A 51-year-old man was admitted with bleeding esophageal and gastric varices which were successfully managed with endoscopic variceal band ligation and cyanoacrylate glue injections. Investigations showed that he had Child A cirrhosis secondary to chronic hepatitis C infection. He also had a history of excess alcohol intake and intravenous drug use. He had been well until this admission. Ultrasound scan confirmed liver cirrhosis with splenomegaly. He was started on propanolol and discharged. Three months later, his serum alpha-fetoprotein was markedly elevated (16,045 µg/L). A computer tomography (CT) scan showed a hepatic lesion, 8.0 cm × 7.5 cm in size, consistent with hepatocellular carcinoma (HCC) in segments seven and eight. MRI scan confirmed a large hepatic lesion with tumor extension in the inferior vena cava (IVC) (Figure 1). An echocardiogram showed tumor extension in the IVC (Figure 2) and prolapsing into the right atrium. The patient was treated with transcatheter chemoembolization and eventually succumbed 6 months later to metastatic disease.

Invasion of the IVC and the right atrium is rare and has been reported in <2% of patients with HCC. It often signifies advanced disease and curative therapies are often not possible. The risk of tumor embolism is high, and maybe the initial manifestation of HCC. Extension of tumor or thrombus may lead to right ventricular outlet obstruction. Surgical resection has been reported to reduce embolic complications. However, most patients die within a few months of diagnosis secondary to disease progression or acute tumor embolism.

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Detection of retroperitoneal fistula of the colon by CT colonography

A 57-year-old man was admitted to our hospital with left lower quadrant abdominal pain. On admission, the abdomen was soft without any signs of peritonitis. There were no significant findings on abdominal X-ray examination. Abdominal CT showed a retroperitoneal cavity in relation to the descending colon. Conventional colonoscopy did not reveal any lesion because of fluid in the rectum and sigmoid colon. Therefore, we performed CT colonography (CTC). A volume-rendered image of CTC revealed a retroperitoneal fistula arising from the descending colon (Figure). The patient underwent left hemicolectomy with side-to-side anastomosis. Histology of the resected specimen revealed a fistula of the colonic wall, with chronic inflammatory cells and some neutrophilic infiltration. The postoperative course was uncomplicated.

Retroperitoneal fistula of the colon is rare, and usually requires surgical treatment. A correct image is important for diagnosis and preoperative assessment. Recent advances in imaging techniques have enabled more accurate preoperative diagnoses of colonic diseases. CTC, also referred to as virtual colonoscopy, is an innovative technology that entails CT examination of the entire colon and computerized processing of the raw data after colon cleansing and colonic distention. In our case, CTC disclosed a retroperitoneal fistula of the descending colon from characteristic features seen on a volume-rendered image. A potential advantage of CTC, as opposed to colonoscopy or barium study, is that clinically significant extracolonic findings may be identifiable. CTC is a useful modality for diagnosis of retroperitoneal fistula of the colon.

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