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It is the most common liver tumor after metastases in the liver, being the most common benign type. It has a frequency of 5 to 20% of the population. It can be unique (60%) several cases ranging from just a few millimetres to more than 20 centimeters. There is debate about the definition of giant hemangioma, some authors consider as 5 centimeters or more, while others consider 10 cm or more. They are more common in women (2 to 6 times more often in women) between the ages of 30 and 50. They can be classified into capillaries (less) or cavernous. Hemangioma consists of masses of blood vessels that are atypical or irregular in their location and size, with the representation characteristic less flow than normal parenchyma (liver tissue). Although its cause is unknown, it is likely to be associated with congenital vascular malformation (from birth). Despite an unclear association with hormonal factors, steroids (anabolics) and estrogens (female hormones), as well as during pregnancy there is an increase in hemangioma. Hemangioma is not slandered. Clinical results Most hemangioma are asymptomatic (without symptoms) and are on imaging trials conducted for other reasons, by the way (accidentally or accidentally). Only 12% have symptoms usually caused by blurs liver capsules or compression of adjacent structures (around the tumor). About 40% of the subjects have symptoms of hemangioma over 4 cm, more than 90% when more than 10 cm symptoms include nausea, vomiting, feeling of healing or fullness (feeling full), jaundice, palpable mass, and pain. Pain though can rarely exist due to thrombosis, heart attack, or hemorrhage in the lesion. Heart failure can occur rarely and sometimes rupture due to trauma. Spontaneous hemangioma rupture is an extremely rare event in the literature (less than 50 cases are described), but mortality is very high (60-75%). such as: Kasabach-Merritt (bleeding, platelet drop, and consumption of coagulopathy elements of coagulopathy), Bloomgart-Bornman-Terblance (chronic inflammatory process with fever and abdominal pain), Osler-Randu-Weber, Clippel-Ternaunai-Weber (several hemangioma) , or with scintigraphy with marked red blood diaphers. Typical lesion presents the following characteristics with contrast administration by tomography: the lesion has a lower density than the liver (hypodensity) in a non-contrast phase followed by perferic filling (ring aspect or in the arterial phase, with the slow and progressive filling of the periphery of the lesion in the portal phase to the center in the portal phase and in the later phases (equilibrium) it becomes denser than the liver. On the MRI it is a lobalized lesion, septat, homogeneous, hypointense on T1. And very hypersensiveness on T2. When the contrast approaches, they present characteristics similar to those found on the tomography. Small hemangiomas smaller than 2 cm may be indistinguishable from other even malignant hypervascular lesions. A puncture biopsy is not required in the vast majority of cases, including offering risks such as hemorrhage. Therapeutic approach Although effective treatment of hemangioma hemangioma is surgical extirpation, it is rarely indicated. Indications for surgical removal are described in the literature: the patient with symptoms, rapid growth of lesions, doubts in cancer or the presence of complications. Some authors pointed to extirpation in lesions of more than 10 centimeters due to the higher complexity possibility. Dr. Stefano Goncalves Jorge INTRODUCTION Hemangioma small benign tumors formed novel blood vessels. They occur during embryo formation, prior to birth, and can occur in several organs, including the skin and liver. Red birth spots are usually caused by hemangioma on the skin. In general, hemangioma remains unchanged after birth, and can grow but rarely causes any symptoms, especially when it is in the liver. There, as a rule, find at random, for some examination (ultrasound, tomography or MRI), performed for another reason. Hemangiomas are the most common benign liver tumors, usually found in young women (through conventional gynecological ultrasound). They affect 0.4 to 7% of the total population and are plural (more than one) and 70% of cases. Usually the lesions are small, but in 10% of cases they can exceed 5 cm in diameter, called giants. Symptoms are uncommon and even in people with symptoms (abdominal pain, pachamentiso after feeding, fever, nausea and vomiting), many are another disease (such as dyspepsia) and eventually the discovery of hemangioma by accident. However, if the hemangioma is too large (some even occupy almost the entire liver), there is a risk that it is torn (after an injury rarely torn alone), generating internal bleeding or that forms clots inside that consume platelets and clotting factors and cause