MINIREVIEWS

5934 Development of clustered regularly interspaced short palindromic repeats/CRISPR-associated technology for potential clinical applications
   Huang YY, Zhang XY, Zhu P, Ji L

5946 Strategies and challenges in treatment of varicose veins and venous insufficiency
   Gao RD, Qian SY, Wang HH, Liu YS, Ren SY

5957 Diabetes mellitus susceptibility with varied diseased phenotypes and its comparison with phenome interactome networks
   Rout M, Kour B, Vyree S, Lulu SS, Medicherla KM, Suravajhala P

ORIGINAL ARTICLE

Clinical and Translational Research

5965 Identification of potential key molecules and signaling pathways for psoriasis based on weighted gene co-expression network analysis
   Shu X, Chen XX, Kang XD, Ran M, Wang YL, Zhao ZK, Li CX

5984 Construction and validation of a novel prediction system for detection of overall survival in lung cancer patients

Case Control Study

6001 Effectiveness and postoperative rehabilitation of one-stage combined anterior-posterior surgery for severe thoracolumbar fractures with spinal cord injury
   Zhang B, Wang JC, Jiang YZ, Song QP, An Y

Retrospective Study

6009 Prostate sclerosing adenopathy: A clinicopathological and immunohistochemical study of twelve patients
   Feng RL, Tao YP, Tan ZY, Fu S, Wang HF

6021 Value of magnetic resonance diffusion combined with perfusion imaging techniques for diagnosing potentially malignant breast lesions
   Zhang H, Zhang XY, Wang Y

6032 Scar-centered dilation in the treatment of large keloids
   Wu M, Gu JY, Duan R, Wei BX, Xie F

6039 Application of a novel computer-assisted surgery system in percutaneous nephrolithotomy: A controlled study
Contents

Thrice Monthly Volume 10 Number 18 June 26, 2022

6050 Influences of etiology and endoscopic appearance on the long-term outcomes of gastric antral vascular ectasia

Kwon HJ, Lee SH, Cho JH

Randomized Controlled Trial

6060 Evaluation of the clinical efficacy and safety of TST33 mega hemorrhoidectomy for severe prolapsed hemorrhoids

Tao L, Wei J, Ding XF, Ji LJ

6069 Sequential chemotherapy and icotinib as first-line treatment for advanced epidermal growth factor receptor-mutated non-small cell lung cancer

Sun SJ, Han JD, Liu W, Wu ZY, Zhao X, Yan X, Jiao SC, Fang J

Randomized Clinical Trial

6082 Impact of preoperative carbohydrate loading on gastric volume in patients with type 2 diabetes

Lin XQ, Chen YR, Chen X, Cai YP, Lin JX, Xu DM, Zheng XC

META-ANALYSIS

6091 Efficacy and safety of adalimumab in comparison to infliximab for Crohn's disease: A systematic review and meta-analysis

Yang HH, Huang Y, Zhou XC, Wang RN

CASE REPORT

6105 Successful treatment of acute relapse of chronic eosinophilic pneumonia with benralizumab and without corticosteroids: A case report

Izhakian S, Pertzov B, Rosengarten D, Kramer MR

6110 Pembrolizumab-induced Stevens-Johnson syndrome in advanced squamous cell carcinoma of the lung: A case report and review of literature

Wu JY, Kang K, Yi J, Yang B

6119 Hepatic epithelioid hemangioendothelioma after thirteen years' follow-up: A case report and review of literature

Mo WF, Tong YL

6128 Effectiveness and safety of ultrasound-guided intramuscular lauromacrogol injection combined with hysteroscopy in cervical pregnancy treatment: A case report

Ye JP, Gao Y, Lu LW, Ye YJ

6136 Carcinoma located in a right-sided sigmoid colon: A case report

Lyu LJ, Yao WW

6141 Subcutaneous infection caused by Mycobacterium abscessus following cosmetic injections of botulinum toxin: A case report

