vomiting for one day. She gave no history of painful movements at the hip or flank pain. At presentation she had dehydration, fever (38°C), tachycardia, and low blood pressure (90/60 mmHg). Abdomen was distended, guarded, rigid and tender throughout. Bowel sounds were absent. Per rectal examination revealed fecal staining and anterior boginess. Spine and bilateral hip-joint examination was normal. Fine inspiratory crepitations were heard on chest auscultation.

Investigations: hemoglobin 8.5 g/dL, WBC 18000/mm³. Plain X-ray of the abdomen revealed ground-glass appearance with raised diaphragm but no intra-peritoneal free air.

Treatment was initiated with nasogastric aspiration, IV fluids, and broad-spectrum antibiotics. Dehydration was corrected over the next 4 hours. Pancreatitis was ruled out by abdominal ultrasonography. Needle aspiration of the peritoneum in the left flank revealed thick pus.

Laparotomy revealed 1.5 liters of pus in the peritoneal cavity, and edematous but otherwise normal bowel loops. A search for the cause of pyoperitoneum revealed left -sided iliopsoas abscess, partially drained through a 1 cm x 1 cm rent in the overlying peritoneum and iliopsoas sheath. This opening was enlarged to drain the abscess completely. After saline lavage, a 28F tube drain was placed in the region of the left ilio-psoas muscle.

Postoperatively, she was shifted to the ICU for elective ventilation and vasopressor support. However, she continued to deteriorate, developed adult respiratory distress syndrome, irreversible shock and coagulation failure and died on the fourth postoperative day.

The anatomy of the ilio-psoas muscle allows extension of infection to the posterior mediastinum or upper thigh. Therefore, iliopsoas abscess may present with pus collection in the upper thigh, mediastinitis and meningitis.

One case has been reported in whom peritonitis resulted from rupture of iliopsoas abscess into the peritoneal cavity during per rectal examination. Another case of peritonitis due to rupture of iliopsoas abscess has been reported recently in an infant. The present case is the first reported adult patient who presented with peritonitis following spontaneous rupture of iliopsoas abscess.

The reasons for rare rupture of iliopsoas abscess into the peritoneal cavity include the tough fibrous iliopsoas sheath that prevents intraperitoneal rupture. Secondly, features of acute infection dominate, compelling the patient to seek medical attention well before its possible rupture into the peritoneal cavity. In cases with delayed presentation pus tends to trickle down into the groin and eases tension on the iliopsoas sheath.

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Testicular choriocarcinoma with gastric metastasis presenting as hematemesis

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We report a 28-year-old man who presented with hematemesis due to choriocarcinoma of testis metastatic to the stomach. Gastroscopy showed a polypoidal lesion. Testicular wedge biopsy confirmed mixed germ cell tumor, the choriocarcinomatous portion alone getting metastasized to the stomach. He was initiated on chemotherapy with actinomycin-D, etoposide and methotrexate, but died due to multiple metastases to the lung and brain. [Indian J Gastroenterol 2004;23:223-224]

Key words: Stomach, testes

Gastric choriocarcinoma causing GI bleeding is unusual; most of these are primary choriocarcinomas of the stomach. Testicular germ cell tumor metastasizing to the stomach is extremely rare.

A 28-year-old man presented with non-colicky upper abdominal pain for one month and hematemesis and melena for one week. There was no similar history or any history pertaining to chronic liver disease or peptic ulcer disease in the past. At admission he was hemodynamically stable and physical examination was remarkable for gynecomastia and minimal enlargement and hardness of the left testis.

Upper GI endoscopy revealed a polypoidal mass lesion in the stomach. Ultrasonography showed enlarged para-aortic lymph nodes. CT abdomen confirmed these findings; the section through the testes showed abnormal hypodense lesion on the left side. Chest X-ray and CT chest showed metastases in the lungs. Alpha-fetoprotein (708 ng/mL [normal <30]) and beta human chorionic gonadotropin (hCG; >25,000 mIU/mL [normal <5]) levels were markedly elevated. Histology from the stomach mass was reported as metastatic choriocarcinoma.
Wedge biopsy from the testicular mass confirmed the primary tumor to be mixed germ cell tumor.

A final diagnosis of mixed germ cell tumor of the testis with the choriocarcinomatous element alone metastasizing to the stomach was made. He was initiated on chemotherapy regimen with actinomycin-D, etoposide and methotrexate along with folic acid. During the first week of chemotherapy the patient developed generalized tonic-clonic seizures. CT scan of the brain revealed a metastasis in the parietal lobe. CSF beta hCG was found to be 280 IU/mL. Intrathecal methotrexate was added to the chemotherapy regimen. Serial CSF beta hCG levels after starting this therapy were 144.5 IU/mL, 115.2 IU/mL, <5 IU/mL, 58 IU/mL and 62 IU/mL. The patient died 6 weeks after starting chemotherapy.

Approximately 50% of patients with testicular germ cell tumors present with metastasis. Apart from nodal metastasis, distant spread can occur to the liver, lung and brain. Hematemesis can be due to metastatic implants in the gastric mucosa or retroduodenal nodal metastasis eroding into the duodenum. Beta subunit of hCG will be raised in high titers due to large tumor burden. Testicular wedge biopsy should be done even in cases without palpable testicular lump or sonological evidence before labeling it as primary gastric choriocarcinoma.

The prognosis of cases with gastric metastasis is poor because bowel metastasis is preceded by extensive nodal metastasis and is usually associated with hematogenous spread to other organs. Management is with chemotherapy, with or without radiotherapy. There are rare instances of massive bleed being managed with laparoscopic gastric resection, although long-term prognosis is poor.5

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Multiple tubular and cystic intestinal duplications

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Duodenal and colonic duplication presenting as mass in a neonate is rare. We report a 52-cm-long tubular, total colonic and 5-cm-long cystic duodenal duplication in a two-day-old neonate. Both the duplications could be excised without resection of the normal bowel. [Indian J Gastroenterol 2004;23:224-225]

Key words: Bowel duplication, colon, duodenum

A limentary duplications are uncommon and usually present during the first decade of life. They are mostly single, tubular/cystic, located on the mesenteric side, and less than 10 cm in size. They may present as a mass or as its complications.

A 2-day-old neonate presented with severe abdominal distension and tachycardia. He was a full-term normally delivered child. He had no vomiting and had passed meconium. The child was tachypneic and had icterus. The abdomen was soft but massively distended with visible loops seen. Per rectal examination was normal.

Routine investigations and arterial blood gases were within normal limits. X-ray of the abdomen showed full flanks with few specks of air distributed evenly. Ultrasonography showed a dilated bowel loop and a 5 cm x 4 cm cystic swelling in the subhepatic region separate from the dilated loop. Rest of the viscera was normal.

Laparotomy revealed a long mesenteric-sided total colonic tubular duplication occupying almost the whole abdomen. It was 52 cm in length, ending blindly at both the ends. It could be easily dissected from the mesentery without bowel resection. Another cystic lesion was attached to the second part of the duodenum and had no communication with the intestinal lumen. This could also be easily dissected and removed (Fig). Histology showed both duplications to be lined by normal gastrointestinal mucosa.

Fig: Polypoidal lesion in stomach with superficial excoriation

Wedge biopsy from the testicular mass confirmed the primary tumor to be mixed germ cell tumor.

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