posed of milk), or trichobezoars (composed of hair). Phytobezoars account for 40% of all bezoars and are composed of materials of vegetable origin that human beings cannot digest (seeds, peels, roots, etc.); they develop through a multifactorial process. Individuals with a greater propensity to develop phytobezoars include not only vegetarians but also individuals who do not chew their food well, those with impaired gastric motility, and those with hypochlorhydria, as well as those who have undergone gastrectomy. A history of gastric surgery is a risk factor because it reduces the surface area of the stomach and acid secretions, causing inadequate digestion and allowing larger masses of agglomerated material to pass into the small intestine\(^1\)\(^–\)\(^3\).

Phytobezoars can also occur in patients who have had bariatric surgery. In addition to the aforementioned factors, nonabsorbable sutures can act as vegetable fiber hooks, resulting in a bolus that forms in the anastomosis. Phytobezoar formation evolves to intestinal obstruction in 60% of cases.

CT has become the imaging examination of choice for the diagnosis of acute abdominal obstruction, because it is a rapid method that produces high-resolution images to confirm the obstructive scenario, often making it possible to identify the etiologic factor. On CT, intestinal obstruction is characterized by gas distension and dilatation of proximal loops that are collapsed or are proportionally smaller than the dilated proximal intestinal loops (with a caliber > 2.5 cm), distal to the obstruction. The obstructive scenario can be confirmed that the treatment had been successful (Figure 1D).

Hepatocellular adenoma (HCA) is a rare benign tumor of the liver that is commonly seen in women of reproductive age and is associated with the use of OCs\(^1\)\(^–\)\(^3\). The annual incidence of HCA is 3–4 cases/100,000 women who have used OCs for an extended period of time. Approximately 25% of patients with HCA experience bleeding, the risk of which increases in parallel with an increase in tumor diameter. Malignant transformation occurs in up to 4% of all cases of HCA\(^2\)\(^–\)\(^4\). The risk of malignant transformation also increases as tumor diameter increases, and excision is generally recommended for tumors that are still larger than 5 cm in diameter after OC discontinuation\(^4\).

Transarterial embolization (TAE) is widely used for the treatment of bleeding adenosomas and can be performed before elective surgery to reduce intraoperative blood loss. In HCA patients, TAE can reduce the size of large adenosomas, multiple adenosomas, or adenosomas that are in a surgically inaccessible location, in order to reduce symptoms and the risk of bleeding\(^5\)\(^–\)\(^7\). Given that the risk of malignant transformation is directly proportional to the size of the adenoma\(^7\), TAE can reduce this risk. However, the role of TAE as an elective therapy in HCA is unclear, because it is not known whether it reduces the risk of hemorrhage or malignant transformation of residual HCA, despite reports of a reduction in tumor size\(^8\).

In patients with HCA, the most common complication of TAE is post-embolization syndrome, followed by transient renal insufficiency and cyst formation\(^8\). In the case presented here, the patient evolved to late liver abscess after embolization of a hepatic adenoma.
the adenoma. To our knowledge, there have been no previous reports of this complication. The treatment of pyogenic liver abscess includes intravenous antibiotic therapy and percutaneous drainage guided by ultrasound or CT.

Acute or elective TAE seems to be a safe procedure for the management of HCA. Because of its minimally invasive and parenchyma-preserving properties, together with its ability to reduce the size of tumors located at anatomical sites that make surgery difficult, elective TAE offers a reasonable alternative to surgery.

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Additional value of a dynamic contrast-enhanced study for detection of a small neuroendocrine tumor of the rectum on magnetic resonance imaging

Dear Editor,

Screening colonoscopy revealed a subepithelial lesion in the rectum of a 70-year-old asymptomatic man, a finding that was subsequently confirmed by endoscopic ultrasound (Figure 1A). The patient then underwent magnetic resonance imaging (MRI), performed in accordance with the routine protocol, on which the lesion was not detected. An MRI scan was complemented with a dynamic study, which revealed a 5 mm lesion that showed contrast enhancement in the early phase and no enhancement in the later phases (Figure 1B,C). Subsequently, endoscopic ultrasound was performed for diagnostic and therapeutic purposes, including resection of the lesion (Figure 1D), the histopathological diagnosis of which was a differentiated neuroendocrine tumor.

Neuroendocrine tumors can occur in various organs, and they account for 1.5% of all gastrointestinal or pancreatic neoplasms(1). In the gastrointestinal tract, the rectum is the second most commonly affected region, accounting for 21–27% of cases(2). Although most neuroendocrine tumors are idiopathic, up to 25% are associated with genetic syndromes such as multiple endocrine neoplasia type 1, neurofibromatosis type 1, von Hippel-Lindau disease, and tuberous sclerosis(3–5). They can produce hormones and metabolically active amines, resulting in symptoms(5). Nonfunctioning neuroendocrine tumors, which are more common, frequently appear as locally advanced disease