendiceal neoplasm mimicking an ovarian lesion: A case report and review of literature	
media: A case report		Borges AL, Reis-de-Carvalho C, Chorão M, Pereira H, Djokovic D	
Li XJ, Yang L, Yan XF, Zhan CT, Liu JH	2344	Granulomatosis with polyangiitis presenting as high fever with diffuse alveolar hemorrhage and otitis media: A case report	
		Li XJ, Yang L, Yan XF, Zhan CT, Liu JH	
2352 Primary intramedullary melanoma of lumbar spinal cord: A case report	2352	Primary intramedullary melanoma of lumbar spinal cord: A case report	
Sun LD, Chu X, Xu L, Fan XZ, Qian Y, Zuo DM		Sun LD, Chu X, Xu L, Fan XZ, Qian Y, Zuo DM	
2357 Proliferative glomerulonephritis with monoclonal immunoglobulin G deposits in a young woman: A ca report	2357	Proliferative glomerulonephritis with monoclonal immunoglobulin G deposits in a young woman: A case report	
Xu ZG, Li WL, Wang X, Zhang SY, Zhang YW, Wei X, Li CD, Zeng P, Luan SD		Xu ZG, Li WL, Wang X, Zhang SY, Zhang YW, Wei X, Li CD, Zeng P, Luan SD	



World Journal of Clinical Cases	
Thrice Monthly Volume 9 Number 10 April 6, 2021	
Nocardia cyriacigeorgica infection in a patient with pulmonary sequestration: A case report	
Lin J, Wu XM, Peng MF	
Long-term control of melanoma brain metastases with co-occurring intracranial infection and involuntary drug reduction during COVID-19 pandemic: A case report	
Wang Y, Lian B, Cui CL	
Solitary bone plasmacytoma of the upper cervical spine: A case report	
Li RJ, Li XF, Jiang WM	
Two-stage transcrestal sinus floor elevation-insight into replantation: Six case reports	
Lin ZZ, Xu DQ, Ye ZY, Wang GG, Ding X	
Programmed cell death protein-1 inhibitor combined with chimeric antigen receptor T cells in the treatment of relapsed refractory non-Hodgkin lymphoma: A case report	
Niu ZY, Sun L, Wen SP, Song ZR, Xing L, Wang Y, Li JQ, Zhang XJ, Wang FX	
Pancreatic cancer secondary to intraductal papillary mucinous neoplasm with collision between gastric cancer and B-cell lymphoma: A case report	
Ma YH, Yamaguchi T, Yasumura T, Kuno T, Kobayashi S, Yoshida T, Ishida T, Ishida Y, Takaoka S, Fan JL, Enomoto N	
Acquired haemophilia in patients with malignant disease: A case report	
Krašek V, Kotnik A, Zavrtanik H, Klen J, Zver S	



Contents

Thrice Monthly Volume 9 Number 10 April 6, 2021

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CASE REPORT

Long-term control of melanoma brain metastases with co-occurring intracranial infection and involuntary drug reduction during COVID-19 pandemic: A case report

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Abstract

BACKGROUND

Melanoma brain metastasis is a common cause of death in melanoma patients and is associated with a poor prognosis. There are relatively few reports on intracranial infections after brain metastasis resection.

CASE SUMMARY

Here we report a case of melanoma brain metastases in a patient harboring a BRAF V600E mutation, who experienced intracranial tumor progression despite previous combined treatment with a programmed death (PD)-1 inhibitor, axitinib, and vemurafenib. She repeatedly underwent local therapy, including stereotactic radiosurgery and intracranial surgery, and developed central nervous system infection. Treatment with vemurafenib combined with cobimetinib resulted in an intracranial progression-free survival of 10 mo. During the coronavirus disease 2019 (COVID-19) pandemic, the patient did not visit the hospital for regular vemurafenib treatment, and experienced intracranial progression after involuntary drug reduction for 1 mo. The patient subsequently received various systemic treatments including vemurafenib, PD-1 inhibitor, and chemotherapy, with an overall survival of 29 mo as of September 2020.

CONCLUSION

We report the first case of melanoma brain metastases with co-occurring intracranial infection and unintended drug reduction during the COVID-19 outbreak. Long-term control of the intracranial lesions was achieved with systemic and local therapies.

Key Words: Melanoma; Intracranial infection; Brain metastases; COVID-19; Local therapy; Case report



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Core Tip: We report a melanoma patient with brain metastases who had long-term control of intracranial lesions with the combination of local therapy and BRAF/MEK inhibitor. During the treatment course, the patient experienced intracranial infection and unwanted drug reduction during the coronavirus disease 2019 outbreak.

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INTRODUCTION

Melanoma is a rare, aggressive tumor and the brain is a common metastatic site. Melanoma brain metastasis is associated with a poor prognosis, with a median overall survival (OS) of 3-5 mo^[1,2]. In patients harboring *BRAF* mutations, BRAF and MEK inhibitors significantly increase the intracranial control rate and OS for brain metastases^[3]. However, compared to extracranial lesions, the duration of response is short; progression of intracranial lesions is the main reason for treatment failure^[4]. Here we report a case of melanoma brain metastases in a patient harboring a *BRAF* V600E mutation; although the patient experienced unexpected intracranial infection and dose reduction, long-term control of intracranial metastases was achieved with a combination of BRAF/MEK inhibitor and local therapies.

