infection, with hepatitis as the predominant feature.

A 76-year-old man was admitted to hospital for elective surgery for grade 3 piles. He had had sore throat, abdominal pain and fever of up to 39°C, for 5 days prior to admission. He had a past history of angina and osteoarthritis, and was exposed to sexually transmitted disease 10 years earlier. He had had no genital lesions after the exposure. His alcohol consumption was 20 g/week.

He looked pale and had fever. A papulo-vascular rash was present on the face and trunk. Other findings included pharyngitis, tonsillitis and tender hepatomegaly. Per rectal examination showed grade 3 prolapsed piles.

Investigations: hemoglobin 11.2 g/dL, total leucocyte count 8300/µmm, with normal differential count, platelet count 200,000/ µmm. Liver function tests revealed total bilirubin 3 mg/dL (direct 3.9 mg/dL); AST 2398 IU/L, ALT 1500 IU/L; prothrombin time 27 seconds (control 13). Blood urea was 40 mg/dL, creatinine 1.8 mg/ dL. Urine for leptospirosis was reported negative. Ultrasonography of abdomen showed presence of gallstones and minimal free fluid. Hepatitis B surface antigen, IgM anti-core antibody, HIV and VDRL were negative.

A Tracck smear from skin lesions showed mononuclear cells with large intranuclear inclusion bodies surrounded by a halo, suggestive of herpes inclusion bodies. IgM antibodies to herpes simplex virus showed a titer of 1:12 (cut-off level: 0.32), suggesting acute herpes simplex infection. IgM antibodies against cytomegalovirus were negative. The patient developed severe abdominal pain, anuria, marked metabolic acidosis, hypotension and hypoglycemia in the next 48 hours and died of renal failure and disseminated intravascular coagulation. Since death intervened before the results of immunoscopy and macroscopy of skin scraping were available, he could not receive acyclovir therapy.

Herpes simplex hepatitis is rare and is generally a part of disseminated infection. Predisposing factors for dissemination include organ transplantation, immunosuppression and pregnancy.1 Clinically and on imaging, the condition may mimic liver abscess.2 Mucocutaneous lesions occur in many but not all affected individuals.2 Serum transaminases are elevated 100- to 1000-fold but the patient is often anicteric.

Laboratory abnormalities which are associated with increased mortality include raised serum creatinine, thrombocytopenia, prolonged partial thromboplastin time, and a high percentage of band forms on the blood smear.3 Mortality is as high as 80% due to delay in diagnosis. Most often the condition is diagnosed only at autopsy.4 Acyclovir early in the course of the disease has been known to alter the prognosis of generalized infection but beneficial effect on hepatitis is not proven.4

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Volvulus of the descending colon with anomalous meosocolon

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Volvulus of the cecum, transverse colon and sigmoid colon is common. A patient with isolated volvulus of the descending colon, leading to gangrene of that segment, is reported. [Indian J Gastroenterol 1997; 16: 34-35]

Key words: Intestinal gangrene

A 70-year-old man presented to the emergency department of our hospital with history of abdominal pain, vomiting and constipation for 3 days. Examination of the abdomen showed distention and signs of peritonism and acute intestinal obstruction. Rectal examination revealed blood on the finger-tip. Vital parameters were normal. Abdominal X-ray revealed a distended loop of large gut with 'bird's beak' sign.

At laparotomy, a loop of descending colon, which had undergone a 180° anti-clockwise torsion due to an anomalous mesocolon, resulting in gangrene of the loop, was seen. The sigmoid colon, which had a separate mesentery was healthy. Resection of the gangrenous portion and end-to-end anastomosis in two layers were done after placing in a figure of eight loop for decompression of the proximal colon. The loop was removed after 48 hours and the patient recovered uneventfully.

