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 duodenoejunostomy.

Adhesive obstruction is common following the ileoanal 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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Synchronous adenocarcinoma and MALT lymphoma of stomach

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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...
Synchronous occurrence of adenocarcinoma and primary lymphoma of the stomach has been documented. We report a patient in whom adenocarcinoma of the stomach was in juxtaposition to lymphoma of the mucosa-associated lymphoid tissue (MALT) type.

A 40-year-old woman presented with pain in the abdomen and an episode of hematemesis in the recent past. On examination, she was malnourished and anemic. Per abdomen examination revealed a palpable mobile lump in the epigastrium, with no organomegaly. The other systems were unremarkable. Hemogram revealed mild microcytic hypochromic anemia. Chest X-ray was normal. Endoscopy revealed a huge ulceroproliferative growth in the body and biopsy was reported as poorly differentiated adenocarcinoma. Surgical exploration revealed a hard, nodular and polypoidal growth along the lesser curvature reaching up to the serosal aspect, with multiple enlarged nodes along the lesser curvature. The gastroesophageal junction was uninvolved. The patient was subjected to subtotal gastrectomy.

Pathology: The gastrectomy specimen revealed a growth (6 cm x 5 cm x 2 cm) extending along the lesser curvature from the cardiac end almost up to the resection margin. The stomach wall was thickened. One excelling ulcer 2 cm in diameter was present on the mucosal aspect of the tumor. The cut surface was homogeneous and grayish white.

Histological examination showed two populations of neoplastic cells. One consisted of adenocarcinoma cells of diffuse type, the other of lymphoma of MALT type. These were closely admixed, although forming sheets of one type at places. The adenocarcinoma at places showed signet ring morphology and ill-formed glands. The tumor cells showed intracytoplasmic and extracellular mucin. The lymphoid population consisted of plasma-oid lymphoid cells, plasma cells, mature lymphocytes, and centrocyte-like cells (CCL) admixed with a few immature lymphoid cells. At places reactive lymphoid follicle formation was present.

Both cell types were seen infiltrating up to the serosa. In some areas the cells were so closely admixed that they could be differentiated only by immunostaining (peroxidase antiperoxidase method), where the adenocarcinoma component stained strongly for epithelial marker (CEA; monoclonal, Dako) and the lymphoma component for lymphoid cell marker (LCA; monoclonal, Dako).

The adjacent mucosa showed intestinal metaplasia and prominent lymphoid follicles. No Helicobacter pylori was present. Two lymph nodes from the lesser curvature showed both adenocarcinoma and immature lymphoid cells (lymphoma stage IIIE, modified Ann Arbor staging). The patient was administered chemotherapy (CHOP regimen) and at 12 months is disease-free.

Synchronous adenocarcinoma with primary gastric lymphoma has been reported. Initial reports described intestinal type of adenocarcinoma to be more frequent; a recent review did not report more frequent occurrence of the intestinal type. In other studies detailed immunophenotypic categorization of the lymphoma was not carried out and MALT lymphoma was not a well-recognized entity. Some biopsies previously reported as pseudolymphoma have now been labeled to be low-grade B-cell lymphoma of MALT type.

Differentiation and identification of the two cell types can be difficult on hematoxylin and eosin stained sections. In such cases histochemistry for mucin and immunostaining would be helpful. In our case the adenocarcinoma cells showed intracytoplasmic positivity with alcian blue staining (pH 2.5) with focal signet ring cell differentiation. In addition, immunostaining for CEA and LCA helped to distinguish between the two populations.

No lymphoepithelial lesion was present in our case. It is known that in cases where gastric MALT lymphoma and carcinoma are in intimate contact, or where metaplastic or dysplastic glands are present, no lymphoepithelial lesion is seen. In our case, areas of widespread intestinal metaplasia were present.

H. pylori has been found in a mean of about 50% of cases with gastric carcinoma and about 90% of cases with MALT-type gastric lymphoma. In synchronous cases reported by Wooterspoon and Issacs, 78% had H. pylori. In our case no H. pylori was noted, probably because of extensive intestinal metaplasia. Cotter et al. reported difficulty in finding H. pylori in surgical specimens in patients with synchronous carcinoma and lymphoma.

The diagnosis of synchronous adenocarcinoma and lymphoma in the stomach may be missed. This is particularly important in cases of diffuse adenocarcinoma, when the appearance of large atypical (epithelial) cells within the infiltrate of CCL cells may be dismissed as being scattered transformed cells, which characteristically form a part of the infiltrate of low-grade MALT lymphoma.

There has been no systematic study of the prognosis.
of these tumors. However, lymph node status seems to be important. In one study [6] 6 patients had metastatic deposits in lymph nodes (carcinoma-1, lymphoma-2, lymphoma and carcinoma-3); of these, 4 patients died within 3 to 10 months. Two patients who did not have lymph node involvement were well at 33 and 122 months.

Clear guidelines for management are not yet designed as the condition is relatively rare and newly accepted.

References

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**Double pylorus**

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We report a 55-year-old man presenting with postprandial epigastric pain and vomiting. Barium meal study suggested two openings from the stomach to the duodenum. Endoscopy revealed double pylorus with chronic duodenal ulcer, suggesting the second opening as an acquired one. [Indian J Gastroenterol 1999;18:83]

Key words: Peptic ulcer

Double pylorus — congenital or acquired — is an unusual deformity.

A 55-year-old man presented with postprandial epigastric pain and occasional vomiting. Sudden clinical findings were anemia and tender epigastrum. Barium meal X-ray of stomach and duodenum raised the possibility of two passages from the stomach to the duodenum (Fig). During video endoscopy, two orifices, divided by a septum, were seen from the stomach into the duodenum. The endoscope could be negotiated into the duodenal bulb through the upper orifice; there was an active ulcer on the anterior wall. The lower passage could not be negotiated.

Double pylorus is usually acquired, due to penetrating ulcer producing a pyloroduodenal fistula; rarely, it may be congenital. It occurs above or below the pylorus. The fistula tract is composed of granulation tissue, which may reepithelialize later.

In our case, considering that the patient was old and had chronic duodenal ulcer, we believe the double pylorus was acquired.

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Spontaneous isolated lesser sac hematoma in a patient with hemophilia

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In patients with hemophilia, hematomas in the mesentery and bowel wall have been described uncom-