LETTERS

Obstructive Jaundice due to Chronic Duodenal Ulcer Disease

Sir,

A 50 year old non-alcoholic male presented with increasing jaundice and clay-colored stools for three months. On examination, there was mild hepatomegaly. Liver function tests confirmed obstructive jaundice. During endoscopic pancreatography, a large ulcer was seen in the duodenal cap. A cholangiogram film showed a 1 cm long narrowing of the retro-duodenal portion of the common bile duct (CBD). An upper gastrointestinal series confirmed the duodenal ulcer. A transhepatic cholangiogram (Fig) showed a smoothly tapering narrowing of the CBD.

At surgery, dense adhesions were seen around the CBD; the healed duodenal ulcer was seen to be adherent to the underlying CBD. A cholecdocho-duodenostomy was performed. The patient recovered uneventfully. Biopsies from the site of obstruction revealed no evidence of malignancy.

In spite of the close proximity of the CBD to the first portion of the duodenum, periductal fibrosis severe enough to produce obstructive jaundice is rare. About 4% of patients with obstructive jaundice have duodenal ulcers; but, only 4% of these patients have the duodenal ulcer as the cause of jaundice.\(^1\) To produce obstruction of the CBD, the ulcer has to be about 5 cm distal to the pylorus and be situated on the posterior or superior wall of the duodenal cap.\(^1\)

In a setting of duodenal ulcer disease, pain radiating to the back followed by development of obstructive jaundice should raise the possibility of a cause-effect relationship between the ulcer and jaundice. Radiological demonstration of the site of obstruction at the retroduodenal portion with the presence of a duodenal ulcer is highly suggestive of such a diagnosis.

Surgery is invariably indicated for these patients.\(^1\) A cholecdocho-jejunostomy or a cholecdocho-duodenostomy are the preferred forms of bypass surgery.\(^2\)

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References


Longitudinal Shortening of Esophagus in Advanced Corrosive Injury

Sir,

We evaluated 10 consecutive cases with corrosive structures of the esophagus. All of them had long-segment (average 12 cm), high-grade strictures extending up to the cardio-esophageal junction. Each of the cases had a sliding hiatal hernia with the cardio-esophageal junction situated at an average of 4 cm above the diaphragm (Fig). There was no correlation between the length of the structure and the extent of hiatal hernia as judged by the degree of cephalad displacement of the cardio-esophageal junction in relation to the diaphragm.

This, to us, suggests longitudinal narrowing in association with concentric strictures. We have found only one reference to the association of hiatal hernia and long-segment corrosive structure of the esophagus.\(^1\) We wish to highlight this association in view of the high frequency in our material.

This finding gains added significance when these strictures are treated by balloon dilatation. There is a high chance of gastro-esophageal reflux following balloon dilatation because of the involvement of the lower...
esophageal sphincter. This could lead to reflux esophagitis and precipitate formation of recurrent stricture.  

Since these strictures are generally long, these patients are treated with esophageo-coloplasty in our institution.

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References

Bile Ascites following Percutaneous Trucut Needle Liver Biopsy

Sir,

We would like to report an unusual complication, namely, asymptomatic bile ascites, following a percutaneous trucut needle liver biopsy in a 5 year old boy with underlying chronic liver disease. No surgical intervention was needed.

A 5 year old boy was admitted with jaundice of 8 weeks' duration. Examination revealed features of chronic liver disease and a moderate degree of firm hepatosplenomegaly. Liver function tests revealed a total bilirubin of 204 μmol/L, and conjugated fraction of 136 μmol/L. SGOT and SGPT 86 IU (1.43 μmol/L) and 80 IU (1.33 μmol/L), serum albumin 3.2 g/dl (32 g/L) and globulin 3.8 g/dl (38 g/L). Alkaline phosphatase was 15 KAU (1.77 μmol/L). Prothrombin time index was 60%. Hepatitis B antigen was negative by ELISA method, as was the workup for Wilson's disease, autoimmune hepatitis and φφ — antitrypsin deficiency. Non bleeding grade I esophageal varices were demonstrated on upper gastrointestinal endoscopy. An ultrasound of the abdomen excluded extrahepatic biliary tract obstruction and revealed altered hepatic echotexture and no dilatation of intrahepatic radicles.

The patient underwent a percutaneous liver biopsy with a trucut needle. The procedure was uneventful. Ascites was noticed on the fourth day after the biopsy. The patient was otherwise asymptomatic. Abdominal paracentesis revealed bilious fluid which was bacteriologically sterile and had a protein content of 2.2 g/dl (22 g/L). Ascitic fluid bilirubin and repeat serum bilirubin levels done at the same time were 119 μmol/L and 85 μmol/L respectively. A repeat ultrasound showed ascites and did not reveal any additional abnormality. As the ascites resolved within 4 weeks without surgical intervention, and the patient was completely asymptomatic, cholangiographic studies were not done. The liver biopsy suggested features of cirrhosis.

Our case illustrates an unusual complication of percutaneous needle biopsy of the liver. The incidence of bile ascites complicating liver biopsy has been reported to be 0.04% to 0.09%. The indolent course in our patient could be ascribed to a slow leak of sterile bile, probably from rupture of one of the small intrahepatic ducts.

It would be unlikely that a puncture of the gallbladder resulted in this complication. This is supported by the complete recovery without surgical intervention: cholecystectomy has been recommended as the treatment for gallbladder injury. In fact, surgical exploration is necessary to repair the leak in a majority of cases with bile ascites. Besides, there was no gallbladder tissue demonstrable histopathologically in the biopsy specimen and the patient had no symptoms. An isotope hepatobiliary scan would have been helpful in demonstrating the site of leak, but unfortunately was not available to us then.

Scheidt reported a similar case following fine needle biopsy of the liver. Piccinello et al reported a higher complication rate of bile peritonitis with trucut needle as compared to Menghini needle. Bile leak leading to