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Authors:
Pablo Olcina Domínguez, Luis Estela Villa, Arancha Villadóniga Sánchez, Rocío Avellana Moreno, Sergio Gil Rojas, Jesús García-Cano Lizcano

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Brunneroma: an infrequent duodenal neoplasm

Pablo Olcina Domínguez (1). Luis Estela Villa (2). Arancha Villadóniga Sánchez (2). Rocío Avellana Moreno (3). Sergio Gil Rojas (1). Jesús García-Cano Lizcano (1).

1. Servicio de Aparato Digestivo. Hospital Virgen de la Luz. Cuenca. Spain.
2. Servicio de Cirugía General y Aparato Digestivo. Hospital Virgen de la Luz. Cuenca. Spain.
3. Servicio de Cirugía General. Hospital Clínico San Carlos. Madrid. Spain.

Pablo Olcina Domínguez
E-mail: olcinapod@gmail.com
Servicio de Aparato Digestivo. Hospital Virgen de la Luz. Cuenca. España.

Dear Editor,

An 83-year-old male presented at our institution's emergency department with long lasting epigastric discomfort, weight loss and diarrhea. Physical exam and basic laboratory tests showed no remarkable findings. Upper endoscopy revealed in the anterior wall of the duodenal bulb a sessile lesion (Paris 0-IIa) with smooth surface, slightly ulcerated at its top (figure 1A). Biopsies demonstrated a protein background and intestinal epithelium without dysplasia. Endoscopic ultrasound found a hypoechogenic oval lesion with a heterogenic content and cystic areas, dependent on the submucosal layer without infiltration signs (figure 1B). A CT scan showed an 18 mm duodenal lesion without infiltration, suggestive of gastrointestinal stromal tumor (figure 1C). Somatostatin-receptor scintigraphy was normal although an increased in serum cromogranine was found. After discussion in the oncologic committee at our institution, a laparoscopic resection was planned. Surgical full-thickness resection of the posterior wall of the duodenal bulb and primary closure was performed (figure

1D). The postoperative period was uneventful and a histologic diagnosis of Brunneroma was made. The patient remains asymptomatic 6 months after surgery. Brunneroma or Brunner gland's adenoma is an uncommon type of gastrointestinal tumor (1)

Brunner glands are located in the duodenal bulb deep mucosa, and secrete bicarbonate and mucus to neutralize acid secretion from the stomach. A Brunneroma, is a benign neoplasm, a hamartoma of Brunner glands which can also contain adipose tissue, smooth muscle and lymphoid cells (2). This lesion is usually benign, notwithstanding that a 0,3% malignant transformation has been reported (3). They are mostly asymptomatic although in some cases hemorrhage, obstruction or compression due to lesion growth can be seen (4). After the initial finding in upper endoscopy, endoscopic ultrasound is the most useful method to rule out deep invasion (1, 5). Treatment is based on polypectomy, endoscopic mucosal resection or surgical laparoscopic resection (3).

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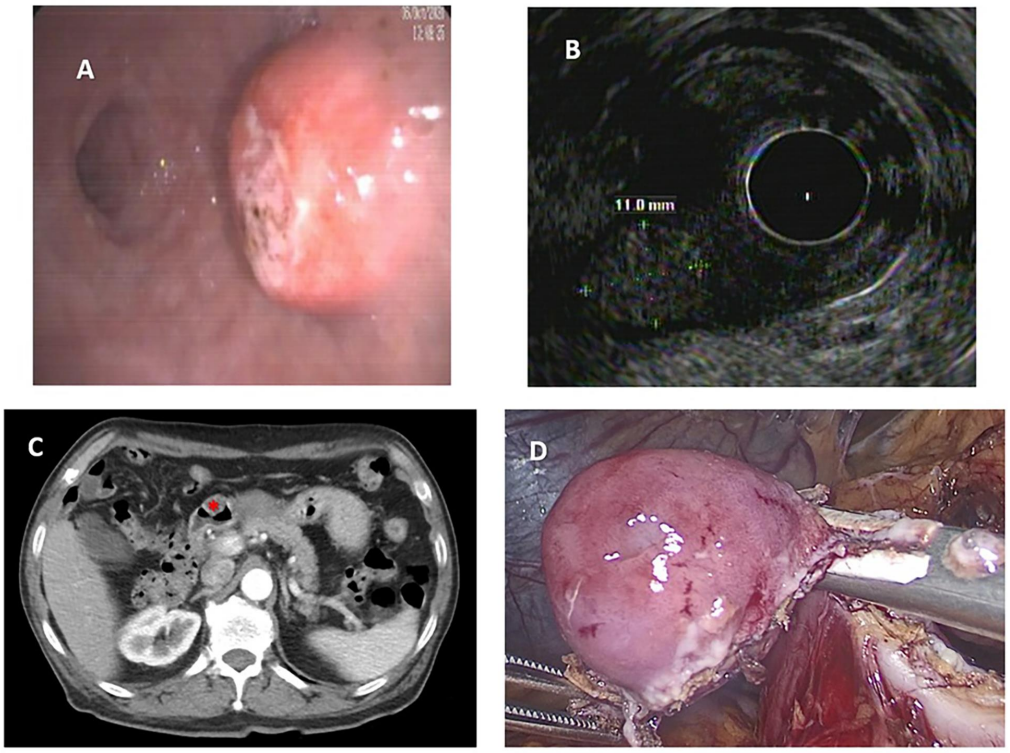

Fig1. A. Endoscopic vew of duodenal bulb lesion. B. Endoscopic ultrasound image of the lesion C. CT scan (*) D: Laparoscopic resection of the lesion