Case Snippets

Ectopic pancreas as a cause of gastric outlet obstruction in an infant

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We report a one-month-old male child who presented with clinical and radiological features of gastric outlet obstruction. Surgical exploration showed presence of a prepyloric mass; histological examination of the resected specimen confirmed presence of ectopic pancreatic tissue. The child is well 8 months later. [Indian J Gastroenterol 2004;23:219]

Key words: Pyloric obstruction

Ectopic pancreatic tissue has been reported at several sites along the gastrointestinal tract and elsewhere, but it is most commonly found in the stomach and duodenum where it usually remains silent unless complicated by a pathological process.1,2 Pyloric ectopic pancreas may present primarily with features of gastric outlet obstruction, usually in adults and children beyond the first year of life; as a cause of neonatal gastric outlet obstruction, it is extremely rare. To the best of our knowledge only seven cases have been reported in English literature till date.1-6

A one-month-old male child presented with intermittent projectile non bilious vomiting and failure to gain weight for one week. There were no associated symptoms. On examination the baby appeared active, but mildly dehydrated. Examination showed a soft, non tender abdomen with mild epigastric fullness and no intra-abdominal palpable lump or visible peristalsis. Chest and neurological examination were normal.

Upper GI contrast study suggested features of gastric outlet obstruction. Ultrasonography of abdomen was reported as normal. Routine laboratory investigations were normal. A provisional diagnosis of infantile hypertrophic pyloric stenosis was made. Surgical exploration after initial resuscitation revealed a well-defined mass measuring 5-6 mm in diameter in the prepyloric region with proximal dilated stomach and normal pyloric canal. Suberosal excision of the mass was done; histological examination showed acini and ducts, confirming the diagnosis of ectopic pancreatic tissue. The postoperative period was uneventful. The child is well 8 months later.

Ectopic pancreatic tissue rarely causes symptoms in the newborn.1 Pyloric ectopic pancreas usually remains a silent gastrointestinal anomaly unless bleeding, obstruction or malignant transformation complicates it.1 The most common feature is of pyloric obstruction mimicking infantile hypertrophic pyloric stenosis;1-4 this occurs probably secondary to pancreatic inflammation.1

The preoperative diagnosis remains a challenge. The presence of a submucosal filling defect with central umbilication on contrast study is characteristic.1,2,5

The treatment of pyloric ectopic pancreas is primarily surgical.1 The management aims at complete excision of the ectopic pancreatic tissue along with thorough intra-abdominal exploration for presence of ectopic pancreatic tissue at other sites so that the development of complications later could be avoided.1,3

References

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Sewing needle appendicitis in a child

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A six-year-old boy presented with abdominal pain and vomiting five days after accidental ingestion of a sewing needle. The presence of the needle in the right iliac fossa on plain roentgenogram along with signs of appendicular inflammation on clinical and laboratory evaluation provided a clue to the diagnosis. Surgical exploration revealed inflamed appendix with the ingested needle in its lumen. The child recovered after appendectomy, and is well six months later. [Indian J Gastroenterol 2004;23:219-220]

Key words: Children, foreign body

Appendicitis as a complication of ingested foreign bodies is extremely rare in children. To the best of our knowledge only two children with foreign body appendicitis due to ingested needle have been reported in English literature till date.1,2

A six-year-old boy presented with pain in the right lower
abdomen with recurrent vomiting and low-grade fever for two days. He had accidentally ingested a sewing needle six days back but had concealed the history at that time. On examination the child was febrile. The abdomen was non-distended, with tenderness and guarding in the right iliac fossa especially at McBurney’s point.

Investigations: hemoglobin 9.5 g/dL, WBC 13000/cumm (polymorphs 96%); renal and liver function tests were normal. Plain roentgenogram of the abdomen showed the ingested needle in the right lower abdomen (Fig). Ultrasonography showed minimal free fluid in the right iliac fossa along with local tenderness.

Surgical exploration revealed an inflamed pelvic appendix with minimal amount of free fluid in the right iliac fossa. The needle was present in the cecum with its tip projecting midway into the appendicular lumen. Appendicectomy resulted in satisfactory recovery; histological examination confirmed inflammatory changes in the appendix. The child is well six months later.

Foreign body appendicitis is extremely uncommon in children. Although most ingested foreign bodies pass through the gastrointestinal tract, appendicular foreign bodies have been reported with an incidence of 0.0005%.1,3 Among reported foreign bodies resulting in appendicular inflammation are shotgun pellets, bird shots, and needles.1,3,4,5

The diagnosis of foreign body appendicitis is based on history of foreign body ingestion, followed by features suggestive of appendicular inflammation along with the presence of the ingested foreign body in the right lower abdomen in a static position on serial radiographs.1,3

The treatment is primarily surgical. Early surgical intervention is recommended even in asymptomatic cases with a high index of suspicion of presence of foreign body in the appendicular lumen so that the high morbidity associated with delayed diagnosis and resulting complications is avoided.1,2

References

Dieulafoy lesion in mid-esophagus with esophageal varices

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Dieulafoy lesion is an uncommon cause of gastrointestinal (GI) bleeding. Most such lesions are reported in the stomach, though a few have been reported in the distal esophagus. We report a 54-year-old man who presented with upper GI bleeding and had esophageal varices but bled from a Dieulafoy lesion 5 cm above the proximal end of the varices. [Indian J Gastroenterol 2004;23:220-221]

Key words: GI bleeding, vascular malformation

Dieulafoy lesion is a large-caliber arteriole that protrudes through a tiny mucosal defect.1 A majority of these occur in the stomach, although a few have been reported in the distal esophagus and elsewhere. Its association with portal hypertension and esophageal varices has not been described.

A 54-year-old man with well-controlled diabetes mellitus and hypertension since 10 years presented with large quantity of painless hematemesis. He denied any substance abuse or regular intake of NSAIDs. There was no significant past medical history. On examination his vital parameters and systemic examination were normal.

Investigations: hemoglobin 9.4 g/dL; coagulation profile was normal. Upper GI endoscopy revealed four columns of grade 2 varices and mild portal hypertensive gastropathy. There was active spurting from a vessel about 5 cm above the proximal end of the varices. Endoscopic sclerotherapy of the varices was performed with polidocanol but as the bleeding persisted 2 mL epinephrine was injected (1:10000 dilution) into the spurting vessel, which arrested the bleeding. Further investigations (biochemistry, imaging) revealed chronic liver disease. Viral markers for hepatitis B and C were negative. The patient was discharged; a second session of sclerotherapy was done a month later.

Five months after the initial episode during a check endoscopy he developed active bleeding again. Endoscopy revealed an actively spurting vessel at about 30 cm from the incisors

References

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