Case Snippets


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Volvulus and gangrene in intra-abdominal colon after colonoplasty for esophageal stricture
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Ten years after colonoplasty using the left colon for impassable corrosive stricture of the esophagus, a 27-year-old woman developed volvulus and gangrene of the remaining intra-abdominal colon. It was resected and colostomy was done. In the second stage, after 3 months, the ascending colon and cecum were mobilized and anastomosed to the rectal stump. Eight years later, the patient is asymptomatic. [Indian J Gastroenterol 2000;19:190]

Key words: Large bowel volvulus

The descending colon and part of the transverse colon are commonly used for colonoplasty for management of impassable corrosive stricture of the esophagus. Some immediate and late complications have been reported, but there is no report of late volvulus with gangrene of the remaining intra-abdominal colon.

A 17-year-old girl was admitted with progressive dysphagia three weeks after swallowing sulfuric acid. She was subjected to repeated intregrade dilation with esophageal bougies, but 5 months later the stricture became impassable. A feeding gastrostomy was performed initially. Later, coloplasty was done using the left two-thirds of the transverse colon and descending colon. A transverse-sigmoid colon anastomosis was done, and the mesentry of the sigmoid colon was fixed to the posterior abdominal wall to prevent herniation, obstruction and volvulus. She recovered uneventfully.

About 10 years later, she was admitted with severe pain in the abdomen, obstipation, progressive distension of the abdomen and absent bowel sounds. Plain X-ray of the abdomen showed dilated small bowel loops. An enema did not produce stools but the returning fluid was blood-tined.

At exploration, there was volvulus of the sigmoid colon and remaining part of the transverse colon, leading to gangrene of the sigmoid colon up to the rectosigmoid junction and remaining part of the transverse colon and a part of the ascending colon. The gangrenous colon was resected, rectum was closed and colostomy was performed using the remaining ascending colon. The postoperative recovery was uneventful.

After three months the abdomen was re-explored, ascending colon and cecum were mobilized, and ascending colon was anastomosed to the rectum; cecostomy was done. Discharge through the cecostomy persisted for about three months, then closed spontaneously. Eight years later, the patient is asymptomatic with normal swallowing and normal passage of stools.

Colonoplasty is the preferred mode of restoration of swallowing in patients suffering from end-stage benign esophageal disease. Our patient led a normal life for 10 years after coloplasty using the left colon. She then presented with volvulus and gangrene of the sigmoid colon, transverse colon and part of the ascending colon, despite the mesentry of the sigmoid colon being attached to the posterior abdominal wall. Such a complication has not been reported earlier.

Although the gangrene extended into the ascending colon because of the altered anatomy, the postoperative recovery was good.

References

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Bleeding scrotal varices as presentation of Budd-Chiari syndrome
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Budd-Chiari syndrome presents with ascites, edema and bleeding from esophageal varices. Presentation as bleeding scrotal varices is rare. We report a patient with Budd-Chiari syndrome who presented with recurrent bleeding from scrotal varices for 20 years. [Indian J Gastroenterol 2000;19:190-191]

Key words: Scrotum bleeding

Budd-Chiari syndrome (BCS) comprises various clinical conditions that are associated with obstruction to the flow of blood from the liver to the right heart. Chronic BCS commonly presents with ascites, leg edema, and

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Paterson-Kelly syndrome and celiac disease – a rare combination

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Paterson-Kelly syndrome is characterized by an association of iron deficiency with dysphagia. We describe a patient with this syndrome who was later diagnosed to have celiac disease. [Indian J Gastroenterol 2000:19:191-192]

Key words: Anti-gliadin antibody, cricoid webs, iron-deficiency anemia, Plummer-Vinson syndrome

Paterson-Brown Kelly syndrome (Plummer-Vinson syndrome, sideropenic dysphagia or post-cricoid web dysphagia) comprises iron deficiency (with or without anemia) and dysphagia (with or without esophageal web) and is considered a rare clinical entity. This syndrome has been reported rarely from India despite widespread prevalence of iron deficiency. Iron-deficiency anemia as a presenting feature of celiac disease is rare. Further, celiac disease presenting as Paterson-Kelly syndrome is very rare. We report a patient with celiac disease who presented as Paterson-Kelly syndrome.

A 37-year-old man presented with breathlessness on exertion, easy fatigability and difficulty in swallowing solid food for one year. He denied history of fever, abdominal pain, loose motions or loss of appetite or weight. On examination, he had pallor, koilonychia and mild hepatosplenomegaly.

Investigations: Hemoglobin 8.0 g/dL, mean corpuscular volume 60 FL, mean corpuscular hemoglobin 22.2 pg, mean corpuscular hemoglobin concentration 30 g/dL, total leukocyte count 6 x 10³/L, and platelets 200 x 10³/L. His liver and renal function tests were normal. His serum iron was 32 mg/dL (normal 35-140), total iron-binding capacity 435 mg/dL (300-400), and serum ferritin 5.0 ng/mL (16.4-293.9); blood film was suggestive of microcytic hypochromic anemia. Upper gastrointestinal endoscopy revealed esophageal web in the post-cricoid region, which was dilated to 15 mm. Histology of endoscopic duodenal biopsy showed total villous atrophy (Fig). His antigliadin antibody IgA titer was 95 IU/mL (normal <5) and endomyosal antibody was positive.

A diagnosis of Paterson-Kelly syndrome due to celiac disease was made. He was treated with gluten-free diet and