Sporadic, multiple adenomatous polyposis coli treated with ileo-endorectal pull-through

Adenomatous polyps are extremely rare in children less than 12 years of age.1

A six-year-old boy presented with bleeding per rectum for one year. The child was anemic (hemoglobin 5 g/dL) and hypoproteinemine (serum protein 3.5 g/dL). Digital rectal and proctoscopic examination revealed a bunch of polyps; one of these was sent for histological examination. Barium enema and colonoscopy showed that the whole colon was studded with polyps. Histology showed adenomatous polyp. Upper gastrointestinal endoscopy did not show any polyps. There was no peri-oral or axillary fold hyperpigmentation. Ophthalmoscopic examination did not show any retinal lesions. Pedigree charting of two generations did not show any such case. Ophthalmoscopic examination of family members did not show any retinal lesion.

Due to the poor general condition of the child, ileal pouch reconstruction was deferred and total colectomy with ileo-endorectal pull-through with ileo-anal anastomosis at the anal reservoir can be constructed when the patient is relatively healthy and can withstand a bigger procedure.2

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References


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Dysphagia due to olanzepine, an antipsychotic medication

Olanzapine is currently one of the most commonly used anti-psychotic medications. The side-effect profile of the drug is considered favorable compared to older medications.

A 24-year-old man, a known patient of bipolar affective disorder, was admitted with a diagnosis of mania. He was started on olanzapine 20 mg/day and sodium valproate 1000 mg/day. He complained of increased salivation and difficulty in swallowing his saliva 5 days after starting his medication. Over the next few days he had difficulty in taking food orally or drinking water; a nasogastric tube was inserted and his nutrition and hydration were maintained. ENT examination ruled out local pathology. The patient did not have fever, rigidity, involuntary movements, other weakness, focal neurological deficit or signs of parkinsonism. The olanzapine dose was reduced to 10 mg/day and was stopped over the next 5 days. The dysphagia resolved over the next week, and the patient was continued on sodium valproate 1000 mg/day and clonazepam 4 mg/day.

Dysphagia is a rare side effect of olanzepine therapy. Reports of dysphagia due to risperidone1 and

References


Familial adenomatous polyposis are now recognized to be Mendelian dominant and the gene responsible (APC gene) has been located on the short arm of chromosome 5.2 Pigmented spots in the retina and DNA tests for FAP gene are important screening methods.2 There was no symptomatic, genetically related individual in two generations of our case. None had pigmented spots in the retina. DNA tests for FAP gene could not be performed. In all probability our case had sporadic disease.

Total colectomy with removal of the rectal mucosa and ileo-endorectal pull-through is a simple and dependable procedure. With passage of time the neorectum, i.e., terminal ileum undergoes dilatation and there is spontaneous correction of the problem of stool frequency. If this does not occur even after one year a reservoir can be constructed when the patient is relatively healthy and can withstand a bigger procedure.

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clonazepam are available, while data regarding this side effect of olanzapine are scarce. The US FDA has recently issued a warning about the possibility of aspiration pneumonia and dysphagia in elderly individuals with dementia on olanzapine. The dysphagia remits on decrease or stoppage of the medication.

The occurrence of dysphagia in this young man in the absence of other side effects is interesting. Knowledge about these side effects of antipsychotics would aid the physician in avoiding invasive and expensive tests for evaluation of dysphagia.

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References

Esophageal bezoar in a patient with normal esophagus

Esophageal bezoars are very rare but are known to occur in patients with structural and functional abnormalities of the esophagus. They occur in patients with esophageal motility disorder or anatomical defects, e.g., diverticulum, hiatus hernia, and post gastric surgery. They may also occur in patients with particular eating habits, such as excessive consumption of persimmon (a fruit with a relatively high gum and pectin content), perdiem (bulk laxative) or chewing gum. Critically ill patients on mechanical ventilator receiving feeds via nasogastric tubes, and receiving sucralfate and antacid therapy are also at risk of development of esophageal bezoars. These bezoars form in the esophagus as a result of regurgitation of stomach contents. Altered esophageal pH, gastroesophageal reflux, and presence of prosthetic device in the esophagus all contribute to the development of esophageal bezoars.

A 65-year-old lady presented with sudden onset of total dysphagia. Barium swallow revealed a fusiform expanded portion of the lower esophagus just proximal to the diaphragmatic hiatus, simulating a hiatus hernia. Delayed flow of barium was seen proximal to and around this filling defect. However distally, there was no obstruction to passage of barium into the stomach. Fiberoptic esophagoscopy revealed a large, yellowish, firm mass with a relatively hard central core. There was no bleeding on contact or on piecemeal removal of the mass. The bezoar was removed by a rigid endoscope under general anesthesia.

The material removed showed undigested food material; hence a diagnosis of phytobezoar was made. Barium study performed after the procedure revealed smooth passage of barium. There was no evidence of disturbed motility or stricture of the esophagus. A small sliding hiatus hernia was noted.

Seggie reported a patient in whom a gastric phytobezoar was regurgitated into the esophagus during an episode of vomiting. It became impacted there, giving rise to severe acute dysphagia and changes of severe ulcerative esophagitis due to pressure and secondary infection. The occurrence of a bezoar in a normal esophagus is exceptional.

The mainstay of the diagnosis and treatment of esophageal bezoar has been endoscopy. Large bezoars have been fragmented and evacuated. However there are reports of medical management of bezoars; papain and cellulose and pancreatic enzymes have been used for dissolution of esophageal bezoar.

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References

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Fig: Barium swallow (oblique view) showing mass at lower end of esophagus. Note barium flowing around mass.