An initial psychological assessment was done and the patient was started on oral fluoxetine with a diagnosis of depressive psychosis. She is asymptomatic on follow up.

More than 90% of trichobezoars occur in women, with a peak incidence in the second decade of life. The majority of patients with a trichobezoar do not have a psychiatric disorder.1

The only satisfactory treatment for large trichobezoars is early surgical intervention, which carries a mortality rate of less than 5%.2 A thorough search must be made at laparotomy to exclude extensions and daughter bezoars. Surgical removal is curative and recurrences rare. However, postoperative psychiatric evaluation and counseling is a must.3,4

References

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Intra-arterial contrast-enhanced spiral CT: adjunct to angiography for localizing obscure gastrointestinal bleed

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We report two patients with obscure GI bleed in whom we performed intra-arterial contrast-enhanced spiral CT scan of abdomen with the angiography catheter in the superior mesenteric artery (SMA). The technique localized the lesions to the mid jejunum and distal duodenum. [Indian J Gastroenterol 2002; 21:230-231]

Key words: Gastrointestinal bleed

U p to 20% of gastrointestinal (GI) bleeds are of obscure origin.5 Endoscopy is the principal investigative modality; angiography is done when endoscopy is inconclusive. Spiral CT is being increasingly used in evaluation of obscure GI bleeds.5-7 We combined spiral CT of the abdomen with selective intra-arterial superior mesenteric artery (SMA) contrast injection in two patients with obscure GI bleed.

Case 1: An 80-year-old man presented with melena of one-week duration. There was no history of similar episodes in the past. He was not on any drugs that could alter the coagulation profile. He had no other co-morbidities. His hemoglobin level was 6.5 g/dL on admission. He received 2 units of blood and was hemodynamically stable. Upper and lower endoscopies were negative except for some blood clots in the terminal ileum. Selective superior mesenteric artery (SMA) injection showed doubtful extravasation of contrast into what appeared to be the jejunum. The patient was shifted to the CT scan suite with the catheter in situ. Spiral CT scan, done after injection of 20 mL of iodine contrast through the catheter, showed an enhancing 1-cm lesion in the mid jejunum with extravasation of contrast (Fig). The patient underwent resection-anastomosis of the jejunum and the lesion was found to be a leiomyoma. Postoperative period was uneventful and on eight months' follow up the patient is disease-free.

Case 2: A 67-year-old man with no co-morbidities presented with hematemesis of one-day duration. He had one similar episode six months before, which was managed conservatively. He was not on any drugs that could modify the coagulation profile. On admission his hemoglobin level was 4 g/dL and he was hemodynamically unstable. Following multiple transfusions his hemodynamic status improved. Upper GI endoscopy showed reflux of fresh blood into the proximal duodenum. Colonoscopy was non-contributory. Selective SMA injection showed extravasation of contrast; however, the exact segment of bowel could not be localized. Spiral CT scan, done following injection of 20 mL of contrast through the catheter, revealed a small diverticulum with air-fluid level in the third part of the duodenum, with extravasation of contrast. At surgery a solitary 2 cm x 3 cm diverticulum was visualized on the antimesenteric border with a bleeding ulcer at the apex of the diverticulum. Diverticulectomy was done. Postoperative period and follow up for 6 months were uneventful.

Active small bowel bleed, which is usually inaccessible through both upper and lower endoscopy, can be identified angiographically and by radionuclide scans.

Fig: Spiral CT scan showing intraluminal mass in mid jejunum with focal extravasation of contrast (arrow)
Radionuclide scans are very sensitive in detecting blood loss from the GI tract but are less accurate than angiography in localizing the site of bleeding. The role of intravenous contrast-enhanced spiral CT in evaluation of GI bleed is well known. However, it is not sensitive enough to show a bleeding point. Demonstrating a diverticulum or leiomyoma by spiral CT is not proof enough to assume that it is the cause for the bleed. Ettore et al. observed that combining spiral CT scan with angiography helps in localizing GI bleeding. In our experience we found that the technique not only localizes but also diagnose the cause of bleeding. We feel that SMA injection will be most appropriate as a majority of GI bleeds with negative upper and lower GI endoscopy arise in the small bowel territory.

In conclusion, intra-arterial contrast-enhanced spiral CT scan of abdomen with the angiography catheter in the SMA holds promise as a useful adjunct to SMA angiogram in localizing and diagnosing the cause for obscure GI bleed. The exact localization of the lesion by this technique is valuable in areas like the distal duodenum and the duodenjejunal flexure, which are relatively difficult areas to access during surgery and are likely to be overlooked.

References

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Gastric mucormycosis

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Mucormycosis is a rare fungal infection that usually involves the head and neck. Gastrintestinal mucormycosis is usually associated with immunocompromised states and advanced malignancies, and has a very high mortality.

A 35-year-old alcoholic man presented with upper abdominal pain, vomiting and fever of 5 days' duration. On examination, he was toxic, dehydrated, with guarding in the upper abdomen and tender hepatomegaly.

Ultrasoundography revealed two hypoechoic lesions, 4 cm x 4 cm each, in the left lobe of the liver, with homogenous appearance. The liver parenchyma was otherwise normal. The findings were confirmed on CT scan, CT scan brain was normal. Blood sugar, serum amylase and creatinine were normal and HIV antibody was negative. Upper GI endoscopy (Fig) revealed an ulcerated plaque-like lesion, about 4 cm x 4 cm, with raised edges and necrotic slough, situated 5 cm distal to the cardia on the lesser curvature. Histology of edge biopsies revealed mucormycosis of the stomach with invasion of the muscularis propria.

Amphotericin-B was given in a dose of 1 mg/Kg/day for 15 days. The patient improved and was discharged after 15 days. Repeat CT and check gastroscopy performed after 2 months revealed complete regression of the lesions.

Phycomycetes are a class of Eumycetes (true fungi) and are characterized by lack of septations. Phycomycetes infection occurs initially by inhalation of spores or implantation in broken skin or mucous membrane. In disseminated disease mycotic emboli may establish metastatic infection in distant organs. The most characteristic histologic feature of the disease is local invasion of blood vessels by fungal organisms, producing acute vasculitis, thrombus formation and ischemic necrosis of surrounding tissue.

Fig: Endoscopic appearance of plaque-like lesion in body of stomach