peritonitis is extremely rare. We report a 51-year-old man who presented with perforative peritonitis and was detected to have jejunal non-Hodgkin’s lymphoma. He was treated with resection of the affected segment with its mesentry and postoperative chemotherapy, and was asymptomatic 5 months later. [Indian J Gastroenterol 2004;23:110-111]

Key words: Small intestine tumor

Tumors of the small intestine are remarkably rare: only 3% to 6% of gastrointestinal tumors and 1% of gastrointestinal malignancies arise from the small bowel. Primary lymphomas account for 2% of all gastrointestinal malignancies and 10%-20% of small bowel malignancies. They are more common in the ileum, consistent with the higher number of lymphocytes there. Perforation of intestinal lymphomas is extremely rare.

A 51-year-old man presented with sudden-onset pain in the periumbilical region since 3 days, increasing in severity since one day, with associated distension of abdomen. There was no history of vomiting or constipation, or ingestion of NSAIDs. On examination he was pale; there was no generalized lymphadenopathy. He had generalized distension of abdomen with tenderness, guarding and rigidity all over the abdomen. On auscultation there were no bowel sounds.

Investigation: Hemoglobin 9.2 g/dL, WBC 8800/mm3. X-ray chest showed gas under both domes of diaphragm.

Emergency laparotomy revealed a perforated tumor mass, approximately 5 cm x 5 cm in size, in the jejunum about 16 cm to 18 cm from the duodeno-jejunal flexure, and another 3 cm x 2 cm lesion about 5 cm distal to the tumor mass with circumferentially thickened bowel. There were multiple hard lymph nodes in the adjacent mesentry. The liver, rest of the small intestine, stomach and large intestine were normal. There was around 800 mL of small bowel contents in the peritoneal cavity. The affected segment of jejunum was resected with a margin of 8 cm, along with adjacent mesentry and lymph nodes. Primary end-to-end anastomosis of the bowel was done after peritoneal lavage. Postoperative recovery was uneventful.

Histology of the resected segment revealed high-grade non-Hodgkin’s lymphoma of anaplastic large cell type. The patient was treated with combination of cyclophosphamide, vincristine and prednisolone. He followed up regularly for 5 months and was asymptomatic till then.

Perforation of a tumor can occur with surrounding desmoplastic reaction and, therefore, primary closure is not advisable. Resection of the affected segment with its mesentry is the only acceptable procedure. Our patient had a perforated jejunal tumor mass, which was diagnosed as a primary GI lymphoma.

In the treatment of a high-grade primary intestinal non-Hodgkin’s lymphoma of anaplastic large cell type, a multimodality approach is superior to surgery or chemotherapy alone. Prognostic factors include the stage at presentation, the presence of perforation, tumor resectability, histologic subtype, and the use of multimodality therapy. Perforated lymphomas usually have higher stage and bad prognosis.

References


Correspondence to: Dr Joshil, Professor, in-Charge GE and Endoscopy Clinic. Fax: (22) 2403 7889. E-mail: joshilom@vsnl.com

Received October 11, 2003, Revised in final revised form April 16, 2004. Accepted April 18, 2004

Spontaneous perforation – a rare complication of choledochal cyst

Gajanan D Wagholkar, Kamal Chettri,* Surinder K Yachha,* Sadig S Sikora

Departments of Surgical Gastroenterology and *Gastroenterology, Sanjay Gandhi Post Graduate Institute of Medical Sciences, Raebareli Road, Lucknow 226 014

We report a 2-year-old girl with spontaneous perforation of choledochal cyst. Preoperative diagnosis was possible by hepatobiliary scintigraphy. In view of emergency presentation and bile peritonitis, management was a staged procedure with peritoneal lavage and T-tube drainage of the biliary system, followed by excision of the cyst and Roux-en-Y hepatico-jejunostomy 3 months later. [Indian J Gastroenterol 2004;23:111-112]

Key words: Bile duct cyst, nuclear scan, rupture

Spontaneous perforation is a rare and ill understood complication of choledochal cyst (CDC).

