and result from earlier hemorrhage within the leaves of the mesentery; a definite history of trauma is seldom obtained.

A 29-year-old man was admitted with history of abdominal distension of 4 months’ duration and dull abdominal pain for 4 days. He also complained of weakness and frequency of urination for 4 months. His bowel habits were normal and there was no history of fever. Approximately 4 months ago he had a fall from a height, followed by low back pain. Clinical and radiological examination at that time had shown no abnormality. He apparently improved with conservative management but was not totally symptom-free. About a month later, he noticed progressively increasing distension of abdomen, accompanied by vague abdominal discomfort and gradually increasing malaise.

On examination the patient appeared pale. There was a smooth, spherical mass measuring approximately 55 cm in transverse axis, occupying almost the entire abdomen, simulating ascites. It was immobile, slightly tender, tense cystic in feel, with definite fluid thrill. The lower margin of the mass was not palpable as it extended into the pelvis. On per rectal digital examination an extraluminal tense cystic mass was palpable through the anterior rectal wall.

Hematological and biochemical investigations were normal except for hemoglobin of 6.9 g/dL. Ultrasonography revealed a huge multiloculated, cystic lesion with thin septations and internal echoes due to debris, extending from the epigastrium to the pelvis and occupying both flanks. The site of origin of the lesion could not be defined. Diagnostic tapping showed free-flowing brownish fluid. The patient could not afford CT scan.

Exploration revealed a huge thick-walled cyst, located within the leaves of the sigmoid mesocolon, which extended from the upper abdomen to deep within the pelvis. On aspiration approximately 5 liters of brownish fluid was evacuated. Careful dissection enabled us to shell out the entire cyst, from between the leaves of the mesentery, without injuring any mesocolic vessel. On opening the cyst it was found to contain plenty of brownish debris.

Postoperative recovery was uneventful. Histology of the cyst wall showed fibrocollagenous tissue without epithelial lining and plenty of hemosiderin-laden macrophages on one side, suggesting a pseudocyst, probably of traumatic origin.

There are varieties of mesenteric cysts, including chylolymphatic, enterogenous, urogenital, teratomatous, traumatic, gas, mycotic, parasitic, tubercular, and cysts following malignant degeneration.1 Traumatic cysts are basically pseudocysts that are lined by fibrous tissue elements instead of epithelium. They are acquired following trauma and rupture of lymphatic or blood vessels. Traumatic cysts are rare entities and only a few cases have been reported;2,3,4 there is only one previously reported huge post-traumatic cyst of the sigmoid mesentery.2 Surgical excision, preferably enucleation, as was done in this case, is the preferred treatment. Mar- supialization, internal drainage or aspiration may be followed by recurrence.

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Bifid liver in a patient with diaphragmatic hernia

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Liver malformations including lobe and segmental abnormalities are rare. We report a 65-year-old lady with complaints of breathlessness and fullness after meals for two months. Investigations revealed a diaphragmatic hernia on the right side with a bifid liver; the right lobe of the liver was among the hernia contents. The lady is asymptomatic after surgical repair. [Indian J Gastroenterol/2005;24:27-28]

Congenital abnormalities of the liver include agenesis of its lobes, absence of segments, deformed lobes, decrease in size of lobes, lobar atrophy, and hypoplastic lobes. Right-sided diaphragmatic hernias are rare because of presence of liver. However, congenital anomalies of the liver may be associated with right-sided diaphragmatic hernia, which presents in childhood.

A 65-year-old woman presented with history of breathlessness, sensation of fullness after meals, and vomiting for two months. She had a history of bronchial asthma since many years, but had no similar complaints or trauma or surgery in the past. Clinical examination revealed decreased respiratory excursions on the right hemithorax, with decreased breath sounds on the right side. The abdomen was scaphoid in shape with no organomegaly.

X-ray chest and abdomen in the standing position revealed a fundic air shadow and air shadows suggestive of bowel loops under the right hemidiaphragm, which was riding high. Ultrasonography revealed a bifid liver with the right liver lobe in the right thorax along with stomach and bowel loops. CT scan of the abdomen confirmed the findings of a bifid liver (Fig), with the stomach and few bowel loops lying high up in the right thorax.

The patient was explored through a upper midline incision and was found to have a large right-sided diaphragmatic hernia with the shrunken finely nodular right liver lobe, stom-
ach and part of the transverse colon herniating into the thorax. The left lobe was larger than the right, and both were joined by a bridge of liver tissue. The stomach had undergone volvulus. On reducing the contents of the hernia the volvulus was corrected and the defect was closed with nonabsorbable suture. Postoperatively the patient’s symptoms were relieved and X-ray showed full expansion of the right lung. She is asymptomatic one year later.

Lobe and segmental abnormalities of the liver are rare. Malformations of the liver are common in the perinatal period since the liver undergoes considerable postnatal reformation. They may produce no symptom and hence may present in any age group as an incidental finding. However, liver anomalies associated with diaphragmatic hernia present early in life. In our case, the patient presented at 65 years of age.

Hepatic anomalies can be divided into two categories, i.e., anomalies due to defective development and those due to excessive development of the liver. Such disturbances are sometimes associated with malformations of other structures, especially the diaphragm and suspensory apparatus of the liver. Defective development of the left lobe of the liver can lead to gastric volvulus. Conversely, defective development of the right lobe either remains clinically latent or leads to portal hypertension.

Anomalies related to excessive development of the liver lead to formation of accessory lobes annexed to the liver. The accessory lobes may run the risk of torsion. Cases with thoracic accessory liver lobe with a normal diaphragm have been reported in literature.

Ectopic liver has been described in the wall of the gall bladder occurring without any connection to the liver. In our patient the right lobe was connected to the left lobe by a thin bridge of liver tissue.

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Pleuro-biliary fistula – a delayed complication following open cholecystectomy
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A 24-year-old lady presented with bilious expectoration and history suggestive of obstructive jaundice, 16 months following open cholecystectomy. Pleurocentesis was done, followed by intercostal drainage, which drained about 300 mL bilious fluid per day for a month. Her symptoms of obstructive jaundice were relieved. A pleuro-biliary fistula was demonstrated by percutaneous transhepatic cholangiogram, HIDA scan and ERCP, which showed complete cut-off at the lower end. The patient underwent bilio-enteric bypass with gastric access loop, with complete healing of the pleuro-biliary fistula. [Indian J Gastroenterol 2005;24:28-29]

Several causes of biliary-bronchial fistula have been described, including trauma, parasitic liver disease, supplicative complications of biliary obstruction, and congenital anomalies.

A 24-year-old lady was admitted elsewhere with colicky, non-radiating pain in the right hypochondrial region, increasing after meals, for 7 months. She underwent open cholecystectomy, but operative details were not available. Postoperatively, on day 2, she developed acute-onset severe pain in the right hypochondrium, with ultrasonography showing minimal fluid collection in the gall bladder fossa. Ultrasonography-guided aspiration of the fluid showed it to be bilious. She was treated conservatively and was asymptomatic since then.

Sixteen months later, she presented with acute-onset breathlessness, copious bilious expectoration, and jaundice. X-ray chest showed a large right-side pleural effusion. Pleurocentesis revealed 300 mL of frank bilious fluid. The next day, an intercostal drain was placed on the right side, draining 300 mL bilious fluid per day for a month. Her jaundice gradually decreased. The patient was then referred to a tertiary-care institute.

ERCP showed complete cut-off of the proximal common bile duct. Percutaneous transhepatic cholangiogram showed a