of these tumors. However, lymph node status seems to be important. In one study of 6 patients with 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.

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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;18:38]

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. Salient 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-
Hemophilia is a heterogeneous disorder resulting from mutation in the factor VIII gene, leading to reduction in factor VIII activity. Soft tissue hematomas and hemarthroses are characteristic of this disorder.

A 10-year-old boy, a known case of severe hemophilia (factor VIII; less than 1%) on factor VIII replacement treatment, presented with non-colicky left hypochondriac pain since two days. There was no history of antecedent trauma. Clinical examination and laboratory investigations were unremarkable. CT scan of the abdomen revealed a high-density lesser sac fluid collection (60 Hoursfield units) suggestive of blood. The collection showed peripheral rim enhancement (Fig). He was treated with parenteral administration of factor VIII concentrates, and was discharged in a stable condition after one week.

Hemophilic patients may bleed into various structures, sometimes due to trivial or imperceptible trauma. Hemarthrosis is the most frequent, painful manifestation of hemophilia. Other common sites of hemorrhage include the subcutaneous tissues, fascia and muscles. The lesser sac is an exceptional site for hemorrhage; Chambers et al reported a case of spontaneous isolated hematoma in the lesser sac of a patient with hemophilia.

The lesser peritoneal sac is usually not well distinguished except when an abnormality such as fluid collection, mass (pseudocyst, neoplasm) or even internal herniation of the gall bladder or intestine, delineates its borders and displaces neighboring organs. Some causes of blood in the lesser sac include hemorrhagic pancreatitis, hepatic or splenic laceration, bleeding from a neoplasm and hemorrhage from a splenic artery aneurysm.

Adelman et al reported a patient with hemophilia who developed intra-mesenteric hematoma following a large meal. They suggested that overdistension of the stomach probably caused tearing of the small blood vessels of the lesser omentum leading to tracking of blood into the greater omentum. As there was no obvious trauma in our patient and no other site of bleeding, we presume that a similar phenomenon might have led to spontaneous lesser sac hemorrhage in our patient.

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Segment IV liver cyst with biliary communication following laparoscopic deroofing

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Simple cysts of the liver rarely have a biliary communication. We record the development of a biliary communication following laparoscopic deroofing of a segment IV simple cyst of liver and document its successful sclerosis with tetracycline. [Indian J Gastroenterol1999;18:39-40]

Key words: Non parasitic liver cyst, biliary fistula

The various treatment modalities for symptomatic non parasitic cysts of liver include open surgical fenestration, total excision and intracystic sclerosant injection. Laparoscopic deroofing is also now described as successful treatment for simple liver cysts.

Factors predicting recurrence following treatment include deep-seated cysts, incomplete deroofing, and right posterior segment location in the liver. Segment IV cysts, due to their central location and proximity to vascular and biliary structures, are also known to present difficulties in

Fig: Contrast-enhanced CT scan of abdomen showing peripheral rim enhancement of fluid collection