Deng L, Luo YZ, Liu F, Yu XH
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>6148</td>
<td>Overlapping syndrome of recurrent anti-N-methyl-D-aspartate receptor encephalitis and anti-myelin oligodendrocyte glycoprotein demyelinating diseases: A case report</td>
<td>Yin XJ, Zhang LF, Bao LH, Feng ZC, Chen JH, Li BX, Zhang J</td>
</tr>
<tr>
<td>6163</td>
<td>Disseminated strongyloidiasis in a patient with rheumatoid arthritis: A case report</td>
<td>Zheng JH, Xue LY</td>
</tr>
<tr>
<td>6168</td>
<td>CYP27A1 mutation in a case of cerebrotendinous xanthomatosis: A case report</td>
<td>Li ZR, Zhou YL, Jin Q, Xie YY, Meng HM</td>
</tr>
<tr>
<td>6175</td>
<td>Postoperative multiple metastasis of clear cell sarcoma-like tumor of the gastrointestinal tract in adolescent: A case report</td>
<td>Huang WP, Li LM, Gao JB</td>
</tr>
<tr>
<td>6192</td>
<td>Presentation of Boerhaave’s syndrome as an upper-esophageal perforation associated with a right-sided pleural effusion: A case report</td>
<td>Tan N, Luo YH, Li GC, Chen YL, Tan W, Xiang YH, Ge L, Yao D, Zhang MH</td>
</tr>
<tr>
<td>6205</td>
<td>Nontraumatic convexal subarachnoid hemorrhage: A case report</td>
<td>Chen HL, Li B, Chen C, Fan XX, Ma WB</td>
</tr>
<tr>
<td>6211</td>
<td>Growth hormone ameliorates hepatopulmonary syndrome and nonalcoholic steatohepatitis secondary to hypopituitarism in a child: A case report</td>
<td>Zhang XY, Yuan K, Fang YL, Wang CL</td>
</tr>
<tr>
<td>6218</td>
<td>Vancomycin dosing in an obese patient with acute renal failure: A case report and review of literature</td>
<td>Xu KY, Li D, Hu ZJ, Zhao CC, Bai J, Du WL</td>
</tr>
<tr>
<td>6227</td>
<td>Insulinoma after sleeve gastrectomy: A case report</td>
<td>Lobaton-Ginsberg M, Sotelo-González P, Ramirez-Renteria C, Juárez-Aguilar FG, Ferreira-Hermosillo A</td>
</tr>
<tr>
<td>6234</td>
<td>Primary intestinal lymphangiectasia presenting as limb convulsions: A case report</td>
<td>Cao Y, Feng XH, Ni HX</td>
</tr>
<tr>
<td>6241</td>
<td>Esophagogastric junctional neuroendocrine tumor with adenocarcinoma: A case report</td>
<td>Kong ZZ, Zhang L</td>
</tr>
<tr>
<td>Page</td>
<td>Title</td>
<td>Authors</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>6247</td>
<td>Foreign body granuloma in the tongue differentiated from tongue cancer: A case report</td>
<td>Jiang ZH, Xu R, Xia L</td>
</tr>
<tr>
<td>6261</td>
<td>Management of type IIIb dens invaginatus using a combination of root canal treatment, intentional replantation, and surgical therapy: A case report</td>
<td>Zhang J, Li N, Li WL, Zheng XY, Li S</td>
</tr>
<tr>
<td>6277</td>
<td>De novo brain arteriovenous malformation formation and development: A case report</td>
<td>Huang H, Wang X, Guo AN, Li W, Duan RH, Fang JH, Yin B, Li DD</td>
</tr>
<tr>
<td>6283</td>
<td>Coinfection of <em>Streptococcus suis</em> and <em>Nocardia asiatica</em> in the human central nervous system: A case report</td>
<td>Chen YY, Xue XH</td>
</tr>
<tr>
<td>6289</td>
<td>Dilated left ventricle with multiple outpouchings — a severe congenital ventricular diverticulum or left-dominant arrhythmogenic cardiomyopathy: A case report</td>
<td>Zhang X, Ye RY, Chen XP</td>
</tr>
<tr>
<td>6307</td>
<td>Thyroid follicular renal cell carcinoma excluding thyroid metastases: A case report</td>
<td>Wu SC, Li XY, Liao BJ, Xie K, Chen WM</td>
</tr>
<tr>
<td>6314</td>
<td>Appendiceal bleeding: A case report</td>
<td>Zhou SY, Guo MD, Ye XH</td>
</tr>
<tr>
<td>6319</td>
<td>Spontaneous healing after conservative treatment of isolated grade IV pancreatic duct disruption caused by trauma: A case report</td>
<td>Mei MZ, Ren YF, Mou YP, Wang YY, Jin WW, Lu C, Zhu QC</td>
</tr>
<tr>
<td>6325</td>
<td>Pneumonia and seizures due to hypereosinophilic syndrome—organ damage and eosinophilia without synchronisation: A case report</td>
<td>Ishida T, Murayama T, Kobayashi S</td>
</tr>
</tbody>
</table>

