Rhinocerebral involvement is most common and is the form most often associated with diabetes. Localized gastrointestinal phymocytosis involves the ileum, colon and stomach but is rarely diagnosed ante-mortem; a majority of patients have disseminated involvement including the central nervous system and lungs. Immunocompromised states, diabetes, advanced malignancies and metabolic derangements, mainly acidosis, are the usual predisposing conditions.

GI mucocytosis is due to ingestion of fungal spores of infected sputum. Secondary infection of pre-existing ulcers or disseminated disease may also occur. Bleeding ulcers, perforation, peritonitis, shock and death are the usual progression. Associated mesenteric vein thrombosis has been described. In clinically suspicious cases, gastric aspirate, stool and blood should be cultured on Sabouraud’s medium. Endoscopically accessible lesions should be biopsied early in the course of the disease. An intradermal skin test using autoclaved culture extracts, and a complement fixation test with such an extract as antigen have also been described.

Amphotericin-B is the drug of choice; other antifungal agents are of no use. Continued use of antibiotics, corticosteroids and immunosuppressive drugs must be re-evaluated. Surgical excision of the infected necrotic tissue, adequate drainage of sinuses, debridement of devitalized tissue and thorough peritoneal lavage must be performed whenever possible. With few exceptions, gastrointestinal phymocytosis pursues a fulminant and rapidly fatal course.

Increased awareness and early recognition of gastrointestinal phymocytosis and initiation of specific therapeutic measures are the key to improved survival of these patients.

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Non-gestational choriocarcinoma

In small intestine

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Choriocarcinoma most commonly arises from intrauterine gestational trophoblastic tissue; non gestational choriocarcinoma is rare. We report a 22-year-old married woman with non-gestational choriocarcinoma in the small intestine. Partial resection of the jejunum and ileum was done, followed by chemotherapy. She was well one year later. [Indian J Gastroenterol 2002;21:232-233]

Key words: Extranodal choriocarcinoma

Choriocarcinoma, a malignant tumor usually of placental origin, is of two types, gestational and non-gestational; the latter is rare. Non-gestational choriocarcinoma occurs in the lungs, mediastinum, kidney and intestines. Gastrointestinal choriocarcinoma is rare; the first case was reported by Sears in 19335 and only a few cases have been reported in since. They are more common in the stomach but have also been reported in the esophagus, small and large intestine.

A 22-year-old married lady was admitted with high-grade fever for 15 days and pain and distension of the abdomen for 2 days. Examination showed marked pallor with pedal edema, distension of abdomen, and absent bowel sounds. Gynecological examination did not reveal any abnormality, though she had history of amenorrhoea for four months.

Investigations: Microcytic hypochromic anaemia (haemoglobin 2.0 g/dl), urine normal. Skiagram showed air under the diaphragm with multiple air-fluid levels. Chest X-ray was normal. Ultrasonography of pelvic organs showed endometrial hyperplasia without any other significant abnormality.

Exploratory laparotomy revealed peritonitis. The jejunum and ileum showed multiple submucosal nodules of 1 cm size with two perforations, each 2 cm x 2 cm, on the antimesenteric border. Liver and spleen were normal. Abdominal lymph nodes were not enlarged and no peritoneal seedlings were detected. Exploration of the pelvic organs revealed normal sized uterus and ovaries; both the fallopian tubes were unremarkable. Partial resection of the jejunum and ileum was done and anastomosis performed. The specimen showed ulcers of irregular shape, measuring 3 cm x 2.5 cm and 3 cm x 2 cm, with perforation in their centers. The edge of the ulcers was irregularly thickened and the margins were reddish brown and necrotic. There were multiple small submucosal nodules around these ulcers. Representative microsections from the ulcers and nodules revealed groups of neoplastic cytotrophoblastic and multinucleated syncytiotrophoblastic cells with bizarre anaplastic nuclei lying in extensive areas of hemorrhagic and necrotic tissue (Fig). A diagnosis of choriocarcinoma in the small intestine was made.

The patient was reassessed. There was no evidence of primary malignancy in the genital organs or metastasis at other sites on clinical examination and imaging. Dilution and curetage was performed to rule out gestational choriocarcinoma. Microscopic examination of the curettings showed secretory endometrium without evidence of trophoblastic tissue. Serum HCG levels were elevated immediately postoperatively but showed declining trends on follow-up. The patient was put on chemotherapy (EMA-CO regimen) and followed-up regularly with serum HCG levels. She was well till one year after surgery.
A 20-year-old man presented with acute intestinal obstruction due to multiple hemangiomas of small intestine extending into the adjoining mesentery. The diagnosis was made at laparotomy and subsequently confirmed on histology. Occurrence of hemangioma in the small intestine and its presentation as acute intestinal obstruction are rare. [Indian J Gastroenterol 2002;21:233-234]

Key words: Intestine obstruction

Hemangioma of the small intestine is rare and its preoperative diagnosis is difficult. Hemangioma involving the mesentery is extremely rare; 15 cases have been reported in Japanese literature. The clinical presentation of intestinal hemangioma is usually with gastrointestinal bleeding and anemia.

A 20-year-old man was admitted with complaints of pain in the abdomen, biliary vomiting and absolute constipation of three days' duration. On examination the patient looked dehydrated. Pulse rate was 144/min, respiratory rate 22/min, and blood pressure 90/70 mmHg. Abdomen was nontender, distended, with palpable gut loops; bowel sounds were increased. X-ray of the abdomen showed multiple air-fluid levels; hemoglobin level was 13.0 g/dL.

Laparotomy revealed hemangioma of the mid small gut extending into the mesentery along the ileal branches of the superior mesenteric vessels and going over the third part of the duodenum and pancreas. The affected part of the gut was stretched over the reddish soft compressible mass and was twisted, enclosing a loop of small intestine. This portion was excised and end-to-end anastomosis was done. Gross examination of the excised tissue revealed a loop of intestine measuring approximately 20 cm in length and 2.5 cm in width. In the center of the loop the mesentery was replaced by a hemangiomatous mass approximately 7.0 cm x 5.0 cm in size, which was encircling the wall of the gut (Fig.). Microscopically the tumor was composed of thin-walled vessels

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Acute Intestinal obstruction due to small gut hemangioma

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