Characteristics of gastric malignancy in eastern India

Information regarding characteristics of gastric malignancy, its demographic pattern, histological type, anatomical locations and various etiological associations, as observed in eastern India, are scanty in the literature. This paper is based on the study of the above features in consecutive cases of gastric malignancy undergoing endoscopy at a cancer center in Calcutta during the period March 1998 to March 2000.

Gastric malignancy was diagnosed on the basis of histological examination of endoscopic biopsy in 110 cases. Demographic characteristics, clinical presentation, and anatomical location of the malignancy were recorded in all cases. The histological types were classified according to the WHO classification.1 The rapid urease test for Helicobacter pylori was carried out using a standard commercial kit on 71 patients with adenocarcinoma and 3 with gastric lymphoma. Dietetic history and history of alcohol could be obtained during the time of examination from 63 patients with adenocarcinoma.

Of the 110 patients, 105 (95.4%) were diagnosed to have adenocarcinoma, 2 (1.9%) squamous cell carcinoma and 3 (2.7%) non-Hodgkin's lymphoma (NHL). More than two-thirds (78.1%) of cases of adenocarcinoma were men, and 23.8% occurred in a younger age group (21-40 years). Dyspeptic symptoms were present in only 31% of cases. In a majority of cases, the tumor was situated in the antrum (60; 57.1%) or body (12; 11.4%) of the stomach. Carcinoma arising from gastrojejunostomy stoma was found in 5 (4.7%) cases, who had earlier undergone surgery for duodenal ulcer. Poorly differentiated histological type was found in the largest (41.9%) number of cases, whereas only 11.4% belonged to the well-differentiated type. The rapid urease test was positive in 25 (35.2%) patients with adenocarcinoma and one of three with NHL. History of intake of excess salt in the diet (as compared to other family members) was found in 75.7%, while that of consuming patti and betel nut and tobacco chewing was found in less number of cases (33.3% and 27.2%, respectively).

A predominantly male population suffers from gastric adenocarcinoma in eastern India, the lesion occurring in the distal part of the stomach in most cases. Similar findings are available from two reports from southern India.5,6 A large number of such patients are young and give history of intake of excess salt in the diet and smoking. However, the rapid urease test for H. pylori infection was found to be infrequently positive in our cases; higher rates (38%-56%) have been reported from other centers in India.5,6,7

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References

Brown Kelly-Paterson syndrome and other eponymous misnomers

I wish to point out a small error in the report on Paterson-Kelly syndrome.1 The appropriate term for this syndrome is Brown Kelly-Paterson (or Paterson-Brown Kelly), named after Drs Adam Brown Kelly and Donald Paterson.2

However, the authors are correct in opting for this eponym rather than the other equally well-known one, Plummer-Vinson syndrome. The paper Vinson wrote was on dysphagia with resulting anemia, considered to be due to hysteria, but with no mention of glossitis. Vinson refers to similar cases having been documented by Plummer, but with no specific reference. In fact, there is no paper in the literature on this subject by Plummer. Perhaps he presented his findings in a lecture or a meeting.
but we do not know for sure.3

It is not uncommon to have such eponymous misnomers in Medicine, where one person discovers an entity but someone else gets the credit. In Gastroenterology alone, Crohn's disease, described earlier by Thomas Dalziel, and the ampulla of Vater, described by Santorini, are examples.3

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Reply from the authors

We thank Dr Pai for his astute observation on the eponym. However, there still seems to be a difference of opinion on the use of terminology for this syndrome.

Most standard textbooks and earlier articles1,2,3 have used the term Paterson-Kelly rather than Paterson-Brown Kelly (or Brown Kelly-Paterson). The reason may be that Brown was probably the middle name and not the surname of Dr Adam Brown Kelly. The original article by Dr Adam Brown Kelly has been referenced as Kelly AB rather than as Brown Kelly A.4 In either case, we feel that it does not matter as long as Drs Paterson and Kelly (or Brown Kelly) are honored for their work.

The controversy on whether to use the terminology Plummer-Vinson or Paterson-Kelly syndrome is longstanding. However, we may mention that Plummer did publish two articles on cardiopasm in 1908 and 1912.5,6

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Idiopathic tension pneumoperitonem

Idiopathic pneumoperitonem is a rare condition considered after exclusion of perforation of intra-abdominal viscous and other known causes of free intraperitoneal gas.1 Conservative treatment is advocated in the absence of clinical signs of peritonitis except when there is a rapidly developing tension pneumoperitonem. Immediate intervention is required in such cases.2

Only one case of idiopathic postoperative tension pneumoperitonem has been reported in literature earlier.3

A 40-year-old man, operated on one year back for intestinal perforation, was presented with acute intestinal obstruction. After resuscitation, he was taken up for exploratory laparotomy, which revealed a band nearly 60 cm proximal to the ileocecal junction causing complete obstruction with gangrene of a small segment of ileum proximal to it. Resection of the gangrenous segment with end-to-end anastomosis was done. The patient was well in the immediate postoperative period and was allowed oral feeds on the fifth postoperative day. The next morning, he complained of ill-defined abdominal discomfort; therefore his oral intake was withheld. He started having abdominal distension in the afternoon, which progressed rapidly. Within four hours his abdomen was tense but distended with air causing respiratory distress and cyanosis.

The laparotomy wound was opened at its lower end at the bedside itself. A gush of air escaped and the abdomen was decompressed. No peritoneal or gut contents came out and his condition improved dramatically. The patient was re-explored with a suspicion of anastomotic leak. Exploration revealed a clean peritoneal cavity with healthy anastomatic line. The postoperative period was uneventful.

Spontaneous pneumoperitonem is labeled as idiopathic only when known causative factors (pneumato
tis, barotrauma, diaphragmatic defects, mechanical ventilation, gas-forming organisms) are absent. In the absence of clinical signs of peritonitis, it usually follows a benign course.4 Tension pneumoperitonem, where the pneumoperitonem builds in rapidly enough to cause extreme distension and respiratory compromise, warrants immediate needle decompression.5

Though pneumoperitonem after laparotomy may persist for a long period, there is only one report of idiopathic tension pneumoperitonem in the postoperative period.4 Since the condition develops rapidly, urgent exploration may appear warranted although simple