cystitis. Though there are reports on the rupture of liver hydatid causing obstructive jaundice and pancreatitis, liver hydatid cyst with daughter cysts in the gall bladder with clear biliary channels are rare.

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Torsion of appendices epiploicae presenting as acute abdomen: laparoscopic diagnosis and therapy

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We report a 65-year-old man presenting with acute pain in the abdomen. Diagnostic laparoscopy revealed gangrenous torsion in one of the appendices epiploicae in the ascending colon. This was excised with harmonic scalpel. [Indian J Gastroenterol 2003;22:68-69]

Key word: Colon

Diseases of the abdominal appendages are uncommon, and they continue to poses a diagnostic challenge for physicians. Complications of these appendages usually present with acute abdominal pain mimicking acute appendicitis.

A 65-year-old man presented with history of pain in the abdomen since 3 days. There was history of nausea but no history of vomiting or fever. Clinical examination revealed right iliac fossa and periumbilical tenderness with no rebound tenderness. No mass was palpable. Hemoglobin was 13.3 g/dL and total leukocyte count 7800/cm3. The clinical diagnosis was acute appendicitis.

Fig: Torsion of appendices epiploicae

Laparoscopy revealed that one of the appendices epiploicae of the ascending colon was gangrenous due to torsion (Fig). The appendix was normal. The gangrenous tissue was excised using harmonic scalpel. The operative time was 15 minutes. The patient was discharged the next day on normal diet.

The appendices epiploicae are located on the antimesenteric border of the colon, namely the cecum and sigmoid colon, and may contain diverticulae. Complications related to them include diverticulitis, intestinal obstruction secondary to adherence to small bowel, torsion and infarction.1,2,4 Torsion and infarction are seen in obese patients where the appendices are bulky, and are usually found in the sigmoid colon where they are the longest.2,3

The right iliac fossa is the most common site for pain and tenderness, even if the sigmoid colon is the affected site. Nausea and vomiting have been reported in 25%-40% of patients and a palpable mass is reported in a similar percentage.4 In our patient the clinical diagnosis was acute appendicitis. However, patients with twisted appendices epiploicae are less well compared to those with acute appendicitis, usually with a slight increase in temperature and leukocyte count.4

Inflammated appendices epiploicae may appear as stricture on barium enema because of the extrinsic compression simulating carcinoma.2,3 CT scan may show a mass effect.1 In the present case ultrasonography reported ileus and no mass. Treatment includes ligation and excision of the gangrenous appendices. Laparoscopy is useful for managing patients presenting with complications.

References
Large nodal metastases from carcinoid tumor causing bowel obstruction

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A 39-year-old man presented with progressively increasing constipation and painful lumps in the abdomen. Exploration showed extensive nodal metastases but no primary lesion was seen. The masses were excised and sigmoid colostomy done. Histology revealed carcinoid tumor with small cell differentiation. A trial of chemotherapy gave no response. At follow up of 18 months he is leading a comfortable life with a colostomy and a biliary stent in place (placed for obstructive jaundice due to porta node). [Indian J Gastroenterol/2003;22:69-70]

Although characteristically indolent, carcinoid tumors are also quite heterogenous both with respect to histologic and endocrine features and to clinical presentation and behavior. We report a patient with malignant carcinoid tumor with occult primary and large nodal metastases causing progressive constipation and large bowel obstruction.

A 39-year-old man presented with painful lump in the right lower abdomen, gradually increasing in size for 6 months, and progressively increasing constipation and diminished urinary stream for 4 months. There was no history of bleeding per rectum. He had no symptoms of the carcinoid syndrome, but had history of loss of weight. On examination, he had a large irregular lump. 10 cm x 10 cm, in the right iliac fossa, which was freely mobile. There was another lump, 3 cm x 3 cm, in the right infraumbilical region with restricted mobility. On rectal examination, an irregular mass was felt in the pouch of Douglas, which was almost completely blocking the rectal lumen about 4 cm from the anal verge. Rectal mucosa on proctoscopy till 4 cm was normal. Both the testes were normal.

Routine laboratory investigations were normal except for raised ESR (40 mm in 1st hour). Ultrasonography and CT scan revealed a large (8 cm x 7 cm), irregular mass at the root of the mesentery, more on the right side. There were few hypodense areas in the mass. A similar mass, 9.5 cm x 4 cm x 6 cm, was seen in the rectovesical pouch, more on the left of midline, causing marked pressure effects on the rectum and distal sigmoid colon (Fig). Liver was normal. On fine needle aspiration cytology a possibility of adenocarcinoma or small cell carcinoma was suggested.

Exploratory laparotomy showed extensive intraperitoneal and retroperitoneal grayish white metastases. An 8 cm x 10 cm hard irregular mass was present in the greater omentum in the right periumbilical region. Another 3 cm x 3 cm mass was present below this, stuck to the parietal peritoneum. A large partially mobile retroperitoneal mass extending deep into the pelvis in the retrovesical pouch was present. Liver, spleen, stomach, pancreas, small and large bowel up to lower sigmoid were normal.

The omental and umbilical lumps were excised. Since excision of the pelvic mass was not possible without perineal approach, only sigmoid colostomy was done. Recovery was uneventful.

Gross examination showed a solid tumor with irregular surface. Microscopic examination revealed tumor cells in groups, separated by thick fibrous septa. The cells were small to moderate in size with scant to moderate eosinophilic cytoplasm; at places they showed spindling. The nuclei were indented, round to oval, with irregularly dispersed chromatin and inconspicuous nucleoli. Five to eight mitoses per 10 HPF were observed. The tumor cells were not arranged in any particular pattern. Stroma was formed of thick fibrous tissue with slight to marked sprinkling of lymphocytes. Vascular invasion was present. Immunohistochemical stain showed positive reaction with chromogranin. A report of malignant carcinoid tumor with small cell differentiation was made.

The patient received four cycles of etoposide 50 mg on days 1-2 and 5-fluorouracil 1500mg on days 1-3 at 3 weekly intervals. Repeat CT scan showed a slight increase in pelvic mass and appearance of metastases in the right lobe of the liver. A large metastasis was also seen at the porta hepatis. The patient otherwise was doing well and gained 6 Kg weight since undergoing surgery. He refused further chemotherapy. Six months later he developed obstructive jaundice and pruritus. Ultrasonography revealed obstruction of the biliary system at the porta hepatis; endoscopic biliary stenting was done. His jaundice abated; 18 months later he is doing well so far.

Carcinoid tumors may show a spectrum of differentiation that ranges from well differentiated to moder-