CASE PRESENTATION

Chief complaints

A 46-year-old Asian woman presented with a fever and headache.

History of present illness

The patient had a seizure and the convulsion localized to the right limbs. Magnetic resonance imaging (MRI) of the brain revealed lesions in the left frontal and temporal regions. Surgical removal of the suspected brain metastases was performed on May 20, 2019, but the postoperative pathologic assessment showed only necrotic tissue without tumor cells. On postoperative day 7, the patient presented with a fever and headache.

History of past illness

The patient was diagnosed with acral melanoma with a Breslow depth of 10 mm in 2016 (Figure 1). Metastasis to inguinal lymph nodes was suspected based on Positron emission tomography/computed tomography examination. The patient later underwent extended resection of the primary lesion and inguinal lymph node dissection, with one nodal metastasis in six dissected lymph nodes. Genetic testing revealed the presence of the BRAF V600E mutation. Her initial pathologic stage was pT4bN1bM0 (American Joint Committee on Cancer/Union for International Cancer Control, 8th Edition).

The patient received adjuvant high-dose interferon therapy and during a comprehensive review 3 mo later, pulmonary metastasis was detected. She was started on toripalimab [a programmed death (PD)-1 inhibitor that has been approved for the treatment of melanoma in China] combined with axitinib [an oral inhibitor of vascular endothelial growth factor (VEGF) receptors 1, 2, and 3] and had a progression-free survival (PFS) of 4 mo, at which point she experienced pulmonary progression. The treatment was switched to vemurafenib and after 9 mo, brain MRI revealed left frontal lobe metastasis. The patient underwent stereotactic radiosurgery (SRS) for the metastasis (24 Gy in 3 fractions) and continued on vemurafenib. Thereafter, she was examined every 6 wk for 10 mo.



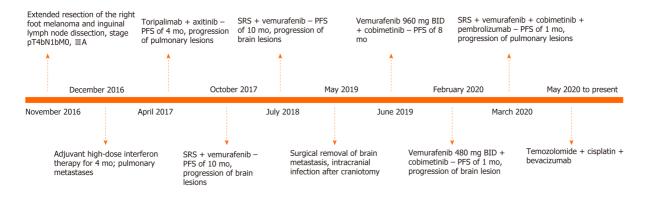


Figure 1 Timeline of the treatment course of the patient. PFS: Progression-free survival; SRS: Stereotactic radiosurgery.

Physical examination

Physical examination revealed signs of meningeal irritation. Vital signs were stable.

Laboratory examinations

A lumbar puncture was performed and the cerebrospinal fluid (CSF) had a white blood cell count of 842/µL, with an elevated lactate level (2.5 mmol/L) and reduced sugar level (2.4 mmol/L).

Imaging examinations

Brain MRI demonstrated left frontotemporal alterations following craniotomy (Figure 2).

FINAL DIAGNOSIS

Intracranial infection.

TREATMENT

The patient was treated with meropenem. In the re-examination 3 d later, the CSF test results were normal. A week later, the patient discontinued the antibiotic and was discharged. A combined treatment regimen of vemurafenib + cobimetinib was initiated on the 20th postoperative day.

OUTCOME AND FOLLOW-UP

The patient continued the treatment of vemurafenib + cobimetinib with monthly follow-up. During the coronavirus disease 2019 (COVID-19) pandemic period in February 2020, the patient was unable to visit specialized hospitals that were not in her city of residence to receive vemurafenib treatment because of travel restrictions, and she self-administered a reduced dose of vemurafenib (from 960 to 480 mg, BID) for 1 mo. In March 2020, the patient was re-examined by brain MRI and a new intracranial metastatic lesion was detected. The patient again underwent SRS with sequential vemurafenib, cobimetinib, and pembrolizumab treatments. After one cycle of combined therapy, imaging examination showed the progression of pulmonary metastases; the patient also presented with thrombocytopenia. The treatment was switched to chemotherapy with temozolomide + cisplatin + bevacizumab. As of September 2020, the patient had completed five cycles of combined chemotherapy and had stable disease.

DISCUSSION

Melanoma is highly malignant and often has a poor prognosis. In recent years,



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vemurafenib + cobimetinib treatment. PD: Progressive disease.

