dl and serum alkaline phosphatase 2196 IU/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 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 ductal 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. 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. Spontaneous perforation is essentially seen in children, with the majority of cases being less than four years of age. In an analysis of more than 1400 cases of CDC reported in Japanese literature the incidence of spontaneous perforation was 1.8%, while in a survey of the Surgical Section of the American Academy of Pediatrics it was found to be 2.1%. 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.

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 peritoneal 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.

References

Correspondence to: Dr Sikora, Additional Professor. Fax: (622) 266 8017, 266 8073. E-mail: sadiqu@epgi.ac.in
Received October 11, 2003, Revised in final revised form March 9, 2003, 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, *Surgeon 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 choroidal metastasis after definitive treatment of the primary tumor. [Indian J Gastroenterol

Fig: T-tube cholangiogram showing type I choledochal cyst
2004;23:112-113

Key words: Esophagus carcinoma, eye

Metastases to ocular uvea from extra-ocular primary tumors are rare, though these are still the commonest uveal malignant lesions. Common primary sites include carcinoma breast, lung, skin melanoma and epithelial ovarian tumors. Among gastrointestinal tumors, common primary sites include stomach, ileum, colon and rectum. Esophageal carcinoma is a rare primary site, being responsible for only one of 70 cases of uveal metastases in one series and none of 227 such patients in another series.

A 46-year-old man presented with history of dysphagia to solids, weight loss and backache for 12 months. On examination, his ECOG performance status was II; physical examination was otherwise normal. Hemogram and blood biochemistry were within normal limits. Upper gastrointestinal endoscopy revealed a nodular growth at 28 cm from the incisors; biopsy from the growth revealed well-differentiated adenocarcinoma. CT scan showed circumferential thickening of the esophageal wall extending for 6 cm from the level of carina, with periesophageal lymphadenopathy but no infiltration of blood vessels or pericardium. No metastases were evident. A diagnosis of well-differentiated adenocarcinoma of the middle third of the esophagus, clinical stage III (T3N1M0) was made.

He was treated with radiotherapy, followed by transhi- thoracic esophagectomy with gastric pull-up and cervical esophago-gastrostomy. Histology of the resected specimen revealed pathological TNM stage III (T3N1M0) tumor with invasion of the serosa and involvement of periesophageal and cervical lymph nodes. He received four cycles of adjuvant chemotherapy using cisplatinum and etoposide. A year later, he presented with diminution of vision and pain in the left eye. CT scan of the orbit revealed left-sided choroid metastasis with retinal detachment. Since investigations did not reveal metastasis at any other site, enucleation of the left eye was done; histology of the resected tissue revealed adenocarcinoma of the choroid. However, he later developed swelling of the left leg; X-ray revealed destruction of left fibula suggestive of metastasis. Palliative radiotherapy to the left orbit and left fibula was given. He however died of progressive disease 19 months after the initial diagnosis.

Ocular metastases from extra-ocular primary solid tumors are infrequent. However, primary uveal tumors being uncommon, metastatic tumors are the commonest intra-ocular tumors among adults. Among women, breast is the commonest primary site, accounting for 85% of cases, whereas among men, lung is the commonest primary site, responsible for 35% of cases.

Common presentations include reduced vision, ocular pain, exophtalmos, retinal detachment, mass lesion, uveitis and secondary glaucoma. Median interval from diagnosis of primary tumor to development of ocular metastasis is 36 months (range 8-240). Treatment includes systemic therapy directed at the primary disease and local treatment modalities.

Only one case of ocular metastasis from esophageal cancer has been reported previously; in that patient, uveal metastasis appeared 3 months after the diagnosis of primary tumor.

References

Correspondence to: Dr Sharma, Assistant Professor, Phone: (11) 2656 8406, 2656 8683. E-mail: atul1@hotmail.com

Received October 13, 2003. Accepted April 5, 2004

Gastric hemangioma: an unusual cause of upper gastrointestinal bleed

A A Bamanikar, A G Diwan, B Benoi

Bharati Vidyapeeth Deemed University Medical College and Hospital, Pune 411 043

We report a 36-year-old lady who presented with hematemesis. Emergency endoscopy showed a polypoidal lesion in the gastric fundus that appeared like a varix. Celiac angiogram confirmed this to be a hemangioma located in the fundus. This was managed by arterial embolization; the patient is symptom-free 6 months later. [Indian J Gastroenterol 2004;23:113-114]

Key words: Embolization, hematemesis

Gastric hemangioma is a rare cause of upper gastrointestinal bleeding. It is difficult to diagnose on endoscopy alone, particularly during acute bleeding.

A 36-year-old previously healthy housewife was admitted with vomiting of about 500-700 mL of fresh blood. There was no history of preceding drug intake. On examination, she was conscious but apprehensive, and overweight. Her heart rate was 90/min, and blood pressure was 100/70 mmHg. There were no mucocutaneous lesions to suggest a cause for hematemesis.

Investigations: hemoglobin 8.5 g/dL, packed cell volume 38%, normal total and differential leucocyte counts, normal platelet count, normal clotting profile, and liver and kidney function tests. Two units of packed red cells were transfused. Emergency upper GI endoscopy showed fresh blood in the stomach, but no lesion in the esophagus or duodenum. Gastric fundus showed a bleeding lobulated, polypoidal lesion about 5 mm in size with tortuous vessel(s) (Fig), suggestive of bleeding.