OPINION REVIEW

7620 Whipple’s operation with a modified centralization concept: A model in low-volume Caribbean centers
Cawich SO, Pearce NW, Narayansingh V, Shakla P, Deshpande RR

REVIEW

7631 Role of micronutrients in Alzheimer’s disease: Review of available evidence
Fei HX, Qian CF, Wu XM, Wei YH, Huang JY, Wei LH

MINIREVIEWS

7642 Application of imaging techniques in pancreaticobiliary maljunction
Wang JY, Mu PY, Xu YK, Bai YY, Shen DH

7653 Update on gut microbiota in gastrointestinal diseases
Nishida A, Nishino K, Ohno M, Sakai K, Owaki Y, Noda Y, Imaeda H

7665 Vascular complications of pancreatitis
Kalas MA, Leon M, Chavez LO, Canalizo E, Sarani S

ORIGINAL ARTICLE

Clinical and Translational Research

7674 Network pharmacology and molecular docking reveal zedoary turmeric-trisomes in Inflammatory bowel disease with intestinal fibrosis
Zheng L, Ji YY, Dai YC, Wen XL, Wu SC

Case Control Study

7686 Comprehensive proteomic signature and identification of CDKN2A as a promising prognostic biomarker and therapeutic target of colorectal cancer
Wang QQ, Zhou YC, Zhou Ge YJ, Qin G, Yin TF, Zhao DY, Tan C, Yao SK

Retrospective Cohort Study

7698 Is anoplasty superior to scar revision surgery for post-hemorrhoidectomy anal stenosis? Six years of experience
Wang YT, Chu KJ, Lin KH, Chang CK, Kang JC, Chen CY, Hu JM, Pu TW

Retrospective Study

7708 Short- (30-90 days) and mid-term (1-3 years) outcomes and prognostic factors of patients with esophageal cancer undergoing surgical treatments
Shi MK, Mei YQ, Shi JL
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>7720</td>
<td>Effectiveness of pulsed radiofrequency on the medial cervical branches for cervical facet joint pain</td>
<td>Chang MC, Yang S</td>
</tr>
<tr>
<td>7738</td>
<td>Correlation between the warning symptoms and prognosis of cardiac arrest</td>
<td>Zheng K, Bai Y, Zhai QR, Du LF, Ge HX, Wang GX, Ma QB</td>
</tr>
<tr>
<td>7749</td>
<td>Serum ferritin levels in children with attention deficit hyperactivity disorder and tic disorder</td>
<td>Tang CY, Wen F</td>
</tr>
<tr>
<td>7760</td>
<td>Application of metagenomic next-generation sequencing in the diagnosis of infectious diseases of the central nervous system after empirical treatment</td>
<td>Chen YY, Guo Y, Xue XH, Pang F</td>
</tr>
<tr>
<td>7785</td>
<td>Prospective single-center feasible study of innovative autorelease bile duct supporter to delay adverse events after endoscopic papillectomy</td>
<td>Liu SZ, Chai NL, Li HK, Feng XX, Zhai YQ, Wang NJ, Guo Y, Gao F, Wang SS, Linghu EQ</td>
</tr>
<tr>
<td></td>
<td><strong>Clinical Trials Study</strong></td>
<td></td>
</tr>
<tr>
<td>7794</td>
<td>Performance of Dexcom G5 and FreeStyle Libre sensors tested simultaneously in people with type 1 or 2 diabetes and advanced chronic kidney disease</td>
<td>Ölafsdóttir AF, Andelin M, Saeed A, Sofizadeh S, Hamoodi H, Jansson PA, Lind M</td>
</tr>
<tr>
<td></td>
<td><strong>Observational Study</strong></td>
<td></td>
</tr>
<tr>
<td>7808</td>
<td>Complications of chronic pancreatitis prior to and following surgical treatment: A proposal for classification</td>
<td>Murrusté M, Kirsimägi Ü, Kase K, Veršinina T, Talving P, Lepner U</td>
</tr>
<tr>
<td>7825</td>
<td>Effects of comprehensive nursing on postoperative complications, mental status and quality of life in patients with glioma</td>
<td>Dong H, Zhang XL, Deng CX, Luo B</td>
</tr>
<tr>
<td></td>
<td><strong>Prospective Study</strong></td>
<td></td>
</tr>
<tr>
<td>7832</td>
<td>Predictors of long-term anxiety and depression in discharged COVID-19 patients: A follow-up study</td>
<td>Boyraz RK, Şahan E, Boylu ME, Korponar İ</td>
</tr>
<tr>
<td></td>
<td><strong>META-ANALYSIS</strong></td>
<td></td>
</tr>
</tbody>
</table>
Contents

Thrice Monthly Volume 10 Number 22 August 6, 2022

7859 Rectal nonsteroidal anti-inflammatory drugs, glyceryl trinitrate, or combinations for prophylaxis of post-endoscopic retrograde cholangiopancreatography pancreatitis: A network meta-analysis
Shi QQ, Huang GX, Li W, Yang JR, Ning XY

