All cholecystectomy specimens received in our department between January 1998 and September 2002 were reviewed. Sections were stained with hematoxylin and eosin. Cases with an eosinophilic infiltrate comprising more than 90% of the inflammatory cells were classified as EC; cases with 50%-75% eosinophils along with other inflammatory cells were termed lympho-eosinophilic cholecystitis (LEC).1

There were 7 cases of EC and 3 of LEC among the 3877 specimens. The age range of the patients was 26-72 years (mean 46) and they included 7 women. One case had peripheral eosinophilia associated with hydatid cyst of liver. Except for one, all cases had gallstones. The histological findings are summarized in the Table. The prevalence of EC was 0.18% and LEC, 0.07%.

Table: Histological findings in gall bladders of patients with eosinophilic and lympho-eosinophilic cholecystitis

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Eosinophilic infiltrate</th>
<th>Muscle</th>
<th>Only muscle</th>
<th>Ulceration</th>
<th>Perimuscular fibrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&gt;90</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>&gt;90</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>3</td>
<td>&gt;90</td>
<td>-</td>
<td>+</td>
<td>+</td>
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<td>7</td>
<td>70</td>
<td>-</td>
<td>-</td>
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<td>8</td>
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<td>-</td>
<td>+</td>
<td>+</td>
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</tr>
<tr>
<td>9</td>
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<tr>
<td>10</td>
<td>&gt;90</td>
<td>-</td>
<td>-</td>
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</tr>
</tbody>
</table>

The reported prevalence of EC varies from 0.2% to 6.4%.1,2 Patients usually present with symptoms of acute cholecystitis. Their average age reported is 37 years.3 Peripheral eosinophilia has not been reported to be associated with EC; when present, EC is likely to be a manifestation of a systemic hyper eosinophilic disorder.4 Rarely EC is associated with rupture of hepatic hydatid cyst into the bile ducts.5 Calculi are reported to be present in up to 40% of cases.3 However, Debbs et al6 found EC and LEC to be more commonly associated with acalculous cholecystitis. Our study showed gallstones in 6 of 7 cases. All cases of acalculous EC reported in literature were men with features of obstructive jaundice; the only case in our study was a woman.

The etiology of EC is obscure. Among the factors implicated are a local eosinophilic inflammatory reaction to gallstones or parasites, a manifestation of eosinophilic gastroenteritis, a systemic hyper eosinophilic syndrome, or an allergic response to drugs or other immunogens. EC has also been reported as a late manifestation of the eosinophilia-myalgia syndrome.

Cholecystectomy appears to be definitive therapy for EC. Steroids are probably indicated when eosinophilic involvement of other organs is found.

References

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**Modified ileo-transverse anastomosis in typhoid bowel perforation**

Mansoor et al1 have advocated modified ileo-transverse anastomosis (MITA) in typhoid ileal perforation of less than 1 cm, multiple perforations, diseased ileum with impending perforation, and friable bowel wall. They used 1-0 plain catgut purse-string suture distal to the anastomosis to divert intestinal contents away from the diseased bowel. How long is such a suture likely to hold in a grossly infected milieu? There have been instances when even chronic catgut dissolves in tissues in less than 72 hours in the presence of infection. What is the period for which intestinal contents are diverted to promote healing?

The authors have compared MITA with simple closure, resection-anastomosis, and ileostomy. I understand this was not a controlled trial, but to really justify the efficacy of MITA it would have been better to compare it with conventional ileo-transverse anastomosis. Also, would there be a role for chromic catgut or synthetic absorbable material for the temporary suture?

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Reply from the authors

Unlike what Dr. Duttaroy writes, we have advocated MITA in typhoid ileal perforations of greater than 1 cm diameter. It is true that plain catgut sutures are not very reliable in grossly infected tissue, but since we used these sutures proximal to the perforations in relatively healthy bowel, we can assume that intestinal contents will be diverted for about 7 to 10 days, which is sufficient period to allow healing.

We agree that it is not proper to compare the results of MITA with simple closure, resection-anastomosis, and ileostomy as the indications for each procedure are different. But we feel that MITA is a better option than conventional ileo-transverse anastomosis since it can completely divert the fecal stream and give temporary rest to the bowel, whereas the conventional anastomosis will not completely bypass the perforation.

Tariq Mansoor, Musharrat Hussain, S Hasan Harris

Laparoscopic left lateral sectorectomy for polycystic liver disease

A combination of surgical resection and fenestration has been the treatment of choice for symptomatic polycystic liver disease. The open approach has been previously reported. We report a patient with polycystic liver disease subjected to laparoscopic resection of the left lateral segment of the liver.

A 51-year-old man presented with epigastric discomfort. On examination, there was an 8-cm, smooth, mobile, epigastric mass suggestive of enlargement of the left liver lobe. Ultrasonography revealed a multicystic lesion in the left lobe of the liver. Liver biochemistry was normal. Hydatid serology was negative. CT scan showed segments 2 and 3 of the liver to be almost totally replaced by the multiloculated cystic mass, with a separate cyst in segment 4B (Fig). The kidneys and pancreas were normal.

In view of the symptomatic mass and uncertain diagnosis, we proceeded with diagnostic laparoscopy. On inserting the scope, thin-walled cysts were seen. One such lesion was aspirated. The fluid was negative for scolices. Povidone iodine was injected and a part of the cyst wall excised. Frozen section confirmed this to be polycystic liver disease. In view of the benign nature of the lesion and its accessibility, a decision was taken to proceed to resect it laparoscopically. The segments 4B cyst was carefully dissected from the porta and marsupialized. The gastrohepatic omentum and left triangular ligament were divided. The pedicle to segments 2 and 3 was dissected by dividing the bridge of liver tissue at the root of the false form ligament and divided between large clips. The liver parenchyma was divided just to the left of the falciform ligament using the Harmonic Scalpel (Ultrasound, Ethicon). The left hepatic vein was isolated intrahepatically, doubly ligated and divided. The specimen was delivered by extending the umbilical port site. Operative time was 3 hours. Blood loss was estimated at 200 mL.

Postoperative recovery was uneventful. Diet was commenced the next day and the patient was fit for discharge in 72 hours. He remains well over a follow-up period of 6 months.

Laparoscopic surgery has replaced open abdominal surgery in a variety of indications, including liver surgery. Laparoscopic wedge resection of the liver has been previously reported in Indian literature. This is the first report in Indian literature of laparoscopic removal of an anatomical sector of the liver. Polycystic liver disease is ideally suited to the laparoscopic approach as it is a benign condition, the parenchyma is thinned out making division easier, and the specimen can be easily delivered after decompressing the cysts, through a small incision.

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References


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