abdomen with recurrent vomiting and low-grade fever for two days. He had accidentally ingested a sewing needle six days back but had concealed the history at that time. On examination the child was febrile. The abdomen was non-distended, with tenderness and guarding in the right iliac fossa especially at McBurney’s point.

Investigations: hemoglobin 9.5 g/dL, WBC 13000/cumm (polymorphs 96%); renal and liver function tests were normal. Plain roentgenogram of the abdomen showed the ingested needle in the right lower abdomen (Fig). Ultrasonography showed minimal free fluid in the right iliac fossa along with local tenderness.

Surgical exploration revealed an inflamed pelvic appendix with minimal amount of free fluid in the right iliac fossa. The needle was present in the cecum with its tip projecting midway into the appendicular lumen. Appendicectomy resulted in satisfactory recovery; histological examination confirmed inflammatory changes in the appendix. The child is well six months later.

Foreign body appendicitis is extremely uncommon in children. Although most ingested foreign bodies pass through the gastrointestinal tract, appendicular foreign bodies have been reported with an incidence of 0.0005%.1,3 Among reported foreign bodies resulting in appendicular inflammation are shotgun pellets, bird shots, and needles.1,3,4,5

The diagnosis of foreign body appendicitis is based on history of foreign body ingestion, followed by features suggestive of appendicular inflammation along with the presence of the ingested foreign body in the right lower abdomen in a static position on serial radiographs.1,3

The treatment is primarily surgical. Early surgical intervention is recommended even in asymptomatic cases with a high index of suspicion of presence of foreign body in the appendicular lumen so that the high morbidity associated with delayed diagnosis and resulting complications is avoided.1,2

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Dieulafoy lesion in mid-esophagus with esophageal varices

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Dieulafoy lesion is an uncommon cause of gastrointestinal (GI) bleeding. Most such lesions are reported in the stomach, though a few have been reported in the distal esophagus. We report a 54-year-old man who presented with upper GI bleeding and had esophageal varices but bled from a Dieulafoy lesion 5 cm above the proximal end of the varices. [Indian J Gastroenterol 2004;23:220-221]

Key words: GI bleeding, vascular malformation

Dieulafoy lesion is a large-caliber arteriole that protrudes through a tiny mucosal defect.1 A majority of these occur in the stomach, although a few have been reported in the distal esophagus and elsewhere. Its association with portal hypertension and esophageal varices has not been described.

A 54-year-old man with well-controlled diabetes mellitus and hypertension since 10 years presented with large quantity of painless hematemesis. He denied any substance abuse or regular intake of NSAIDs. There was no significant past medical history. On examination his vital parameters and systemic examination were normal.

Investigations: hemoglobin 9.4 g/dL; coagulation profile was normal. Upper GI endoscopy revealed four columns of grade 2 varices and mild portal hypertensive gastropathy. There was active spurting from a vessel about 5 cm above the proximal end of the varices. Endoscopic sclerotherapy of the varices was performed with polidocanol but as the bleeding persisted 2 mL epinephrine was injected (1:10000 dilution) into the spurting vessel, which arrested the bleeding. Further investigations (biochemistry, imaging) revealed chronic liver disease. Viral markers for hepatitis B and C were negative. The patient was discharged; a second session of sclerotherapy was done a month later.

Five months after the initial episode during a check endoscopy he developed active bleeding again. Endoscopy revealed an actively spurting vessel at about 30 cm from the incisors
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with three columns of nearly obliterated varices up to 35 cm (Fig) There was a clear area of normal mucosa between the spurting vessel and varices. This was again treated with epinephrine injection. The following day endoscopy showed a vessel in a dimpled area. This was treated with argon plasma coagulation. He received four units of blood (packed RBC), as his hemoglobin level was 7.2 g/dL. He was discharged three days later and has not bled again in the next 2 months.

Approximately 75% to 95% of Dieulafoy lesions are found in the stomach within 6 cm of the gastro-esophageal junction, predominantly on the lesser curve. These lesions have been described in the distal esophagus (2% of cases), duodenal bulb, jejunum, colon and rectum. In our patient the lesion was found in the mid-esophagus, clearly separated from non-bleeding varices below. The association with esophageal varices has not been reported earlier.

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Dissecting intramural hematoma in esophageal carcinoma

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A 50-year-old man with esophageal carcinoma developed severe, refractory, retrosternal chest pain. The diagnosis was made four days later when contrast studies showed an intramural dissecting hematoma of the esophagus. The patient responded to conservative management. [Indian J Gastroenterol 2004;23:221-222]

Key words: Esophagus, esophageal dissection

Intramural dissection of the esophagus occurs when a hematoma forms between the mucosal and muscular layers of the wall. It is a rare cause of sudden severe retrosternal chest pain.

A 50-year-old man on second-line chemotherapy for recurrent esophageal cancer presented with severe retrosternal chest pain, radiating to the back. There was no history of breathlessness or sweating.

A year earlier the patient had been diagnosed to have carcinoma of the lower third of the esophagus and had been treated with chemotherapy and radiation therapy at another center. He was first seen in this hospital when he had a metastatic right supraclavicular node and multifocal recurrence involving the upper and lower thirds of the esophagus. Palliative chemotherapy with docetaxel had been administered two days before the development of the acute chest pain.

The electrocardiogram was normal. The pain worsened over the next few hours despite strong narcotics. Twenty-four hours later the patient also developed low-grade pyrexia. On reassessment it was found that pain was precipitated by swallowing. Examination revealed retrosternal, paraspinal and epi-