Volvulus is defined as torsion of bowel on its mesentery to a degree that is sufficient to result in symptoms. The symptoms are caused by narrowing of bowel, strangulation of blood vessels, or both.5 The prequisites for formation of a volvulus are: (i) the bowel must be freely movable due to elongation of mesentery; (ii) the two points of fixation of the redundant loop of bowel must be in close approximation of each other.5 The parts of the colon that are usually affected are the cecum and the sigmoid colon since these have a sufficiently long mesentery. The descending colon is rarely affected since it is plastered to the posterior abdominal wall even when it has a mesentery, and it is short. In our patient, the descending colon fulfilled both these prequisites, thus allowing volvulus to occur.
Pedunculated giant hemangioma of liver

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A 60-year-old lady with a giant pedunculated hemangioma of the liver who presented with hematemesis due to a bleeding gastric ulcer is described. [Indian J Gastroenterol 1997; 16: 35-36]

Key words: Cavernous hemangioma, liver tumor

Hemangioma is the most frequent benign tumor of the liver but giant hepatic hemangiomas, more than 4 cm in diameter, are rare. Most reports are single or collective reviews. A 60-year-old housewife presented with hematemesis of three days’ duration. There was no history suggestive of peptic ulcer or analgesic intake. She had two episodes of jaundice in the past, treated by local doctors. On examination she was conscious and pale, pulse and blood pressure were not recordable. Abdominal examination revealed a firm, nontender, mobile mass in the upper abdomen. Rectal examination showed presence of melena. The patient had been aware of the mass in the abdomen for the last 20 years, this was associated with intermittent dull aching pain and discomfort in the abdomen. The patient was reasulticated.

Upper GI endoscopy revealed a small ulcer in the posterior wall of the proximal part of the stomach, with evidence of bleeding. Abdominal ultrasonography showed a mass of mixed echogenicity, measuring 7 cm x 8 cm, between the liver and right kidney. Contrast-enhanced CT scan showed the mass enhanced heterogeneously, suggesting that it was a vascular mass. Since the patient had one more episode of hematemesis in the hospital, she underwent surgery.

At laparotomy, there was a 15 cm x 10 cm pedunculated hemangioma arising from the left lobe of the liver (Fig). The rest of the liver was normal. The stomach showed a small ulcer in the proximal part of the body; there was no evidence of active bleeding or malignancy. Truncal vagotomy and gastrojejunostomy were done. As the hemangioma was pedunculated, it was excised after clamping and oversewing the pedicle with interrupted sutures without any significant blood loss. The patient recovered uneventfully. Histology of the mass was consistent with cavernous hemangioma.

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Fig: Pedunculated hemangioma arising from left lobe of liver – intra operative picture

The patient was asymptomatic 4 months later. Repeat endoscopy showed no ulcer in the stomach.

Cavernous hemangiomas are the most common benign tumors encountered in the liver coincidentally at laparotomy. Most are small and asymptomatic, but giant hemangiomas may present as abdominal masses with accompanying feeling of pain and fullness and sometimes a bleeding tendency, such as Kasabach-Merritt syndrome. Spontaneous hemorrhage or rupture is rare, but is associated with high mortality.

Completely pedunculated giant hepatic hemangiomas are rare. Adams et al collected 22 giant hemangiomas over a period of 30 years, but did not report any pedunculated hemangioma. Starzl et al reported 5 patients with superficial giant hemangiomas but none was completely pedunculated. Our patient presented with a mobile abdominal mass.

Symptomatic giant hemangioma of the liver should be treated by surgery, but this can be difficult and hazardous. As most of these tumors are located within the liver parenchyma, a formal hepatic lobectomy or segmental resection is usually required. Rarely, hemangiomas can develop a pedicle with a base of variable width, as in our case, which allows for simple excision and oversewing of the pedicle. The role of hepatic artery ligation, embolization and radiotherapy is still uncertain, but these modalities can be used in cases where the tumor is unresectable and symptomatic. Though corticosteroids have been used with some success in infants, their effectiveness in adults is not known.

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