**LETTER TO THE EDITOR**

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>6338</td>
<td>Stem cells as an option for the treatment of COVID-19</td>
<td>Cuevas-González MV, Cuevas-González JC</td>
</tr>
</tbody>
</table>
ABOUT COVER
Editorial Board Member of World Journal of Clinical Cases, Cristina Tudoran, PhD, Assistant Professor, Department VII, Internal Medicine II, Discipline of Cardiology, "Victor Babes" University of Medicine and Pharmacy Timisoara, Timisoara 300041, Timis, Romania. cristina13.tudoran@gmail.com

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
The WJCC is now indexed in Science Citation Index Expanded (also known as SciSearch®), Journal Citation Reports/Science Edition, Scopus, PubMed, and PubMed Central. The 2021 Edition of Journal Citation Reports® cites the 2020 impact factor (IF) for WJCC as 1.337; IF without journal self cites: 1.301; 5-year IF: 1.742; Journal Citation Indicator: 0.33; Ranking: 119 among 169 journals in medicine, general and internal; and Quartile category: Q3. The WJCC’s CiteScore for 2020 is 0.8 and Scopus CiteScore rank 2020: General Medicine is 493/793.

RESPONSIBLE EDITORS FOR THIS ISSUE
Production Editor: Ying-Yi Yuan; Production Department Director: Xu Guo; Editorial Office Director: Jin-Lei Wang.

NAME OF JOURNAL
World Journal of Clinical Cases

ISSN
ISSN 2307-8960 (online)

LAUNCH DATE
April 16, 2013

FREQUENCY
Thrice Monthly

EDITORS-IN-CHIEF
Bao-Gan Peng, Jerzy Tadeusz Chudek, George Kontogeorgos, Maurizio Serati, Ja Hyeon Ku

EDITORIAL BOARD MEMBERS
https://www.wjgnet.com/2307-8960/editorialboard.htm

PUBLICATION DATE
June 26, 2022

COPYRIGHT
© 2022 Baishideng Publishing Group Inc

INSTRUCTIONS TO AUTHORS
https://www.wjgnet.com/bpg/gerinfo/204

GUIDELINES FOR ETHICS DOCUMENTS
https://www.wjgnet.com/bpg/GerInfo/287

GUIDELINES FOR NON-NATIVE SPEAKERS OF ENGLISH
https://www.wjgnet.com/bpg/gerinfo/240

PUBLICATION ETHICS
https://www.wjgnet.com/bpg/gerinfo/288

PUBLICATION MISCONDUCT
https://www.wjgnet.com/bpg/gerinfo/208

ARTICLE PROCESSING CHARGE
https://www.wjgnet.com/bpg/gerinfo/242

STEPS FOR SUBMITTING MANUSCRIPTS
https://www.wjgnet.com/bpg/gerinfo/239

ONLINE SUBMISSION
https://www.ffpublishing.com
Spontaneous healing after conservative treatment of isolated grade IV pancreatic duct disruption caused by trauma: A case report

Ming-Zhen Mei, Yu-Feng Ren, Yi-Ping Mou, Yuan-Yu Wang, Wei-Wei Jin, Chao Lu, Qi-Cong Zhu

Abstract

BACKGROUND
Trauma is a common cause of pancreatic duct disruption. Surgical treatment is recommended in current clinical guidelines for adult pancreatic injury because non-surgical treatments have higher risks of serious complications or even death compared with surgical treatment.

CASE SUMMARY
A 22-year-old woman was admitted to Tiantai People’s Hospital of Zhejiang Province after 1-h duration of abdominal pain and distension following trauma. The diagnosis was “traumatic pancreatic rupture”. The patient’s symptoms were not severe, her vital signs were stable, and signs of peritonitis were not obvious. Therefore, conservative treatment could be considered, with the possibility of emergency surgery if necessary. After 2 mo of conservative treatment with duct drainage, the pancreatic duct healed spontaneously with no significant complications.

