Rectal botryomycosis mimicking carcinoma

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Botryomycosis is a granulomatous disease that was first recognized in horses. The lesion is infective with fungus-like granules similar to the sulfur granules in actinomycosis. We report 54-year-old woman with a strong suspicion of rectal carcinoma that turned out to be rectal botryomycosis. She responded to erythromycin. [Indian J Gastroenterol 2002;21:202-203]

Key words: Actinomycosis, rectum cancer

Human botryomycosis is usually a localized granulomatous infection of the skin or mucous membrane. We report a woman with rectal botryomycosis that was suspected to be malignancy.

A 54-year-old woman presented with left-sided lower abdominal pain since 1 year. There was no history of vomiting, constipation or bleeding per rectum. She gave no history of loss of weight or of appetite. Her past medical history was not significant. On physical examination, there was a hard mass in the left iliac fossa. Per rectal examination revealed an annular growth 6-7 cm from the anal verge.

Ultrasoundography revealed wall thickening in the rectal region with diverticulum of the urinary bladder. CT scan revealed circumferential thickening of the rectal wall with infiltration of adjacent fat, the left pelvic wall and abdominal wall muscles, suggestive of stage III-B rectal carcinoma. Carcinoembryonic antigen and CA-125 levels were within normal limits. Percutaneous FNAC as well as biopsy showed no tumor cells. Colonoscopy showed extrinsic compression at 10 cm and 44 cm. Colonoscopic biopsy did not show any tumor cells. HIV serology was negative.

At laparotomy, a tumor was found to arise from the pelvis, adherent to the omentum and pelvic wall: the organ of origin could not be ascertained. Multiple biopsies were taken. The mass consisted of multiple abscesses, some with organizing...
Colonic pseudo-obstruction due to herpes zoster

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Visceral motor complications are uncommon manifestations of herpes zoster (varicella zoster). We report a 59-year-old man who developed acute colonic pseudo-obstruction, which followed the appearance of dermatomal herpes zoster. [Indian J Gastroenterol 2002;21:203-204]

Key words: Constipation, viral infection

A colonic pseudo-obstruction can occur as an isolated entity or as part of generalized intestinal pseudo-obstruction. In the acute form, colonic distension is transient and reversible but might be complicated by perforation. Patients may experience repeated episodes. A rare cause is association with lower thoracic, lumbar or sacral herpes zoster.

A 59-year-old man presented with constipation for 15 days. He developed a vesicular rash on the left thoraco-lumbar region 3 days before the onset of constipation. There were no other symptoms. On examination, a resolving herpetic rash was seen on the T10 to L1 region. Abdomen showed mild distension with visible peristalsis, cecal gurgle and normal bowel sounds. Per rectal examination revealed impacted feces. Routine blood tests were normal. Erect X-ray abdomen showed gaseous distension of the large bowel and normal small bowel. Ultrasonography of the abdomen was not contributory.

The patient was managed conservatively with plain water enemas. Colonoscopy and barium meal follow-through done before discharge were normal; the colonic places of the barium study were also normal. At discharge, he was on normal diet and was passing normal stools.

Herpes zoster occurs over sensory dermatomes, but associated motor lesions can occur. Motor neuropathies may be somatic or visceral. Diaphragmatic paralysis is known to complicate cervical zoster, but is usually unrecognized as it is unilateral. Involvement of sacral dermatomes leads to fecal incontinence. Rarely, constipation, hypomotility or even paralytic ileus complicates thoracic lesions.

Visceral motor complications affecting the gut may present as colonic pseudo-obstruction, as in our patient. The possible mechanisms include direct involvement of the extrinsic autonomic nervous system due to centripetal spread from the reinnervated dorsal root ganglion, direct involvement of the intrinsic autonomic nervous system of the colon due to neural spread of the varicella zoster virus, or localized inflammation of the parietal peritoneum contiguous with the line of vesicular eruption causing secondary ileus. The most likely area of involvement is the sacral parasym pathetic division, which supplies stimulatory input to the colon distal to the splenic flexure via sacral columns (S1 to S3). Local inflammation can create massive afferent stimuli to spinal segments S2 to S4, thus blocking efferent parasympathetic supply.

Tribble et al. reported two such cases and reviewed 15 other cases reported in English literature since 1900. They classified such patients into two groups: one, ileus or colonic dilatation without localized spasm and the other, associated with colonic spasm. The former group recovered within 8.5 days; in the latter group 50% of patients had symptoms persisting for more than one year. After this report, there are six reported cases of Ogilvie’s syndrome associated with herpes zoster; a majority of these patients were immunocompromised.

The prognosis is generally good. The need for