ment of diplopia and dryness of mouth and tongue. However, six weeks after surgery, he developed features of myasthenia gravis with bilateral fatiguable ptosis and worsening of ophthalmoparesis, which responded to pyridostigmine and a short course of oral prednisolone. He is off medication and is asymptomatic during the last 18 months.

Chromic gastrointestinal pseudo-obstruction (CGIP) is a classical paraneoplastic syndrome. Its occurrence with thymoma is extremely rare even though several paraneoplastic manifestations have been reported in association with thymoma, including myasthenia gravis, Eaton-Lambert syndrome, subacute autonomic neuropathy, and neuromyotonia.

Pande and Leiss reported a patient with thymoma presenting with intestinal pseudo-obstruction, myasthenia gravis and neuronal anti-acetylcholine receptor antibody. Vernino et al have reported seven patients who had myasthenia gravis with subacute autonomic neuronal failure ranging from isolated gastroparesis to severe pan-autonomic failure. Despite extensive cholinergic dysautonomia, pupil sparing in our patient was similar to 5 of the 7 cases in that series.

Antibodies against nicotinic acetylcholine receptors present on skeletal muscles endplate result in myasthenia gravis; antibodies to neuronal nicotinic acetylcholine receptors present on autonomic ganglia have been reported to be associated with paraneoplastic autoimmune autonomic neuropathy. We hypothesize that our patient had both these antibodies. Acetylcholine receptors on the neuromuscular junction and autonomic ganglia share some structural features. Antibodies specific for ganglionic acetylcholine receptors are found in a majority of patients with paraneoplastic subacute pandysautonomia. These antibodies have the potential to impair synaptic transmission at autonomic ganglia. As both sympathetic and parasympathetic ganglia utilize nicotinic cholinergic synapses, antibodies interfering with ganglionic transmission can cause pan-dysautonomia.

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Received February 16, 2006. Accepted May 6, 2006

Gastric pneumatosis and portal venous gas in superior mesenteric artery syndrome

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Superior mesenteric artery (SMA) syndrome is a condition where compression of the duodenum between the root of the SMA and the aorta results in intermittent obstruction of the third part of duodenum. Portal venous gas associated with nonischemic bowel is uncommon. We report an 81-year-old man who developed gastric pneumatosis and hepatoportal venous gas due to SMA syndrome, which healed without any sequelae. [Indian J Gastroenterol 2006;25:265-266]
associated with mesenteric ischemia, with consequent extended bowel necrosis and fatal outcome. 3

An 81-year-old man was admitted with history of sudden onset of chest and abdominal pain. There was no history of pancreatitis, alcohol abuse, vascular disease, previous surgery, rapid weight loss or change in bowel habits. The abdomen was significantly distended with normal bowel sounds; there was diffuse tenderness to palpation, and mild rebound tenderness. Contrast-enhanced abdominal CT revealed massive dilatation and obstruction of the stomach and proximal duodenum, with extensive gastric pneumatosis (Fig) and portal venous gas. There was no free air in the peritoneum or mass lesion.

At laparotomy, the stomach and duodenum proximal to the root of the SMA were markedly dilated. The apparent site of obstruction was the third portion of the duodenum, which appeared to be constricted by the overriding SMA. The contents of the proximal duodenum could easily be passed into the distal duodenum by manual compression. Pneumatosis was not observed at surgery. After surgical treatment, pneumatosis and portal venous gas improved.

Unlike in our case, the SMA syndrome most commonly occurs in young adult women. 1 Clinically, the condition may present with acute, chronic or intermittent symptoms, usually epigastric pain, abdominal fullness after a meal, vomiting, early satiety, and episodes of nausea and vomiting. 4

The optimal treatment is non-operative manage-

ment, including correction of fluid and electrolyte balance, nasogastric drainage for gastric decompression, small meals, soft diets, and change of position. Surgical management is indicated when conservative measures fail. 1 In this case, we decided to perform emergency laparotomy because of the presence of extensive portal venous gas.

Portal venous gas is a rare radiological finding that appears when gas from the intestine or gas produced by certain bacteria enters the portal venous circulation. In most cases, it is associated with extended bowel necrosis due to mesenteric ischemia and a high mortality rate. The extent of bowel infarction and the time delay from the onset to the diagnosis and surgical management influence the outcome, and aggressive treatment could decrease the mortality rate. We found only one earlier report of SMA syndrome with gastric pneumatosis with portal venous gas. 1

References


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Received March 11, 2006. Accepted May 10, 2006