CONCLUSION
We report a case of pancreatic duct disruption in the head and neck caused by trauma that was treated conservatively and healed spontaneously, providing a new choice for clinical practice. For isolated pancreatic injury with rupture of the pancreatic duct in the head and neck, conservative treatment under close obse-
INTRODUCTION

Trauma is a common cause of pancreatic duct disruption. Surgical treatment is recommended in current clinical guidelines for adult pancreatic injury because, compared with surgical treatment, non-surgical treatments have higher risks of serious complications or even death[1,2]. In this study, we report a case of pancreatic duct disruption in the head and neck caused by trauma that was treated conservatively and which healed spontaneously.

CASE PRESENTATION

Chief complaints

A 22-year-old female patient was admitted to Tiantai People’s Hospital of Zhejiang Province on 13 July 2020 after 1-hour duration of abdominal pain and distension following trauma.

History of present illness

The patient experienced sudden-onset persistent and unbearable abdominal pain, radiating to the lower back, with abdominal distension and nausea, and without vomiting, coma, dizziness, headache, chest tightness, shortness of breath, bloody vomiting, or hemoptysis. The trauma resulted from impact with bicycle handlebars on the upper abdomen during an electrical bicycle accident 1 h earlier.

She had no other complaints. Her sleep and appetite were normal, and her excretion and egestion were both normal.

History of past illness

The patient had an unremarkable medical history.

Personal and family history

The patient grew up in her locality, denied any contact with contaminated water or radiation exposure, and did not smoke or consume alcohol. She had no gestational history, and her annual menstruation cycle was 13/year (q 4-6 wk/duration: 20-30 d).

Physical examination

Physical examination findings on admission: body temperature: 37.2 °C, respiratory rate: 20 breaths/min, blood pressure: 118/63 mmHg, and heart rate: 103 beats/min. The patient had a clear mind, low mood, flat and soft abdomen, tenderness in the upper abdomen, no obvious rebound pain, bowel sounds: 2/min, and no shifting dullness. No other significant abnormalities were observed.

Laboratory examinations

Serum amylase concentration: 1258 U/L (upper limit of normal: 135 U/L), white blood cell count: 17.8 × 10^9/L, neutrophils: 82%, red blood cell count: 4.51 × 10^12/L, hemoglobin: 143 g/L, platelet count: 211 × 10^9/L, C-reactive protein: < 0.499 mg/L, and procalcitonin: < 0.02 ng/mL; liver and kidney function was
normal, the levels of plasma lactate was normal.

**Imaging examinations**
Abdominal computed tomography (CT): The pancreatic head/neck was full in shape, and small lamellar high-density shadows were seen at the anterior edge, with a CT value of 64 HU. There was no edema and thickening of bilateral anterior renal fascia and no peritoneal or retroperitoneal effusion. The lesion was not significantly enhanced during contrast-enhanced CT, and some surrounding low-density exudative shadows were observed (Figure 1).

**FINAL DIAGNOSIS**
The diagnosis was “traumatic pancreatic rupture”.

**TREATMENT**
The patient was informed that her condition was critical, and there were indications for emergency surgery; however, the patient’s symptoms were not severe, her vital signs were stable, and signs of peritonitis were not obvious. Therefore, conservative treatment could be considered, with the possibility of emergency surgery if necessary. The patient was then treated with fasting, gastrointestinal decompression, acid control, digestive enzyme inhibition, anti-inflammation, and fluid replacement. After treatment, her abdominal pain was relieved. Abdominal CT on 14 July 2020 revealed lamellar high-density shadows in the pancreatic head and neck, with no significant increase in fluid collection, and with obvious exudative shadows around the pancreas; fluid accumulation was evident in the abdominal cavity. Conservative treatment was continued, and the patient’s condition gradually improved. A naso-intestinal tube was placed for enteral feeding on 20 July 2020, which was well-tolerated. Repeat ultrasonography on 23 July 2020 revealed local fluid collection in the neck of the pancreas measuring approximately 60 mm × 46 mm × 38 mm and no obvious fluid accumulation in the abdominal cavity. Therefore, catheter drainage of the peripancreatic fluid collection was performed, and approximately 300 mL of pale bloody fluid was removed. Repeat abdominal CT on 24 July 2020 revealed local dissection of the pancreatic head/neck, encapsulated effusion in the form of a pseudocyst measuring 17 mm × 31 mm, and a small amount of fluid in the abdominopelvic cavity (Figure 2). The patient was transferred to Zhejiang Provincial People's Hospital for follow-up treatment on 27 July 2020, during which inflammatory indices were normal, and serum total amylase reached a maximum of 932 U/L (upper limit of normal: 135 U/L), with no significant fluid exiting the drain. Abdominal CT was repeated and revealed that the pancreatic head/neck was morphologically swollen, with increased surrounding encapsulated fluid. Ultrasound-guided peripancreatic catheter drainage by transperitoneal was performed again, and 300 mL of clear pancreatic fluid was removed. The serum amylase concentration decreased to normal after this drainage. On 24 August 2020, puncture pancreatography visualized the distal pancreatic duct. On 25 August 2020, endoscopic retrograde cholangiopancreatography (ERCP) was performed to place a pancreatic duct stent. The pancreatic duct in the pancreatic head was circular in shape and was not connected with the pancreatic duct in the pancreatic body/tail. Therefore, the pancreatic duct stent could not be placed.
OUTCOME AND FOLLOW-UP