ease of bleeding in other organs (Casabah-Merritt syndrome). But even in giant hemangioma symptoms are unusual and the most common are those caused by pushing other structures, such as the stomach, generating early satiety. Linking symptoms with Lesions - Mayo Clinic (1980-1987) Size (see) No. Symptoms of patients (%) 4cm 29 4 (14) 4-10 cm 20 3 (15) zgt:10 cm 20 18 (90) Total 69 25 Diagnostic proof is done using imaging tests. On ultrasound, the typical aspect is rounded, hypergenic (white) lesion with well-defined edges and blood flow on Doppler. The tomography shows the defeat of the capture contrast, usually evenly. Magnetic resonance imaging shows a hypersonic (whiter) lesion in phase T2 and hyposingl (darker) in phase T1. Ultrasound Although the lesion is usually uniform, the pattern of filling with contrast can help diagnose hemangioma and eliminate the possibility of cancer. As the skin of blood vessels, the hemangioma becomes completely complete contrast once it is used. Minor lesions fill up quickly, while larger lesions fill more slowly from the center, with the possibility of filling failures caused by thrombosis and pockets of fibrosis. MRI liver with hemangioma. On the left T2 is an image showing a lighter lesion (arrow) and directly on T1 showing a dark image. S is a spleen. Source Other diagnostic tests are Ct99m scintigraphy and marked red blood cells, arterography and liver biopsy. In some questionable cases, laboratory tests can help distinguish hemangioma from malignant tumors. But usually the diagnosis is made safely only by two methods of visualization, usually one of them is ultrasound. Usually treatment is not required, only clinical observation with examinations is enough (usually a fairly annual ultrasound or every two years). Symptomatic hemangiomas are rare, but symptomatic giants may require treatment. The main therapeutic options are: surgical resection, liver transplantation, liver artery ligation, embolization, radiation therapy and corticosteroid therapy. The choice of treatment will depend on the specifics of each case and the experience and capabilities of the service. The main signs for treatment are: symptoms, diagnostic doubts (in relation to malignant tumors), superficial lesions of more than 6 cm (due to the risk of impairment), hyperproliferation anemia and Kasabah-Merritt syndrome (with the consumption of red blood cells, platelets and clotting factors intra hemangioma), rupture and rapid growth. The size of the hemangioma itself is not a sign of treatment. The prospects for hemangioma are great. Most cases are detected at random, and a person remains impotomic throughout his life. Only a minority need treatment that surgical and with almost zero mortality. Very large hemangiomas can be treated with embolization (preventing the artery that carries blood to it) with varying degrees of success, but with rare complications. This text applies only to hemangioma in the liver. For information on superficial hemangioma or other organs, look for the ABRAPHEL article created at: 02/10/05 Last review: 02/10/05. The vast majority of them have less than 5 cm, but cases of up to 30 cm have been reported. There are often a few of them. At a smaller 1 cm it can be difficult to differentiate with other benign lesions such as adenoma or focal hyperplasia. Blood tests: Changes in liver function tests are rare. If there are any changes, you should check for other reasons for laboratory changes. Tumor markers, such as alpha-fetoprotein or CA19-9, remain unchanged. Ultrasound: Can diagnose the liver node. On ultrasound it looks like a hyper-alcoholic node (whiter than the rest of the liver), well delimited, rounded. Tomography and/or RESONANCE: They are indicated when there is any diagnostic doubt. Can show lesions greater than 0.5 cm. The tomography or resonance of the abdominal cavity helps to determine the size and location of the nodules and allows for an analysis of the health of the rest of the liver. Both tomography and resonance, when performed with contrast, can demonstrate the contrast absorption of hemangioma. Your doctor will determine if you need to order one of these tests. Scintigraphy: Rarely asked. This is a study in which a radio-labeled molecule is injected into red blood cells, which, when injected into the bloodstream, enter the hemangioma. It can be used to confirm hemangioma, but again, it is rarely asked. Hemangioma biopsy: It is contraindicated. It can rarely be used when there is a diagnostic doubt. Diagnostics. Hemangioma hepatico serum tc. hemangioma hepatico serum ecografia. hemangioma hepatico resonancia serum. hemangioma hepatico atipico serum. hemangioma hepatico tomografia serum. hemangioma cavernoso hepatico serum. hemangioma hepatico rm serum. hemangioma hepatico gigante serum

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