7872 Effect of celecoxib on improving depression: A systematic review and meta-analysis
Wang Z, Wu Q, Wang Q

CASE REPORT

7883 Rectal mature teratoma: A case report
Liu JL, Sun PL

7890 Antibiotic and glucocorticoid-induced recapitulated hematological remission in acute myeloid leukemia: A case report and review of literature
Sun XY, Yang XD, Yang XQ, Ju B, Xi NN, Xu J, Zhao XC

7899 Non-secretory multiple myeloma expressed as multiple extramedullary plasmacytoma with an endobronchial lesion mimicking metastatic cancer: A case report
Lee SB, Park CY, Lee HJ, Hong R, Kim WS, Park SG

7906 Latamoxef-induced severe thrombocytopenia during the treatment of pulmonary infection: A case report
Zhang RY, Zhang JJ, Li JM, Xu YY, Xu YH, Cai XJ

7913 Multicentric reticulohistiocytosis with prominent skin lesions and arthritis: A case report
Xu XL, Liang XH, Liu J, Deng X, Zhang L, Wang ZG

7924 Brainstem abscesses caused by Listeria monocytogenes: A case report
Wang J, Li YC, Yang KY, Wang J, Dong Z

7931 Primary hypertension in a postoperative paraganglioma patient: A case report
Wei JH, Yan HL

7936 Long-term survival of gastric mixed neuroendocrine-non-neuroendocrine neoplasm: Two case reports
Woo LT, Ding YF, Mao CY, Qian J, Zhang XM, Xu N

7944 Percutaneous transforaminal endoscopic decompression combined with percutaneous vertebroplasty in treatment of lumbar vertebral body metastases: A case report
Ran Q, Li T, Kuang ZP, Guo XH

7950 Atypical imaging features of the primary spinal cord glioblastoma: A case report
Liang XY, Chen YP, Li Q, Zhou ZW

7960 Resection with limb salvage in an Asian male adolescent with Ewing’s sarcoma: A case report
Lai CY, Chen KJ, Ho TY, Li LY, Kuo CC, Chen HT, Fong YC

7968 Early detection of circulating tumor DNA and successful treatment with osimertinib in th790met-positive leptomeningeal metastatic lung cancer: A case report
Xu LQ, Wang YJ, Shen SL, Wu Y, Duan HZ

https://www.wjgnet.com
Contents

7973 Delayed arterial symptomatic epidural hematoma on the 14th day after posterior lumbar interbody fusion: A case report
Hao SS, Gao ZF, Li HK, Liu S, Dong SL, Chen HL, Zhang ZF

7982 Clinical and genetic analysis of nonketotic hyperglycinemia: A case report
Ning JJ, Li F, Li SQ

7989 Ectopic Cushing's syndrome in a patient with metastatic Merkel cell carcinoma: A case report
Ishay A, Touma E, Vornicova O, Dodik-Gad R, Goldman T, Bisharat N

7994 Occurrence of MYD88L265P and CD79B mutations in diffuse large b cell lymphoma with bone marrow infiltration: A case report
Huang WY, Weng ZY

8003 Rare case of compartment syndrome provoked by inhalation of polyurethane agent: A case report
Choi JH, Oh HM, Hwang JH, Kim KS, Lee SY

8009 Acute ischemic Stroke combined with Stanford type A aortic dissection: A case report and literature review
He ZY, Yao LP, Wang XK, Chen NY, Zhao JJ, Zhou Q, Yang XF

8018 Compound-honeysuckle-induced drug eruption with special manifestations: A case report
Zhou LF, Lu R

8025 Spontaneous internal carotid artery pseudoaneurysm complicated with ischemic stroke in a young man: A case report and review of literature
Zhong YL, Feng JP, Luo H, Gong XH, Wei ZH

8034 Microcystic adnexal carcinoma misdiagnosed as a "recurrent epidermal cyst": A case report
Yang SX, Mou Y, Wang S, Hu X, Li FQ

8040 Accidental discovery of appendiceal carcinoma during gynecological surgery: A case report
Wang L, Dong Y, Chen YH, Wang YN, Sun L

8045 Intra-ampullary papillary-tubular neoplasm combined with ampullary neuroendocrine carcinoma: A case report
Zavrtanik H, Lucar B, Tomažič A

LETTER TO THE EDITOR

8054 Commentary on "Primary orbital monophasic synovial sarcoma with calcification: A case report"
Tokur O, Aydın S, Karavas E
### AIMS AND SCOPE

The primary aim of *World Journal of Clinical Cases (WJCC, World J Clin Cases)* is to provide scholars and readers from various fields of clinical medicine with a platform to publish high-quality clinical research articles and communicate their research findings online.

WJCC mainly publishes articles reporting research results and findings obtained in the field of clinical medicine and covering a wide range of topics, including case control studies, retrospective cohort studies, retrospective studies, clinical trials studies, observational studies, prospective studies, randomized controlled trials, randomized clinical trials, systematic reviews, meta-analysis, and case reports.