The main pancreatic duct was not dilated by transcatheter tube angiography, and there was no obvious liquid dark areas around the pancreas; therefore, the puncture drain was removed. Re-examination on 10 November 2020 revealed that the patient had no discomfort and no abnormalities on physical examination. The serum amylase concentration was 44 U/L. Magnetic resonance cholangiopancreatography (MRCP) suggested slightly dilated pancreatic ducts in the pancreatic tail (Figure 3).

DISCUSSION

The pancreas is a retroperitoneal organ with a deep and hidden location, and pancreatic injury occurs in only 0.4%-6.0% of abdominal trauma cases[1]. The pancreas is located in front of the first and second lumbar vertebrae; therefore, injury is often caused by direct action on the spine owing to crushing force from the upper abdomen, mostly sustained in the pancreatic body. Approximately 39% of pancreatic injuries are associated with pancreatic duct disruption[2]. Isolated pancreatic injury is even more rare, comprising less than 3% of cases[3].

The level of serum amylase has little significance for the early diagnosis of pancreatic trauma. Serum amylase cannot be increased in about 40% of patients, and it can also be increased in non-pancreatic injury and intestinal injury[4]. Adamson et al[5] conducted a retrospective study on 1821 patients with trauma. The level of serum amylase or lipase increased in 116 patients, and only 8 patients finally identified pancreatic trauma. The significance of serum amylase or lipase in the diagnosis of pancreatic trauma is limited, and it also depends on the necessary imaging examination. Currently, CT is the first-line technique for evaluating pancreatic injury. CT is easy to perform, and its high imaging quality, clear display of the pancreatic contours and peripancreatic bleeding, and the option for multiplanar reconstruction, can achieve a diagnostic accuracy rate of > 80%. However, there are limitations in the diagnosis of pancreatic duct disruption, and the accuracy rate needs to be improved by dynamic review[6]. In this case, we performed dynamic CT review to clarify the presence of pancreatic duct disruption. According to the American Association for the Surgery of Trauma (AAST) classification of pancreatic...
injuries, injuries involving the pancreatic duct are classified as grade III or IV injuries, as outlined in Table 1[7]. For hemodynamically stable patients, MRCP can be performed when further clarification of pancreatic duct integrity is needed during follow-up treatment. MRCP has the advantages of being noninvasive and providing accurate pancreatic duct imaging. In this case, complete rupture of pancreatic neck was well established by computed tomography (Figure 2A), so we did not perform MRCP. ERCP can lead to a series of complications, such as bleeding, perforation, and iatrogenic pancreatitis, and is more often used for treatment. This patient’s admission serum amylase concentration was significantly elevated, and the diagnosis of pancreatic duct disruption was confirmed when the elevated amylase finding was combined with the dynamic CT review.

The management of pancreatic injuries is controversial and based on small retrospective studies. There are no randomized studies addressing this issue. Based on the available class III evidence, the Eastern Association for the Surgery of Trauma recommended drainage for Grade 1 and Grade 2 injuries and resection with drainage for Grade 3 or higher[8]. Siboni et al[3] study found nonoperative management of minor isolated pancreatic injuries is associated with lower mortality and shorter hospital stay than operative management. However, in severe trauma, nonoperative management is associated with higher mortality and longer hospital stays than operative management[3].