A 2-year-old girl presented with sudden-onset severe pain in the abdomen followed by progressive abdominal distention and jaundice, of two weeks’ duration. There was history of refusal to accept feeds, vomiting and constipation for two days. Examination revealed moderate dehydration and tachycardia. The child was mildly febrile, with obvious icterus. There was significant abdominal distention with diffuse abdominal tenderness. Bowel sounds were absent.

Investigation: TLC 12,500/mm3, serum bilirubin 4.2 mg/
dl and serum alkaline phosphatase 2196 JU/L (normal 151-471). Other hematological and biochemical investigations were within normal limits. X-ray of the abdomen showed generalized haziness with ground-glass appearance and no evidence of pneumatoperitoneum. Ultrasonography (US) showed segmental dilatation of the extrahepatic bile duct, with no dilatation of the intrahepatic biliary radicles. There was free fluid in the abdomen, with dilated bowel loops. On US-guided aspiration fluid was turbid and bilious. A possibility of spontaneous perforation of CDC was considered. Hepatobiliary scintigraphy showed presence of a CDC with free activity in the peritoneal cavity, suggestive of perforation.

The patient underwent emergency exploration after fluid resuscitation. There was around 2.5 liters of turbid bile in the peritoneal cavity. There was cystic dilatation of the common duct with a perforation laterally just distal to the insertion of the cystic duct, with ongoing leak of bile. A T-tube was placed into the CDC through the site of perforation and abdomen closed after lavage. The child improved rapidly and she was discharged within a week with plan for definitive management at a later date. T-tube cholangiogram showed a type I CDC (Fig). She underwent excision of the CDC with reconstruction by Roux-en-Y hepatico-jejunostomy three months later. Postoperative course was uneventful with no complications.

Spontaneous perforation of CDC is a rare entity. Proposed mechanisms include epithelial irritation of the biliary tract due to refluxed pancreatic juice caused by pancreatobiliary malunion associated with mural immaturity; distal obstruction of the common channel due to protein plugs with abnormal rise in duodenal pressure and anoxic necrosis of the cyst wall; or abnormal congenital mural weakness. Several reports suggest that spontaneous perforation of the bile duct may in fact be a previously unrecognized ruptured CDC.1 In one study, all patients diagnosed as spontaneous perforation of the bile duct at operation were found to have pancreatobiliary junction malformation and CDC on subsequent cholangiogram.2 Spontaneous perforation is essentially seen in children, with the majority of cases being less than four years of age.3 In an analysis of more than 1400 cases of CDC reported in Japanese literature the incidence of spontaneous perforation was 1.8%,4 while in a survey of the Surgical Section of the American Academy of Pediatrics it was found to be 2.1%.1 The site is usually at the junction of the cystic duct with the common hepatic duct, as was in the present case, and is thought to be due to the suboptimal blood supply to this part.1

Presentation is usually subacute, with progressive abdominal distention, vomiting, jaundice, acholic stools and failure to thrive. With development of bile peritonitis the patient may manifest signs of sepsis and ileus. While aspiration of bile in the peritoneal cavity is pathognomonic of perforation, the same can be demonstrated on radionuclide imaging. Management is essentially a staged procedure with perineal toileting and T-tube drainage of the biliary system in the emergency setting. Excision is performed electively at a later date after assessment of pancreatobiliary ductal anatomy by T-tube cholangiogram.1

References

Correspondence to: Dr Silkopa, Additional Professor. Fax: (622) 266 6073, 266 6875. E-mail: sadiq@ibppi.ac.in
Received October 11, 2003, Received in final revised form March 9, 2004, Accepted March 30, 2004

Adenocarcinoma esophagus with choroid metastasis

Devinder Singh, Atul Sharma, Brijesh Arora, N K Shukla,* B K Mohanty**

Departments of Medical Oncology,* Surgical Oncology and**Radiation Oncology, Institute Rotary Cancer Hospital (IRCH), All India Institute of Medical Sciences, New Delhi 110 029

Metastases to the eye are rare and those from carcinoma esophagus are very rare, with only one report in the English literature. We report a 46-year-old man with adenocarcinoma of esophagus who developed isolated choroid metastasis after definitive treatment of the primary tumor. [Indian J Gastroenterol

Fig: T-tube cholangiogram showing type I choledochal cyst

112 Indian Journal of Gastroenterology 2004 Vol 23 May - June