This case presents unusual features: the difficulty in achieving a pre-operative histologic proof despite three sets of endoscopic biopsies, and the circumferential nature of the duodenal involvement precluding endoscopic therapy. Since there was no biliary or pancreatic duct obstruction, the possibility of a benign lesion was high. Yet, CT scan and operative findings were suggestive of an invasive carcinoma and a Whipple resection was required to excise the lesion completely.

Brunner’s gland adenomas should be considered in the differential diagnosis of duodenal lesions, especially where bile and pancreatic ducts are unobstructed. Establishment of a histologic diagnosis by endoscopy will permit endoscopic excision or conservative resection.

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Jejunal leiomyosarcoma presenting as chronic intra-abdominal abscess
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We report a 35-year-old man with jejunal leiomyosarcoma who presented with chronic intra-abdominal abscess. He underwent drainage of the abscess initially but was re-explored four months later when a mass developed. Total excision of the tumor was done. [Indian J Gastroenterol 2001;20:244-245]
Key words: Jejunum tumor

The usual presentations of jejunal leiomyosarcoma are with bleeding, pain in the abdomen, intestinal obstruction, perforation and cachexia. We report a patient with this tumor who presented with chronic intra-abdominal sepsis.

A 35-year-old man was admitted with abdominal distension for one year, rapidly increasing in the last two weeks. Pain in the abdomen, weight loss, low-grade fever, vomiting, and poor appetite were his other symptoms. His bowel habits were normal. He was hemodynamically stable. Pallor, pedal edema, abdominal fluid thrill and minimal tenderness were the positive signs elicited.

Investigations: Hemoglobin 8 g/dL, WBC count 13,000/μL with polymorphonuclear leukocytosis. Biochemical investigations were normal except for hypoalbuminemia. Diagnostic paracentesis yielded thin purulent fluid; microscopy showed polymicrobial flora and Candida albicans. X-ray abdomen showed a large single air-fluid level. CT abdomen (Fig.) showed a 20 cm x 12 cm fluid-filled cavity that enhanced with oral contrast, indicating a bowel communication. The small bowel was pushed to the right side. No mass lesion was detected.

At exploration by a midline incision, an abscess cavity was detected with its wall adherent to the linea alba; about two liters of pus and debris was evacuated. Since the remaining visceras were plastered, further exploration was not done. A Malecot catheter was placed in the cavity. The patient’s general condition improved in the postoperative period. Cavitogram showed a communication with the jejunum. Gradually, a mass was palpable in the abdomen. Re-exploration after four months showed a huge mass, 25 cm x 15 cm, arising from the duodenojejunal flexure with extensive adhesions. Total excision was done. Histology of the mass showed leiomyosarcoma with high mitotic activity.

Sarcomas comprise about 10% of malignancies of the small intestine. They present with weight loss, anorexia, and abdominal pain. Leiomyosarcomas are highly vascular and tend to bleed into the lumen. The bleeding may be occult, presenting as anemia, or it may be overt and massive. Recurrent melena is the commonest symp-

Fig: CT scan showing irregular fluid-containing lesion with mixed density, enhancing with oral contrast indicating bowel communication. Small bowel is pushed to right
tom. Externally growing tumors may outgrow their blood supply, causing necrosis, leading to intraluminal or intraperitoneal bleeding.

Ten percent of leiomyosarcomas present as acute abdomen, due to volvulus, kinking, intussusception or adhesions. Unusual presentations reported include hyperemesis secondary to a β-HCG producing leiomyosarcoma, lethargy, torsion of the small intestine around a sarcoma in a Meckel's diverticulum, and as fever of unknown origin. Leiomyosarcoma presenting as chronic intra-abdominal abscess, as in our case, has not been reported before.

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Herpes simplex esophagitis in immunocompetent individuals

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Herpes simplex esophagitis commonly occurs in immuno-compromised individuals. We report the condition in two immunocompetent individuals (one presenting with retrosternal pain and diarrhea and the other with dysphagia and fever) and in two patients with obstructive airway disease who had received corticosteroid therapy. The first two did not receive treatment, one was lost to follow up and the other is asymptomatic for two years later. The latter two patients received acyclovir therapy. [Indian J Gastroenterol 2001;20:245-246]

Key words: Viral esophagitis

Herpes simplex esophagitis occurs commonly in immunocompromised patients and is relatively rare in apparently immunocompetent hosts. It occurs more often as reactivation of the latent virus; rarely, it may be a primary infection. We report 4 patients with herpes simplex esophagitis who presented between January 1996 and April 2001.

Case 1: A 60-year-old woman presented with history of loose motions and retrosternal pain of 15 days' duration. She had received anti-tuberculosis treatment for six months in the past. On clinical examination her hydration was fair. Esophagogastroduodenoscopy (EGD scope) showed an ulcer, 6 cm x 3 cm, on the anterior wall of the esophagus. The esophageal mucosa was friable with narrowing at the gastroesophageal junction. Esophageal biopsies showed several clusters as well as dispersed cells with opaque ground-glass nuclei, eosinophilic nuclear inclusions and multinucleated cells along with leukocytes. These findings were consistent with herpetic esophagitis. Ulcer biopsy showed esophageal squamous epithelium infiltrated by polymorphs. Nuclei of many of the cells showed intranuclear inclusions. Her HIV status was negative. She did not take any treatment and was lost to follow-up.

Case 2: A 24-year-old man presented with sudden-onset dysphagia and fever of four days' duration. His clinical examination was unremarkable. EGD scope showed multiple circumferential ulcers from the gastroesophageal junction up to 25 cm proximally; they were superficial and non-bleeding. Esophageal biopsies did not reveal any inclusions but ulcer biopsy showed squamous cells with opaque nuclei and multinucleated cells, consistent with herpetic viral inclusions. HSV IgM was negative and HIV status was negative. He did not take any treatment. He was well and asymptomatic until two years on follow-up.

Case 3: A 72-year-old man was admitted with history of backache since 13 days followed by breathlessness, vomiting and hematemesis (three episodes, 150 mL each). He was a known case of seizure disorder, hypertension and chronic obstructive pulmonary disease (COPD). He had received intravenous steroids in the past. On examination he was hemodynamically stable. On auscultation he had bilateral rales. Clinically he was diagnosed to have an acute exacerbation of COPD with upper