A 50 years old female patient presented with a history of persistent bile free vomiting of 15 days' duration. On examination, she was emaciated and dehydrated. Per abdominal examination revealed peristaltic waves moving from the left to right side in the upper abdomen. A hard lump, 5 cm x 2 cm, was felt in the epigastrium. X-ray abdomen showed distension of the stomach. No radiopaque shadow or gas was seen in the biliary channels. Fiberoptic gastroscopy revealed complete gastric outlet obstruction. A probable diagnosis of carcinoma stomach was considered. She was operated on and a mobile mass 3 cm x 3 cm was found in the pyloroduodenal canal. A fistulous communication was present between the thickened gall bladder and duodenum. Gastrotomy was done and a 2.5 cm diameter cholesterol stone was delivered out of the duodenum with a finger. Cholecystectomy was performed after disconnecting the fistula. Retrospectively, the patient gave no history of cholecystitis or biliary colic.

Although the impaction of a gallstone in sites other than the ileum or jejunum is unusual, several cases have been reported of gallstone impaction in the sigmoid colon, pylorus and duodenum. When it obstructs the pyloroduodenal canal, the picture resembles gastric outlet obstruction, and is referred to as Bouveret's syndrome. Adhesions form between the inflamed gall bladder and duodenum and the stone erodes the wall to form a cholecystoduodenal fistula. Fiberoptic gastroduodenoscopy can be of help in the preoperative diagnosis of this condition.

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References

Sir,

Hepatoblastoma in an Adult Female

Hepatoblastoma is an unusual primary embryonic neoplasm of the liver, found almost exclusively in the first decade of life. Its occurrence in adults is extremely rare. The absence of adult hepatoblastoma in the reviewed literature and the rarity of its occurrence in females prompted us to report this case.

A 25 year old female was admitted with intermittent attacks of pain in the right upper abdomen for 9 months. She was aware of a lump in this region for 5 months. No history of fever, jaundice, loss of weight or contact with animals could be obtained.

On examination she was pale but anicteric. The liver was palpable 6 cm below the costal margin; there was no splenic enlargement. No other abnormal physical signs were elicited. Routine blood and urine examinations were normal. Ultrasonography showed a large cystic mass with well defined walls in the right lobe of the liver. A diagnosis of hydatid cyst in the liver was made but could not be confirmed as the patient left the hospital against medical advice.

Two months later she was re-admitted with abdominal pain and distension, vomiting and absolute constipation for 3 days. She was markedly dehydrated; abdominal examination revealed diffuse guarding and rigidity all over. Bowel sounds were sluggish and no definite mass could be palpated. Plain X-rays of the abdomen did not reveal any gas under the diaphragm. Microscopic examination of the fluid after peritoneal tap showed a large number of neutrophils and macrophages, and on culture E. coli and Klebsiella were grown.

At laparotomy for suspected ruptured infected cyst, the following findings were noted; enlarged liver with its right lobe containing a huge cystic mass measuring 20 cm x 10 cm; peritoneal cavity full of purulent material; no daughter cysts; no obvious intestinal pathology.

After peritoneal toilet, the cystic mass in the liver was excised in toto. The patient had a stormy postoperative period and died on the 18th post operative day.

Pathology: Gross examination of the excised specimen showed an encapsulated mass of variated consistency. On microscopic examination, the mass consisted of small to round oval cells, giving a monomorphic appearance, arranged in trabeculae, acini and cords with vesicular nuclei and scanty pink cytoplasm, with normal liver cells at the periphery (Figs 1 and 2).

Fig 1: Tumor mass composed of small round to oval cells giving a monomorphic appearance with normal liver cells at the periphery (H & E x 10).
Leiomyoblastoma of the Stomach

Sir,

Martin (1960) first described six cases of clear cell leiomyoma. Subsequently, two large series were published referring to the condition as leiomyoblastoma. The smooth muscle origin of the tumour is now well accepted but the criteria of malignancy remain debatable. A case of leiomyoblastoma of the stomach seen by us recently illustrates these aspects.

RS, a 54-year-old businessman, was hospitalized with complaints of epigastric pain, unrelated to food, low-grade fever and feeling of a lump in the epigastrium of 7 days' duration. There was no associated vomiting, distension of the abdomen or bowel disturbances. His appetite was well preserved and he did not notice any loss of weight. He was a teetotaller and a non-smoker.

Physical examination revealed the liver to be just palpable below the costal margin and a lump in the epigastric region, about 8 cm x 8 cm in size, firm in consistency, tender and moving freely with respiration and slightly from side to side. There was no bruit over the mass. A clinical diagnosis of amoebic liver abscess or acute pancreatitis with pseudocyst was made.

On investigation, serum alkaline phosphatase, proteins and amylase values were within normal range. Amoebic serology was negative by the ELISA technique.

Abdominal ultrasonography revealed an extrahepatic mass 9.7 cm x 7.7 cm size with vascular channels inside it and normal liver, gall bladder and pancreas. Barium meal examination showed a filling defect in the antral region and an extrinsic pressure over the lesser curvature of the stomach. Endoscopic examination revealed a sessile polyp 3 cm x 3 cm in size in the antral region with intact mucosa over it.

Aspiration cytology on the first occasion showed a few cancer cells, typing of which was not possible due to scanty material while the second and third aspirations showed blood only. Laparotomy was performed with a preoperative diagnosis of dumbbell-shaped leiomyoma with a submucosal and exophytic growth.

At laparotomy, a 12 cm x 12 cm mass was found over the lesser curvature of the stomach with submucosal extension. It was stuck to the caudate lobe of the liver. The mass was removed with a bit of caudate lobe. Partial gastrectomy and gastrojejunostomy were done. No secondaries were seen in the abdomen.

The mass had central areas of necrosis with haemorrhage. Histopathological examination (Fig) revealed oval cells with prominent central nuclei and clear cytoplasm, occasionally intermingled with smooth muscle cells. Mitotic figures were 2 per 10 HPF. The overlying gastric mucosa was normal. The mass appeared to originate mainly from the smooth muscles of the gut or uterus.

Leiomyoblastoma is a relatively benign tumour that has rarely been described in Indian literature. Often it is found incidentally or may present with an apparent or occult gastrointestinal bleeding.

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References