There was severe pain on extension of hip and psoas test was positive. There was no palpable abdominal mass or ascites and rest of the systemic examination including spine was unremarkable.

**Investigations:**
- White cell count 19,000/cm$^3$ (80% polymorphs) and ESR 80 mm in first hour.
- Serum amylase and lipase levels were 644 IU/L and 964 IU/L, respectively.
- Liver and renal biochemistry, lipid profile, serum calcium and blood sugar were normal.
- X-ray showed multiple dense calcifications close to L1 vertebra.
- Ultrasonography revealed a large focal collection in the region of right psoas muscle below the level of right kidney, with evidence of pancreatic calcification.
- CT scan showed bulky right psoas muscle with a hypodense lesion with enhancing walls of size 7 cm x 5 cm x 7 cm. The pancreas was atrophic, with multiple large, dense calcifications in the head and dilated pancreatic duct with intraductal calculi.
- MRI of the thoraco-lumbar region showed hyperintense signal in the right psoas muscle suggestive of fluid collection (Fig). The vertebral bodies and disk spaces were normal.

Aspiration showed purulent foul-smelling fluid and biochemical analysis showed amylase value of 10,256 IU/dL, fluid protein 4.5 g/dL, WBC count 12,750/mm$^3$ (75% polymorphs). Gram stain showed gram-negative bacilli and culture revealed growth of *E. coli*. AFB stain and culture were negative. ERCP revealed dilated main pancreatic duct with calculi, but no ductal leak could be demonstrated. Ultrasound-guided percutaneous drainage of the abscess was done. He was managed with parenteral antibiotics and other supportive treatment for two weeks. CT scan three months later showed complete resolution of the abscess.

Pseudocysts occur in about 25% of patients with chronic pancreatitis but are relatively uncommon in tropical pancreatitis, occurring in 5%-6% of cases. Infected pseudocyst due to chronic pancreatitis presenting as psoas abscess is infrequent, and occurring as the initial manifestation or complication of tropical chronic pancreatitis has not been reported. The mechanism is possibly tracking of the fluid along the psoas muscle. Adequate treatment combines antibiotic therapy with prompt surgical drainage. Percutaneous catheter drainage has also been shown to be effective in selected patients with loculated infected fluid collections in the absence of significant pancreatic or peripancreatic necrosis or severe disease.

**References**

Correspondence to: Dr. Thomas, Professor and Head, E-mail: dr_harishk@yahoo.co.in

Received December 26, 2005. Received in final revised form February 14, 2006. Accepted March 29, 2006

**Metachronous gastric diffuse large B-cell lymphoma and adenocarcinoma**

Kumar Prabhash, G Biswas, Reena Nair, Durgatosh Pandey,* Dipen Maru, Aparna Mahajan,** P M Parikh

Departments of Medical Oncology, *Surgical Oncology and **Pathology, Tata Memorial Hospital, Mumbai 400 012

The development of gastric carcinoma in a patient with gastric lymphoma is rare. *Helicobacter pylori* is a common etiologic agent for both these conditions. We report a 38-year-old lady who was initially diagnosed to have gastric lymphoma and developed early gastric carcinoma on follow up. She was operated on for the carcinoma and is in complete remission since.

**Synchronous gastric adenocarcinoma and mucosa-associated lymphoid tissue (MALT) lymphoma in association with Helicobacter pylori infection, although rare, has been well documented. Metachronous gastric adenocarcinoma following gastric MALT has been reported in 7 cases; H. pylori infection is the common etiologic factor.**

A 38-year-old lady was investigated elsewhere for dyspeptic symptoms and intermittent vomiting. Upper gastrointestinal endoscopy (UGIE) revealed extensive infiltrative growth in the body and antrum of the stom-
ach. She underwent surgical exploration, which revealed a locally advanced growth with a large common hepatic artery node. The disease was considered inoperable; antecolic gastrojejunostomy was performed. Biopsy of the mass revealed non-Hodgkins lymphoma (NHL), diffuse large B-cell type (Fig). Immunohistochemistry was positive for LCA and CD 20; there was no evidence of MALT or H. pylori.

At our hospital, after confirming the histology and completing the staging work-up, a final diagnosis of stage II E B NHL of stomach was made. She was treated with six cycles of CHOP followed by involved-field radiotherapy (50 Gy/28 fractions/45 days) to the upper abdomen.

Six-monthly follow-up endoscopy showed no disease visually or on histology. Five years later she developed dyspeptic symptoms again. UGIE revealed thickened gastric mucosal folds with poor distensibility in the antrum and pylorus; the stomach proximal to the gastrojejunostomy was normal. Biopsy of the thickened fold in the antrum revealed adenocarcinoma. CT scan showed circumferential wall thickening of the distal stomach.

At exploration, there was no obvious tumor on palpation. Distal gastrectomy with D2 lymphadenectomy was performed without disturbing the previous gastrojejunostomy. The postoperative period was uneventful. The postoperative period was uneventful. The histology revealed a small area of ulceration in the antrum with features of adenocarcinoma (Fig) focally invading the submucosa; distal and proximal margins were free of tumor, and all lymph nodes sampled were negative. Rest of the resected stomach showed chronic atrophic gastritis and intestinal metaplasia. There was no evidence of lymphoma, a few H. pylori could be seen. She is disease-free over the last 8 months.

Our patient developed gastric adenocarcinoma 5 years following treatment of gastric DLBL. The postoperative histology report of the resected specimen did not reveal any features of MALT. H. pylori can lead to MALT, which can progress to DLBL. This could be a hypothesis for the development of metachronous adenocarcinoma following treatment of gastric DLBL in our patient, H. pylori being an etiologic factor for both MALT and adenocarcinoma of stomach. The presence of chronic atrophic gastritis and intestinal metaplasia may reflect the evolution of gastric adenocarcinoma; however, only an occasional H. pylori was seen in the resected specimen. Use of alkylating agent and radiotherapy could also contribute to the development of gastric adenocarcinoma.

**References**


**Correspondence to:** Dr Prabhash, Assistant Professor, Room No. 6, Medical Oncology Department. E-mail: kp_madhusingh@yahoo.com

Received December 30, 2005. Accepted February 22, 2006

**Primary small gut volvulus in adult presenting with hematemesis**

Sudhir Kumar Jain, Mayank Jayant, Choden Norbu, Pankaj Kumar Garg

Department of Surgery, Maulana Azad Medical College and associated Lok Nayak Hospital, New Delhi 110 002

Small gut volvulus is rare in adults and usually presents with acute intestinal obstruction. We report a 25-year-old man with primary small gut volvulus who presented with hematemesis. The gangrenous gut was resected at laparotomy. He is well 3 months later. [Indian J Gastroenterol 2006;25:262-263]

**Small gut volvulus**

Small gut volvulus is an uncommon cause of acute intestinal obstruction in adults. Most of the reported cases are secondary to pathology; primary small gut volvulus in adults is extremely rare. A 25-year-old man was admitted with one-day history of blood in the vomitus and continuous, severe, non-radiating upper abdominal pain. There was no significant past medical history. On examination, the patient was pale, dehydrated and febrile (38.0°C) and had tachycardia (100/