### INDEXING/ABSTRACTING

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E-mail: bpgoffice@wjgnet.com [https://www.wjgnet.com](https://www.wjgnet.com)
Commentary on "Primary orbital monophasic synovial sarcoma with calcification: A case report"

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Abstract

The present letter to the editor is related to the study titled “Primary orbital monophasic synovial sarcoma with calcification: A case report”. Orbital synovial sarcoma is one of the rare intraorbital masses seen in adult and pediatric populations. Some case reports in the literature revealed that synovial sarcoma may contain calcifications. Therefore, it is important to make differential diagnosis among calcified orbital masses in childhood.

Key Words: Orbital tumor; Synovial sarcoma; Calcification; Children; Histopathology; Radiology

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Core Tip: This letter to editor serves to contribute additional information regarding differential diagnosis and immunohistochemical features to the article. We hope that by using radiographic and immunohistochemical features, we can assist in differentiating calcified orbital masses in the pediatric population.

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TO THE EDITOR

We read the article ‘Primary orbital monophasic synovial sarcoma with calcification: A case report’[1] with great interest and appreciated the authors for this comprehensive case report. We also thought that it might be favorable to contribute additional information about differential diagnosis and shortly immunohistochemical features to the discussion. For this purpose, we focused on the differentiation among the pediatric intraorbital calcific masses.

In the literature, intraocular[2] and extraocular[3-5] synovial sarcoma cases have been reported. Retinoblastoma is one of the most common intraocular tumors with calcification in children under 5 year old. The presence of calcification is an essential feature[6]. It is hypointense on T2 gravimetric imaging (WI), and slightly hyperintense on T1WI on magnetic resonance imaging (MRI) compared with the vitreous humor. Besides, heterogeneous enhancement can be seen on post-enhanced imaging. This case report reported introocular synovial sarcoma in a 48-year-old female patient[2] and retinoblastoma was not included in the differential diagnosis due to the possible age factor.

Rhabdomyosarcoma is one of the relatively more common masses in children. On computed tomography (CT), it is usually seen as an extraconal irregular ovoid, well-circumscribed mass. If there is adjacent bone destruction, concurrent calcification can be seen. As its size increases, it becomes more heterogeneous and its borders are unclear. The eyelid thickening is a typical finding even without an extension. On MRI, it is hypointense on T1WI and hyperintense on T2WI[7].

Synovial sarcomas should also be differentiated from metastases. The most common pediatric orbital metastases are neuroblastoma. The presence of a primary tumor in the retroperitoneum or posterior mediastinum would facilitate the diagnosis[7]. Hyperdense appearance of neuroblastoma metastases on CT series is also helpful in differential diagnosis[7]. Ewing sarcoma metastasis can also be considered in children. Immunohistochemical features are helpful in differentiating Ewing sarcoma from the synovial sarcoma. EMA and CK7 are helpful in diagnosing synovial sarcoma, while CD99/Fli-1 is helpful in Ewing’s sarcoma[8]. In addition, calcification can be seen as a result of dystrophic calcification in metastatic tumors, unlike the others[3].

Dermoid cyst is one of the most common orbital masses in children. Since it may contain calcification, it should be included in the differential diagnosis of synovial sarcoma. Bone changes may be the cause. The cystic component, fluid levels, and the presence of fat attenuation (associated with high T1 signal on MRI) are helpful in the differential diagnosis[7]. In addition, diffusion restriction on diffusion weight imaging, non-enhancement in post-contrast images, and smooth contours can aid in differential diagnosis[6].

Infantile hemangioma is the most common tumor in infancy and although calcification is rarely present, it should be considered in the differential diagnosis. It is usually located extraconally and makes some changes to adjacent bone like expanding or scalloping, but invasion occurs extremely rare. It is enhanced homogeneously after contrast administration. On T1WI, the well-defined marginalized mass is often isointense to hyperintense compared to muscle, and moderately hyperintense on T2WI with flow voids within the tumor. The presence of a flow void is an important feature to differentiate from the other masses[7].

Meningiomas account for 2% of primary orbital tumors and they are caused by the periosteum of the orbital wall. It may show coarse diffuse calcifications and sclerosis in the optic foramen that are helpful in the diagnosis. Although not specific, central radiolucent line may be seen[3,6].

Peripheral nerve sheath tumor (PNST) is one of the calcified intraorbital tumors. Histopathologically, it can express SI00, EMA, CK7, CK19, TLE 1, and SOX10 as synovial sarcoma. On the other hand, while PNST expresses CD34, it is rarely seen in synovial sarcoma[3,9].

Finally, we could contribute to the current study about immunohistochemical features of synovial sarcomas. They nearly all express EMA (+) and cytokeratin (especially CK 7) (+), and 30% of them express focal S100 (+). CD99 (+) is also expressed in 60%-70%, and LTE1 (+) occurs in > 90%. In contrast, CD34 is rarely/seldom expressed. The current study presented that EMA, CK 7, and S-100 were negative and CD34 was positive in immunohistochemical study, unlike the previous studies[3,5,9].

FOOTNOTES

Author contributions: Tokur O and Aydin S contributed equally to this work; Tokur O, Aydin S, and Karavas E designed the letter; Tokur O and Aydin S performed the research; Tokur O wrote the manuscript; all authors have read and approved the final manuscript.

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REFERENCES