Mohseni et al[9] research showed pancreatic resection for the treatment of grade III and IV penetrating pancreatic injury is not associated with a significant decrease in mortality but is associated with a significant increase in hospital length of stay. Drainage alone of the pancreatic bed may be a viable option, even for high-grade injuries[9]. For traumatic pancreatic injury, the optimal treatment strategy can be formulated only when the patient’s vital signs, abdominal signs, degree of pancreatic injury, and the presence of surrounding organ injury are considered comprehensively.

Recently, the use of endoscopic stenting of the pancreatic duct for the successful treatment of pancreatic duct disruption has been increasingly reported[10]. In a recently published report showing patients with pancreatic trauma who had received pancreatic stents undergoing ERCP 0-15 d after the trauma, the stents were removed after 4-8 wk and at follow-up between 6-24 mo. Endoscopic stent treatment may avoid emergency pancreatic resection and should always be considered in the management of patients with traumatic pancreatic duct injury[11]. When the patient is admitted to our hospital, the condition of this case was stable, so we did not chose pancreatic duct stent implantation. Compared with pancreatic resection, which is highly invasive and affects patients’ quality of life, endoscopic treatment is undoubtedly a new treatment strategy and is gradually gaining more attention.

**CONCLUSION**

In this case, after 2 mo of conservative treatment with duct drainage, the pancreatic duct healed spontaneously with no significant complications. This case provides a new consideration for clinical practice: In isolated pancreatic injury with rupture of the pancreatic duct in the head and neck, conservative treatment under close observation is feasible. In young and fit populations with stable hemodynamics, no signs of peritonitis, and no obvious active bleeding on abdominal CT, conservative treatment can be considered first, combined with dynamic CT review and fluid drainage. Endoscopic pancreatic duct stenting can then be considered if appropriate because, in some cases, the pancreatic duct can heal spontaneously.

---

**Table 1 American Association for the Surgery of pancreatic trauma for the pancreas**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Type of injury</th>
<th>Description of injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Hematoma</td>
<td>Minor contusion without duct injury</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
<td>Superficial laceration without duct injury</td>
</tr>
<tr>
<td>II</td>
<td>Hematoma</td>
<td>Major contusion without duct injury or tissue loss</td>
</tr>
<tr>
<td></td>
<td>Laceration</td>
<td>Major laceration without duct injury or tissue loss</td>
</tr>
<tr>
<td>III</td>
<td>Laceration</td>
<td>Distal transection or parenchymal injury with duct injury</td>
</tr>
<tr>
<td>IV</td>
<td>Laceration</td>
<td>Proximal transection or parenchymal injury involving ampulla</td>
</tr>
<tr>
<td>V</td>
<td>Laceration</td>
<td>Massive disruption of pancreatic head</td>
</tr>
</tbody>
</table>

1 Advances one grade for multiple injuries up to grade III.
FOOTNOTES

Author contributions: Mei MZ and Ren YF have contributed equally to this work; Mei MZ and Ren YF made substantial contributions to acquisition of data, analysis, and interpretation of data; Mou YP, Wang YY, Jin WW, Lu C, and Zhu QC made substantial contributions to the conception, acquisition of data, analysis, and interpretation of data; all authors have been involved in drafting the manuscript and revising it critically for important intellectual content; All authors read and approved the final manuscript and take full responsibility for appropriate portions of the content and agree to be accountable for all aspects of work.

Supported by Traditional Chinese medicine Science and Technology Project of Zhejiang Province, No. 2020ZB029.

Informed consent statement: Written informed consent was obtained from the patient for the publication of this case report and the accompanying images.

Conflict-of-interest statement: The authors declare that they have no competing interests.

CARE Checklist (2016) statement: The authors have read and revised according to the CARE Checklist (2016).

Open-Access: This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: https://creativecommons.org/Licenses/by-nc/4.0/

Country/Territory of origin: China

ORCID number: Ming-Zhen Mei 0000-0003-0673-5748; Yu-Feng Ren 0000-0003-4605-2271; Yi-Ping Mou 0000-0002-0778-6022; Yuan-Yu Wang 0000-0001-8462-7211; Wei-Wei Jin 0000-0002-2974-9598; Chao Lu 0000-0003-050-1086; Qi-Cong Zhu 0000-0003-3281-7288.

S-Editor: Gong ZM
L-Editor: Filipodia
P-Editor: Gong ZM

REFERENCES
