described in children, with cherry tomato pips and grape seeds serving as bezoars.[3,4] Carcinoid of the ileocecal area has been associated with ten fruit pip bezoars in an adult.[5] We describe probably the first report of obstruction caused by cherry fruit pip bezoars without antecedent obstructive cause.

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Liver cell adenoma with co-existing hepatic granulomas in an HIV-positive patient

Hepatic or liver cell adenoma is a benign neoplasm that has the potential of transformation to hepatocellular carcinoma.[1] Among other factors, liver cell adenoma is strongly linked to excess hormonal exposure, especially oral contraceptives.[2]

A 28-year-old non-alcoholic, unmarried man presented with fever since 3 weeks. He also had heaviness in the right hypochondrium since 1 1/2 years and 4 Kg weight loss in the last 1 year. He had suffered from fever twice in the last 2 years, diagnosed as due to typhoid, and had undergone appendicectomy 1 year back.

His liver function tests were normal except for alkaline phosphatase (100 IU/L; normal). The Mantoux test showed 15 mm x 12 mm induration with ulceration after 72 hours. He was started on anti-tubercular treatment elsewhere. He also tested positive for HIV by the Western blot assay. His CD4 count was 267 cells/cmm (reference range: 350-1408) and CD8 count was 670 cells/cmm (230-1195). Ultrasonography revealed a space-occupying lesion in the right liver lobe and splenomegaly. CT scan (Fig) showed a 11.5 cm x 10.1 cm x 7.9 cm arterial-phase enhancing lesion replacing segments 5 and 6 and extending into segments 7 and 8. CT-guided biopsy carried out elsewhere was reported as hepatocellular carcinoma with

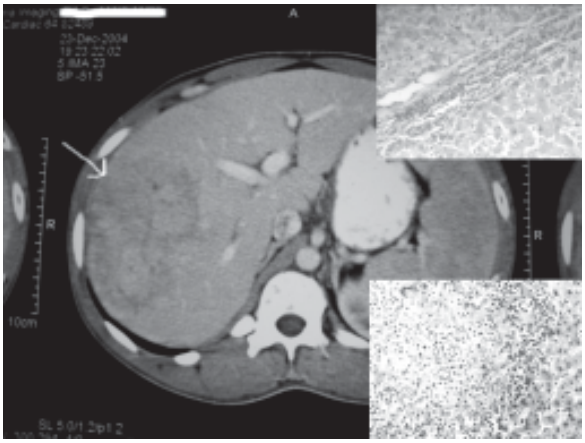

Fig: Contrast–enhanced CT scan showing lesion in right lobe of liver (arrow) with histology of adenoma (upper inset) and granulomas in 'normal' liver (lower inset)

oncocytoid features. Alfa-fetoprotein levels were normal and hepatitis B and C serology was negative. The patient was operated on for excision of the right lobe of liver; the remnant liver was grossly normal. Postoperative recovery was uneventful.

Histology showed a well-circumscribed liver cell adenoma. Some nuclei were large and hyperchromatic. Several multinucleated cells were also noted. Noncaseating epithelioid cell granulomas were seen in the non-adenomatous liver lobules. No acid-fast bacilli or any other pathogens were identified.

HIV virus type I (HIV-1) infection and AIDS are associated to an opportunistic pathology, which includes various types of tumors, as a consequence of elimination of immunosurveillance.[3] Other factors, however, may participate in AIDS-associated oncogenesis. The HIV-1 Tat protein that is secreted by the HIV-1 infected cells and taken up by normal cells is a likely candidate, because of its growth-promoting activity, angiogenic functions and anti-apoptotic effect.[3] Both non-neoplastic and neoplastic lesions were more frequent in tat-transgenic than in control mice, with 40.6% versus 10.1% incidence for hepatic adenomas.[3]

Epithelioid granulomas are known to be associated with primary biliary cirrhosis, sarcoidosis, AIDS, hepatic neoplasms, and certain infections. The presence of granulomatous hepatitis outside the adenoma has been earlier documented only on a background of long-term oral contraceptive usage.[4] In our patient with fever as the presenting complaint and response to anti-tubercular treatment, it is difficult to be definite about the true etiology of the granulomas.

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FORM IV

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