tom. Extrinsically growing tumors may outgrow their blood supply, causing necrosis, leading to intraluminal or intraperitoneal bleeding.

Ten percent of leiomyosarcomas present as acute abdomen, due to volvulus, kinking, intussusception or adhesions. Unusual presentations reported include hyperpension secondary to a hCG producing leiomyosarcoma,2 lethargy,3 torsion of the small intestine around a sarcoma in a Meckel's diverticulum,4 and as fever of unknown origin.5 Leiomyosarcoma presenting as chronic intra-abdominal abscess, as in our case, has not been reported before.

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Herpes simplex esophagitis in immunocompetent individuals

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Herpes simplex esophagitis commonly occurs in immunocompromised individuals. We report the condition in two immunocompetent individuals (one presenting with retrosternal pain and diarrhea and the other with dysphagia and fever) and in two patients with obstructive airway disease who had received corticosteroid therapy. The first two did not receive treatment, one was lost to follow up and the other is asymptomatic two years later. The latter two patients received acyclovir therapy. [Indian J Gastroenterol 2001;20:245-246]

Key words: Viral esophagitis

Herpes simplex esophagitis occurs commonly in immunocompromised patients and is relatively rare in apparently immunocompetent hosts. It occurs more often as reactivation of the latent virus; rarely, it may be a primary infection. We report 4 patients with herpes simplex esophagitis who presented between January 1996 and April 2001.

Case 1: A 60-year-old woman presented with history of loose motions and retrosternal pain of 15 days’ duration. She had received anti-tuberculous treatment for six months in the past. On clinical examination her hydration was fair. Esophagogastroduodenoscopy (EGD) scope showed an ulcer, 6 cm x 3 cm, on the anterior wall of the esophagus. The esophageal mucosa was friable with narrowing at the gastroesophageal junction. Esophageal biopsies showed several clusters as well as dispersed cells with opaque ground glass nuclei, eosinophilic nuclear inclusions and multinucleated cells along with leukocytes. These findings were consistent with herpetic esophagitis. Ulcer biopsy showed squamous epithelium infiltrated by polymorphs. Nuclei of many of the cells showed intranuclear inclusions. Her HIV status was negative. She did not take any treatment and was lost to follow-up.

Case 2: A 24-year-old man presented with sudden-onset dysphagia and fever of four days’ duration. His clinical examination was unremarkable. EGD showed multiple circumferential ulcers from the gastroesophageal junction up to 25 cm proximally; they were superficial and non-bleeding. Esophageal biopsies did not reveal any inclusions but ulcer biopsy showed squamous cells with opaque nuclei and multinucleated cells, consistent with herpetic viral inclusions. HSV IgM was negative and HIV status was negative. He did not take any treatment. He was well and asymptomatic until two years on follow-up.

Case 3: A 72-year-old man was admitted with history of backache since 13 days followed by breathlessness, vomiting and hematemesis (three episodes, 150 mL each). He was a known case of seizure disorder, hypertension and chronic obstructive pulmonary disease (COPD). He had received intravenous steroids in the past. On examination he was hemodynamically stable. On auscultation he had bilateral rales. Clinically he was diagnosed to have an acute exacerbation of COPD with upper

Fig: Endoscopy showing esophageal ulcers with exudate involving distal third of esophagus. At places exudate has formed a membrane

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GI bleed.

Investigations: normal hemogram. Chest X-ray showed generalized osteoporosis with no pleuro-parenchymal lesion. EGD copy showed esophageal ulcers with exudates (Fig), suggestive of infective esophagitis. Esophageal brushings as well as biopsy from the edges of the ulcers showed multinucleated giant cells and eosinophilic intranuclear inclusion bodies. HIV and HSV IgM were negative. Barium swallow showed multiple filling defects.

He was treated with oral acyclovir 200 mg five times a day for five days and on follow-up was asymptomatic for one year. He expired later following an acute exacerbation of COPD, which was preceded by hematemesis and melena for one day.

Case 4: A 70-year-old woman presented with melena. She was a known case of bronchial asthma and was on oral steroids for eight years. She also gave a history of pulmonary tuberculosis in the past and had a non 'Q' myocardial infarct earlier. EGD copy showed confluent ulceration on the vocal cords, esophagus and stomach. Esophageal brushings and ulcer biopsy showed several multinucleated giant cells with ground-glass molded nuclei, consistent with herpetic esophagitis. HSV IgM was negative, but HSV IgG was positive.

She was treated with intravenous acyclovir 500 mg 8 hourly for nine days. However, she had associated pneumonia, became septicemic and died.

Herpes simplex esophagitis occurs more commonly as reactivation of latent virus, but rarely may be a primary infection. It is more common in immunocompromised patients. This report highlights the occurrence of HSV esophagitis in non-immunocompromised individuals and patients with respiratory illness who receive steroids intermittently or continuously.

The occurrence of HSV esophagitis in immunocompetent individuals is rare. Ramanathan et al.1 found 38 cases of herpes simplex esophagitis in literature; their age ranged from 1-76 years and there was male predominance (3:2:1). Nearly a fourth had a prodrome of systemic manifestations preceding the onset of esophageal symptoms. Endoscopically, extensive involvement was common, showing friable mucosa, ulcers and whitish exudates. The distal esophagus was most commonly affected. Histology alone may miss the diagnosis and the addition of tissue viral culture optimizes the diagnostic sensitivity. The disease is usually self-limiting, and the benefit of antiviral therapy is not known.1

Rosa et al.2 reported five cases and found reports of 64 cases of herpes simplex esophagitis in immunocompetent patients. They recommended acyclovir to prevent complications. Both our immunocompetent patients had extensive esophageal disease, and did not receive treatment. One patient was well 2 years later.

HSV esophagitis can occur in patients with respiratory diseases who receive intermittent or continuous oral steroid or even inhaled steroid.3,4 Hemstreet et al.5 reported a patient who was on inhaled steroid therapy and developed concomitant candida and herpes simplex esophagitis. One of our patients had received corticosteroid therapy intermittently.

In summary, herpes simplex esophagitis in immunocompetent individuals is a rare entity preceded by systemic prodrome in some patients. Whether antiviral treatment is indicated is controversial. Intermittent corticosteroid therapy and inhaled steroid therapy also predispose to herpes simplex esophagitis.

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Ruptured splenic abscess presenting as pneumoperitoneum

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Spontaneous pneumoperitoneum follows perforation of hollow viscus; rarely, it may arise from pulmonary interstitial emphysema or intestinal inflammatory disease. We report a 30-year-old man with ruptured splenic abscess who presented with acute abdomen and had pneumoperitoneum. He was treated with splenectomy and is asymptomatic 2 months later. [Indian J Gastroenterol 2001;20:246-247]

Key words: Escherichia coli abscess

Free intraperitoneal air follows perforation of intra-abdominal hollow viscus in over 90% of cases.1 Rarer causes include iatrogenic causes, intrathoracic source or inflammatory intestinal pathology.2 Rupture of splenic abscess with generalized peritonitis is rare.3 We report a patient with ruptured splenic abscess who presented with acute abdomen with pneumoperitoneum.

A 30-year-old man presented with acute upper abdominal pain since 2 days. He had no history of trauma, acid-peptic disease or ingestion of any ulcerogenic drugs. He was nonalco-