GI bleed.

Investigations: normal hemogram. Chest X-ray showed generalized osteopenia with no pleuro-parenchymal lesion. EGD scopy showed esophageal ulcers with exudates (Fig), suggestive of infective esophagitis. Esophageal brushings as well as biopsy from the edges of the ulcers showed multinucleated giant cells and eosinophilic intranuclear inclusion bodies. HIV and HSV IgM were negative. Barium swallow showed multiple filling defects.

He was treated with oral acyclovir 200 mg five times a day for five days and on follow-up was asymptomatic for one year. He expired later following an acute exacerbation of COPD, which was preceded by hematemesis and melena for one day.

Case 4: A 70-year-old woman presented with melena. She was a known case of bronchial asthma and was on oral steroids for eight years. She also gave a history of pulmonary tuberculosis in the past and had a non 'q' myocardial infarct earlier. EGD scopy showed confluent ulceration on the vocal cords, esophagus and stomach. Esophageal brushings and ulcer biopsy showed several multinucleated giant cells with ground-glass moulded nuclei, consistent with herpetic esophagitis. HSV IgM was negative, but HSV IgG was positive.

She was treated with intravenous acyclovir 500 mg 8 hourly for nine days. However, she had associated pneumonia, became septicemic and died.

Herpes simplex esophagitis occurs more commonly as reactivation of latent virus, but rarely it may be a primary infection. It is more common in immunocompromised patients. This report highlights the occurrence of HSV esophagitis in non-immunocompromised individuals and patients with respiratory illness who receive steroids intermittently or continuously.

The occurrence of HSV esophagitis in immunocompetent individuals is rare. Ramanathan et al found 35 cases of herpes simplex esophagitis in literature; their age ranged from 1-76 years and there was male predominance (3:2:1). Nearly a fourth had a prodrome of systemic manifestations preceding the onset of esophageal symptoms. Endoscopically, extensive involvement was common, showing friable mucosa, ulcers and whitish exudates. The distal esophagus was most commonly affected. Histology alone may miss the diagnosis and the addition of tissue viral culture optimizes the diagnostic sensitivity. The disease is usually self-limiting, and the benefit of antiviral therapy is not known.

Rosa et al reported five cases and found reports of 64 cases of herpes simplex esophagitis in immunocompetent patients. They recommended acyclovir to prevent complications. Both our immunocompetent patients had extensive esophageal disease, and did not receive treatment. One patient was well 2 years later.

HSV esophagitis can occur in patients with respiratory diseases who receive intermittent or continuous oral steroid or even inhaled steroid. Hemstreet et al reported a patient who was on inhaled steroid therapy and developed concomitant candida and herpes simplex esophagitis. One of our patients had received corticosteroid therapy intermittently.

In summary, herpes simplex esophagitis in immunocompetent individuals is a rare entity preceded by systemic prodrome in some patients. Whether antiviral treatment is indicated is controversial. Intermittent corticosteroid therapy and inhaled steroid therapy also predispose to herpes simplex esophagitis.

References

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Ruptured splenic abscess presenting as pneumoperitoneum

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Spontaneous pneumoperitoneum follows perforation of hollow viscus; rarely, it may arise from pulmonary interstitial emphysema or intestinal inflammatory disease. We report a 30-year-old man with ruptured splenic abscess who presented with acute abdomen and had pneumoperitoneum. He was treated with splenectomy and is asymptomatic 2 months later. [Indian J Gastroenterol 2001;20:246-247]

Key words: Escherichia coli abscess

Free intraperitoneal air follows perforation of intra-abdominal hollow viscus in over 90% of cases. Rarer causes include iatrogenic causes, intrathoracic source or inflammatory intestinal pathology. Rupture of splenic abscess with generalized peritonitis is rare. We report a patient with ruptured splenic abscess who presented with acute abdomen with pneumoperitoneum.

A 30-year-old man presented with acute upper abdominal pain since 2 days. He had no history of trauma, acid-peptic disease or ingestion of any ulcerogenic drugs. He was nonalco-
Port-site infection with Mycobacterium chelonoi following laparoscopic appendectomy

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We report a 14-year-old girl who developed port-site infection with Mycobacterium chelonoi following laparoscopic appendectomy. She was treated with local exploration and excision of sinuses that developed at the site, followed by antibiotic agents for six months. She has had no recurrence of infection at two years. [Indian J Gastroenterol 2001; 20: 247-248]

Key words: Laparoscopy adverse effects

Mycobacterium chelonoi, an atypical mycobacterium classified as a rapid-grower, is a ubiquitous organism widely distributed in the environment. Recent reports have highlighted its increasing role in surgical infections. We report a patient who developed port-site infection with M. chelonoi following laparoscopic appendectomy. A 14-year-old girl presenting with recurrent right iliac fossa pain underwent diagnostic laparoscopy and appendectomy. She had received perioperative prophylaxis with intravenous cefotaxime and metronidazole. The reusable metal instruments used for surgery were immersed in 2% glutaraldehyde for 30 minutes and rinsed with autoclaved water. Three ports (one 11 mm and two 5 mm) were utilized and the specimen was extracted via the 11-mm umbilical port without contamination of the wound. Histology of the appendix revealed chronic appendicitis.

A month later, she developed abscesses at the sites of the umbilical and suprapubic ports, which were drained under local anesthesia. Pursestitch failed to show any organisms. The abscesses recurred a month later and again at three months after surgery. Exploration of the wounds under general anesthesia revealed two sinus tracts, one running from the umbilicus towards the left iliac fossa and another passing from the suprapubic wound towards the right iliac fossa. Both were excised down to the rectus sheath through wide elliptical incisions. Histology showed granulomatous lesions (Fig) in the tracts and culture identified M. chelonoi as the causative organism.

References