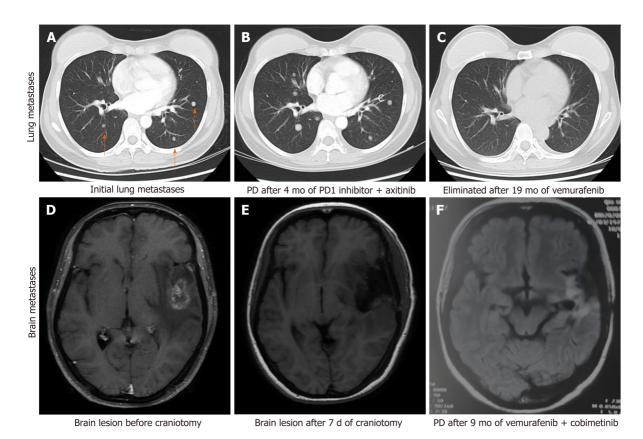


Figure 2 Representative images of lung and brain metastases in our patient at different stages of treatment. A: Initial lung metastases; B: Progression of lung metastases after 4 mo of progressive disease-1 inhibitor + axitinib treatment; C: Lung metastases eliminated after 19 mo of vemurafenib treatment; D: Metastatic brain lesions before craniotomy; E: Metastatic brain lesions 7 d after craniotomy; F: Progression of brain metastases after 9 mo of

> advances in immunotherapy and targeted therapy have significantly improved the survival rate^[3,5-7]. For patients harboring BRAF mutations, the combination of BRAF and MEK inhibitors yields a high response rate with a median survival of 1 year^[5]; immunotherapies such as PD-1, programmed death ligand (PD-L) 1, or cytotoxic T lymphocyte antigen (CTLA) 4 inhibitors have a lower initial response rate but longer response duration. Although in preclinical models BRAF and MEK inhibitors enhanced the antitumor efficacy of immunotherapy^[8,9], clinical studies^[10,11] have shown that combining BRAF and MEK inhibitors with PD-1 or PD-L1 inhibitor was associated with a higher risk of grade 3/4 treatment-related adverse events necessitating dose reduction or treatment discontinuation in a large number of cases. The optimal treatment regimen for patients with advanced melanoma with BRAF mutations has yet to be established.

> Our patient preferred the PD-1 inhibitor toripalimab combined with the VEGF inhibitor axitinib as the initial systemic treatment. Axitinib combined with PD-1 blockade has shown promising antitumor activity in patients with metastatic mucosal melanoma, with a median PFS of 7.5 mo^[12]. PFS in our patient was only 4 mo on this treatment, indicating that it was not very effective. Although the patient experienced intracranial progression several times after switching to BRAF inhibitor and the combination of BRAF and MEK inhibitors, on the latter regimen the disease has been controlled for nearly 30 mo until treatment failure occurred when the patient undertook dose reduction on her own.

> This case also illustrates that the combination of local therapy and BRAF/MEK inhibitor offers a survival benefit for melanoma patients with brain metastasis. It was previously reported that SRS combined with BRAF/MEK inhibitor treatment had a 1year local intracranial control rate of 72%^[13], and concurrent or post-SRS BRAF/MEK inhibitors increased intracranial tumor control and improved OS in patients^[14]. SRS may affect blood-brain barrier permeability and increase the intracranial delivery of BRAF/MEK inhibitors^[15]. The strategy of combining local and BRAF/MEK inhibitor therapies warrants more detailed investigation in order to determine the optimal modality and sequence of local and BRAF/MEK inhibitor therapies, along with the associated risks.



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Our patient had an intracranial infection after craniotomy for tumor resection. Intracranial infection is among the most common perioperative complications of craniotomy, with a reported incidence of 1.4%-9.5% [16-19] and high rates of long-term complications and mortality. There are relatively few reports on intracranial infections after brain metastasis resection, which has an estimated incidence of 4%^[20]. To our knowledge, secondary intracranial infection after resection of melanoma brain metastasis has not been previously reported. Longer operation time, external drainage, and contamination of surgical wounds increase the risk of post-craniotomy intracranial infection^[20-22]. None of these risk factors were present in our case, except for a long operation time (4 h). The infection was quickly controlled after antibiotic treatment, allowing the systematic antitumor treatment to proceed. Our experience with this case also demonstrates that when selecting the local treatment modality for patients with melanoma brain metastasis, severe complications such as intracranial infection should be considered.

Antitumor treatments can be lifesaving and improve patients' prognosis. However, in the context of COVID-19, physicians have become more cautious when administering antitumor therapy. At the same time, because of travel restrictions and lockdown, many patients from small cities or the countryside are unable to visit cancer specialists in major cities for treatment. In this type of public emergency situation, diagnosis and treatment as well as drug distribution via the internet are an option. In fact, since the COVID-19 pandemic, our hospital and many others in China and worldwide have established efficient telemedicine and remote counseling systems^[23-25] for the convenience of patients to diminish the possibility of adverse events or disease progression as a result of involuntary dose reduction or treatment discontinuation.

CONCLUSION

Melanoma brain metastasis is a major challenge in the treatment of melanoma. Intracranial infection after craniotomy for resection of melanoma brain metastasis is a very rare event and has not been specifically reported in the literature. Based on our case, patients with melanoma brain metastases can achieve long-term control of intracranial lesions with a combination of BRAF/MEK inhibitors. Our experience also highlights the importance of considering severe complications of local therapy and establishing internet-based diagnosis and treatment procedures.

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