Fig: Gastrografin study showing leakage of contrast from esophagus (long arrow) into right pleural cavity (short arrow) the right pleural cavity. He had dramatic improvement on stopping oral feeds and placement of a nasogastric tube. Serial Gastrografin and methyl blue dye studies showed a decreasing leak, which closed off in 4 weeks’ time with development of pseudointestinal. Barium study and endoscopy subsequently did not reveal any motility disorder or narrowing in the esophagus. Oral feeds were introduced gradually; he tolerated them well. The chest tube was removed; the rest of his hospital stay was uneventful. Sixteen weeks after discharge, he was doing well. On questioning, he revealed that he had passed the blister pack intact per rectum 5 days after its ingestion.

Ingested FB frequently (25%-68%) lodge in the esophagus, and only 1% result in esophageal perforation. However, with sharp FB, as in our patient, the frequency of perforation is as high as 35%. These FB usually get embedded in local tissues or migrate into nearby structures. Of the five patients with blister pack ingestion reported in English literature, three had intestinal perforation, one had gastric perforation, and one had esophageal impaction. None had esophageal perforation or passed it intact per rectum, as in our case.

We suggest that explicit instructions for use must be included with drugs dispensed in blister packs.

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References

Massive hemorrhage from colonic ulcers in typhoid fever

Intestinal hemorrhage is a well-known complication of typhoid fever that usually occurs during the third week of illness. Massive bleeding can occur from ulcerations in the terminal ileum, cecum and rarely ascending colon.

A 26-year-old man presented with massive lower gastrointestinal hemorrhage requiring transfusion of 7 units of packed red cells. He had a 3-week history of fever, headache and muscle pains. He complained of ill-defined right lower quadrant discomfort, generalized weakness, anorexia and a recent 4-Kg weight loss. Physical examination revealed a pale, diaphoretic man with pulse rate of 110/min and BP 84/50 mmHg. The abdomen was tender in the right lower quadrant.

Investigations: hemoglobin 6.4 gm/dL, WBC 6.2 x 109/L. Titer of antibodies to O and H Salmonella antigens were 1:640 and 1:80, respectively. Blood culture was positive for S. typhi. Liver function and coagulation parameters were normal. Upper GI endoscopy was normal. Colonoscopy revealed multiple irreglar, punched-out ulcers distributed diffusely in the ascending colon and cecum; they ranged in size from 0.5 cm to 1.5 cm. Microscopy of colonic biopsy tissue revealed acute colitis with predominant polymorphic infiltrate and superficial ulcerations; periodic acid-Schiff stain showed no evidence of amebae. Stool cultures were negative for pathogens. Amelie serology was negative.

The patient was managed with blood transfusions and antibiotics. He left the hospital in good health after 10 days. One month later, he was symptom-free and colonoscopy was normal.

In typhoid fever, the distribution of ulcers in the intestinal tract parallels the anatomic location of Peyer’s patches; most hemorrhages from ulcerations therefore arise in the vicinity of the terminal ileum. However, colonic ulcers have also been reported; these occur in the proximal colon but may occur on the left side.

Colonoscopy can localize the bleeding source, and local endoscopic therapy in the form of endoclips or sclerotherapy can be considered before surgery, which has been the conventional treatment in such patients.

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