LETTERS

Free Peritoneal Gas in Ulcerative Colitis

Sir,

I report a young patient with ulcerative colitis who had persistent free peritoneal gas without any evidence of perforation. The possible cause for free air was pneumatosis cystoides intestinalis (PCI).

A 32-year-old man with histologically-proven ulcerative colitis was admitted with diarrhea and low-grade fever for two months. He was passing 5–6 stools/day, containing blood and mucus. There was no history of pain in abdomen, vomiting or arthritis. He had pulmonary tuberculosis 10 years ago, which was treated adequately. Examination revealed a thin built man with moderate pallor. The abdomen was soft with no evidence of hepatomegaly or free fluid. Bowel sounds were normal.

Routine X-ray chest revealed free air under both domes of diaphragm. Abdomen X-ray showed air in the wall of the colon in addition to free air under the diaphragm. Barium enema showed pancolitis with collar-sud ulcers but no leakage of contrast. As there was no clinical or radiological evidence of perforation, the free peritoneal gas was considered as benign pneumatocoele and he was managed conservatively with intravenous fluids, steroids and oral S-aminosalicylate acid. The diarrhea was controlled and he went home on oral medications and normal feeds. Repeat X-ray abdomen after 4 weeks again showed large amount of free air under the diaphragm, though the patient was almost symptom-free.

The overall clinical picture was suggestive of PCI though classical radiological signs showing cystic or linear collection of gas protruding into the contrast column were missing. As the colitis was in remission and the PCI produced no symptoms, no specific treatment for it was instituted. Three months later, the patient was asymptomatic and there was complete disappearance of peritoneal gas.

PCI is most commonly identified on plain radiography though it can be identified on computed tomography, endoscopy or at surgery. The condition is often overlooked, and when identified its clinical relevance may be misinterpreted. It may produce no symptoms or may be associated with diarrhea with abdominal pain and distention (60%), mucoid diarrhea (32%), and diarrhea with marked flatulence (39%), rectal bleeding and tenesmus. Rarely intestinal obstruction may develop either from large cysts or from adhesions, volvulus or intussusception. PCI should also be considered in otherwise healthy patients with vague abdominal complaints and who are found to have free air beneath the diaphragm.

To my knowledge, this is the first reported case of free peritoneal air possibly due to PCI in ulcerative colitis; resolution of pneumatocele paralleled the disease activity of colitis.

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Indian J Gastroenterology 1996; 15 (3): 112-114

Reference

Esophageal Dilatation Using Balloon alongside Endoscope

Sir,

The method described by Nanivadekar et al. is ingenious and is a safe method of dilatation under direct vision in patients with esophageal strictures and achalasia. This is especially useful in centers which do not possess 'through-the-scope' (TTS) or 'over-the-scope' balloons and where screening or image intensifier facilities are not available or are inadequate.

We have been using this method to dilate achalasia cardia in adults since 1993; using an Olympus OGF or XP-20 endoscope with Walden-Link 20-2294 pneumatic balloon dilator, we have performed dilatation in 11 cases so far. We do not tie the balloon and the endoscope together as suggested by Nanivadekar et al.; instead we simply hold these together and pass these down the esophagus. This gives greater mobility and freedom to the scope which can thus be separately advanced or pulled back and repositioned while the assistant firmly holds on to the balloon allowing a better vision of the gastroesophageal junction. Also, there is no danger of the thread slipping and falling in the throat.

The procedure is very safe as it is done under direct vision and is about as good as a TTS balloon. In our cases there were no failures and no complications.

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Reference

Sir,

Though the method used by Nanivadekar et al. for esophageal dilatation in pediatric patients using balloon along the side of the endoscope is commendable, I feel that it is redundant as there is no need for a pediatric endoscope with a small channel just because the patient is a child. When the procedure is done under general anesthesia with the airway protected, there is no difficulty in using adult endoscope with a 2.8 mm biopsy channel. I have done 76 therapeutic procedures like injection sclerotherapy, stricture dilatation and foreign-body removal in small children under general anesthesia using such a scope without any difficulty. The youngest child was only 3 months old.
Pediatric endoscopes may be useful when procedures are done under conscious sedation but are unnecessary when these done under general anesthesia.

Reply from the Author

Sir,

We are happy to know that Drs Singh and Pruthi are using a method similar to that used by us in stricture esophagus and to dilate achalasia cardia. We have not used this method in the latter cases but, of course, it should work equally well.

Because of the presence of an endotracheal tube in children, it is difficult to manipulate the balloon without tying it loosely to the endoscope. Moreover, the presence of the endotracheal tube prevents the threads from falling into the larynx or further. Hence these do not pose a risk to the patients.

We are pleased to know that Dr Siva Prasad has passed an adult endoscope in a 3-month-old child. We have never attempted this in children below 5 years. Even in older children, due to the presence of an endotracheal tube during anesthesia, we have encountered difficulty while negotiating the endoscope through the throat. Hence we do not routinely use the adult endoscope below the age of 8 years and use it in younger children only when our pediatric endoscope is under repair.

Whisky Bottle in the Rectum

Sir,

The rectum is known to have allowed misadventures by accommodating objects of foreign bodies like fruits, kitchen articles, candles, balls and bottles. To this list, we add an unusually large whisky bottle, which could not be retrieved per rectum and eventually needed laparotomy.

A 25-year-old man presented with pain in the abdomen which started after a whisky bottle was pushed into his rectum by his friends during a quarrel in an inebriated state, the previous evening. Skiagram of the abdomen revealed a large glass bottle occupying the pelvis, mouth facing cephalad (Fig). It could not be taken out through the anal route despite full relaxation under general anesthesia, compelling us to undertake a successful laparotomy for the purpose.

Foreign bodies have been introduced in the rectum for a variety of reasons, including deviated sexual behavior, senility, intoxication, masturbation or as part of a practical joke.1 There are reports of even forcible insertion of objects into the rectum, usually during group quarrels.2 Gentle manual or endoscopic removal of these foreign bodies is advisable in suitable cases. If this fails, gentle dilatation of the sphincter under anesthesia has been reported to facilitate manual removal in most instances.3 In case these maneuvers fail, as in the present case, there should be no hesitation to undertake laparotomy as this will prevent sphincter damage.

References
3. Modified Urea Broth Versus Christensen’s Urea Broth for Detecting Helicobacter pylori

Sir,

The characteristic ability of Helicobacter pylori to produce a large quantity of urease has been used as a diagnostic feature.1 We compared the conventional Christensen’s urea broth with a modified urea broth to detect H pylori in patients with upper gastrointestinal symptoms. Two gastric biopsy specimens obtained at endoscopy were fixed in 10% neutral buffered formalin for routine paraffin embedding; sections were stained by Giemsa stain for detection of H pylori by histology. This was used as the ‘gold standard’. One fragment each was also inserted into the two broths.