but we do not know for sure.\textsuperscript{2}

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.\textsuperscript{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 articles\textsuperscript{1,2,3} 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.\textsuperscript{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 long-standing. However, we may mention that Plummer did publish two articles on cardiopasm in 1908 and 1912.\textsuperscript{5,6}

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5. Plummer HS. Cardiopasm: with a report of 40 cases. JAMA 1908;51:549-54.

Idiopathic tension pneumoperitoneum after laparotomy

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

Only one case of idiopathic postoperative tension pneumoperitoneum has been reported in literature earlier.\textsuperscript{3} A 40-year-old man, operated on one year back for intestinal perforation, 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 tautly 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 anastomotic line. The postoperative period was uneventful.

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

Though pneumoperitoneum after laparotomy may persist for a long period, there is only one report of idiopathic tension pneumoperitoneum in the postoperative period.\textsuperscript{3} Since the condition develops rapidly, urgent exploration may appear warranted although simple
decompression of the abdomen is sufficient.

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Fig: CT scan showing mass lesion in gall bladder

deference of malignancy was found. Subsequent investigations for a tuberular focus elsewhere were negative. Currently the patient is doing well on antitubercular therapy.

Tuberculosis of the gall bladder has been classified as 1. military tuberculosis with ulcerating tubercles in gall bladder; 2. gall bladder tuberculosis in association with severe generalized tuberculosis; 3. tuberculosis limited to gall bladder, often discovered at operation or histology; and 4. gall bladder involvement in association with tuberculosis in other peritoneal organs.

Our case belongs to group 3. Gallstones may predispose to development of tuberculosis in the gall bladder as only two cases of acalculous tubercular gall bladder have been reported. The present case emphasizes the need for a histological diagnosis in all patients with suspected gall bladder cancer.

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