Pancreatic hydatid cyst
RAJINDER SINGH, ATUL KHULLAR
Department of General Surgery, Postgraduate Institute of Medical Education and Research, Chandigarh 160 012

A patient with primary hydatid cyst involving the tail of the pancreas and treated successfully by distal pancreatectomy is reported. Additionally, we performed splenectomy because the spleen was lifted on to the cyst, and cholecystectomy for cholelithiasis. [Indian J Gastroenterol 1999;18:35]

Key words: Cystic lesion of pancreas

The organs most commonly involved by hydatid disease are the liver and lungs. It is also known to occur in the brain, heart, bones, adrenals, kidneys, ovaries, pelvis and retroperitoneum. Hydatid cyst of the pancreas is rare.

A 60-year-old housewife presented with recurrent episodes of upper abdominal pain of two years' duration. Examination revealed deep tenderness in the left hypochondrium; no lump was palpable.

Investigations: hemogram, and renal and liver biochemistry were normal. Serum amylase was 228 SU (normal 72-160). X-ray chest and abdomen did not reveal any abnormality. Ultrasonography showed contracted gall bladder containing multiple echogenic shadows with posterior shadowing. The pancreas showed a multiloculated cystic shadow in the tail, measuring 11.2 cm x 11.5 cm x 9.9 cm, suggestive of hydatid cyst. The liver and other viscera were normal. CT scan confirmed the findings with cyst density ranging from -5 to 35 HU (Fig). Casoni's test was positive but indirect hemagglutination for hydatid disease was not suggestive.

At laparotomy the whole mass was mobilized, along with the spleen. The cyst was arising from the tail of the pancreas. Distal pancreatectomy and splenectomy was performed. Because of cholelithiasis the gall bladder was also removed. The patient recovered uneventfully and was discharged on the 8th postoperative day. Cut section of the specimen showed multiple daughter cysts and histology confirmed them to be hydatid cysts. The rim of the pancreas showed normal pancreatic tissue on histology.

Pancreatic involvement in hydatid disease is rare; Belding gave an incidence of less than 0.1%. The disease in the pancreas could be primary or secondary. Primary cyst occurs when the larvae of the echinococcus escape the liver and the lung filter and settle into the pancreatic parenchyma, through the systemic circulation. In this form normal pancreatic tissue is seen creeping over the cyst, as in our case. Secondary cyst occurs when the a subcapsular hydatid in the liver near the retroperitoneum extends out or ruptures and gets deposited onto the pancreatic surface. This incorporates pancreatic capsule as pericyst.

Mathai et al reported a pancreatic hydatid presenting as chronic pancreatitis. This was probably a primary pancreatic hydatid that ruptured into the duct. Pancreatic hydatid is also known to present as pancreatic abscess.

The treatment depends on the location of the cyst, and its relation to the biliary system and pancreatic duct. Enucleation of the cyst is the simplest procedure for surface cysts. Instillation of sclerosing agents is not recommended as there is a risk of initiating pancreatitis. Distal pancreatectomy is a good procedure for cysts in the tail of the pancreas; the spleen may also have to be removed. Pancreatico-duodenectomy is recommended for cysts in the pancreatic head causing jaundice or duodenal fistula.

References

Correspondence to: Dr Singh, Addl Professor
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Superior mesenteric artery syndrome following ileo-anal pouch procedure
K V RAVINDRA, P RAJASEKHAR, A P ROZARIO, A V PAIS, P G THOMAS
Department of Surgery, St Johns Medical College, Bangalore 560 034

A rare complication following ileo-anal pouch procedure is the occurrence of superior mesenteric artery syndrome. We report a patient with ulcerative

Fig: CT scan showing multiloculated hydatid cyst in tail region of pancreas. Pancreatic mass is seen creeping over the cyst.
colitis who developed vascular compression of the duodenum following J-pouch construction. [Indian J Gastroenterol 1999;18:35-36]

**Key words:** Inflammatory bowel disease

Vascular compression of the duodenum (superior mesenteric artery syndrome) is a well characterized condition following severe cachexia and prolonged recumbency. We report the rare occurrence of this syndrome following total proctocolectomy and ileo-anal pouch construction for ulcerative colitis.

A 23-year-old man suffering from ulcerative colitis underwent total proctocolectomy with ileo-anal pouch (J-pouch with 15 cm limbs) construction. There was difficulty in taking the pouch down to the dentate line. We therefore made release incisions on the small bowel mesentery, ligated tethering vascular arcades and completed the pouch-anal anastomosis. Postoperatively the patient progressed satisfactorily except for a persistently high nasogastric aspirate (average 1.5 l/day). On the seventh postoperative day, plain X-ray of the abdomen showed a hugely dilated stomach (Fig). Gastrografin study revealed obstruction at the level of the third part of the duodenum. At a second laparotomy the same day, compression of the third part of duodenum by the stretched mesenteric root with the superior mesenteric artery was found. The duodenum was released from the retroperitoneal attachments, transected at the third part and anastomosed anterior to the superior mesenteric artery pedicle. The obstruction was relieved and the patient was discharged ten days later. He remains well one and a half year later.

Among the conditions associated with vascular compression of the duodenum are severe wasting, spinal trauma needing body cast, and dietary disorders (anorexia nervosa, malabsorption). The condition has also been reported with the ileo-anal pouch anastomosis.1,2,3

Total proctocolectomy with ileo-anal pouch construction requires complete mobilization of the small bowel with freeing of the mesentery from the posterior abdominal wall. Various techniques described for lengthening the small bowel in order to enable the pouch to reach the dentate line include ligating vascular arcades, ligation of the ileocolic artery, and making release incisions on the mesentery.4 Despite these measures, there is sometimes difficulty in taking the pouch down to the dentate line. The superior mesenteric artery may then be put on stretch and this can rarely cause compression of the third part of duodenum.

Superior mesenteric artery syndrome has been managed by either freeing the duodenum from the retroperitoneal attachments and mobilizing it from the second part of the duodenojejunal flexure (Strong's technique)5 or a bypass gastrojejunostomy or duodenojejunostomy.

Adhesive obstruction is common following the ileo-anal pouch anastomosis.6 One should also be aware of the possibility of vascular compression while managing these cases. It might be worthwhile doing a prophylactic relocation of the duodenum anterior to the superior mesenteric artery in cases where the root of the mesentery is found to be indenting the third part of the duodenum at the end of the pouch construction.

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**Correspondence to:** Prof Thomas. Fax: (80) 553 1786

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**Synchronous adenocarcinoma and MALT lymphoma of stomach**

K VAIPEI, R CHOPRA, R SINGH,* D SINGH**

Departments of Histopathology, *General Surgery and **Radiotherapy, Postgraduate Institute of Medical Education and Research, Chandigarh

We describe a patient in whom adenocarcinoma and lymphoma occurred simultaneously in the stomach. She presented with pain and lump in the epigastrium with history of hematemesis. Endoscopy revealed a growth involving the lesser curvature, and

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**Fig:** X-ray of abdomen showing hugely dilated stomach