Asymptomatic gallstone: what are its functional characteristics?

Mohandas and Patil\(^1\) state that "preventive cholecystectomy be offered to all young healthy women in northern India when they are diagnosed to have asymptomatic gallstones." Kapoor\(^2\) outlines six situations that may qualify for such a drastic measure. Is the label 'healthy' appropriate for women with gallstones? Does the incidence of cancer differ between symptomatic and asymptomatic patients with gallstones?

Currently a patient with gallstone and suspected biliary pain is labeled as 'symptomatic'. We propose that gall bladder ejection fraction (GBEF) is a more objective and reproducible parameter for determining disease.\(^3\) We routinely measure GBEF with cholecystokinin (CCK) in all patients suspected of biliary pain. Post-CCK pain with low EF is labeled biliary in origin, and pain with normal EF as non-biliary. About 30% of patients (unpublished data) with gallstones have normal EF and many of these are followed by watchful waiting.\(^4\) Most patients with low EF are subjected to laparoscopic cholecystectomy, with relief of pain in more than 90%.\(^5\)

We suggest that the six indications outlined by Kapoor\(^2\) can be replaced by an objective parameter like GBEF.

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References

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Cecal web causing neonatal intestinal obstruction

Cecal web is a rare entity, presenting in adults as a mass lesion or space-occupying lesion.\(^1,2\) We are not aware of any report of cecal web presenting as acute intestinal obstruction in a neonate.

A 2-day-old full-term male baby weighing 2.8 Kg was admitted with history of no passage of meconium since birth, associated with abdominal distension and bilious vomiting. His mother’s antenatal history was uneventful, and the neonate was born of normal vaginal delivery. Physical examination revealed diffuse abdominal distension with visible bowel loops. The neonate was dehydrated. On rectal examination there were mucus pellets only. Serum electrolytes were normal; X-ray abdomen showed multiple air-fluid levels.

After stabilizing the neonate, we explored his abdomen through right supra-umbilical incision. Findings at surgery were a thick, edematous cecum, with patchy gangrenous changes, dilated ileum and micro-colon from ascending colon onwards. An intraluminal mass, 2 cm × 2 cm, was palpable at the junction of the cecum and ascending colon. Cecotomy revealed a thick-walled complete membrane between the cecum and ascending colon with small central opening (Fig). The cecum and adjoining ileum and ascending colon were resected and ileum was anastomosed to ascending colon. Biopsy revealed ectopic gastric mucosa of fundic type containing mainly chief and parietal cells.

The baby passed meconium on the postoperative day 5. He was allowed orally on day 6 but suffered from neonatal septicemia and expired on day 10.

The clinical entity of cecal web has been poorly defined. We believe this anomaly is a rare part of the colonic atresia spectrum.\(^2\) Regarding its pathophysiology two main hypotheses are proposed: failure of recanalization and vascular accident.\(^3\)

Wolffe\(^4\) concluded that gastric mucosa occurring at heterotopic locations is mainly of two varieties. If the tissue is exclusively pyloric glandular epithelium or if only scattered chief and parietal cells are present, the mucosal change is most likely an acquired process. On the other hand, if the tissue...