it may avoid prolonged, uncomfortable, costly and invasive procedures.

References

Ileoceleal Intussusception Produced by Lymphoblastic Lymphoma of Ileum

Sir,

We report a case of ileocecal intussusception produced by a lymphoblastic lymphoma of the terminal ileum in a teenager.

A 16 year old girl presented with two months' history of non-radiating colicky pain with progressively enlarging lump in the right lower quadrant of the abdomen. She had history of vomiting off and on with low-grade fever and significant weight loss over the same period. Physical examination of the abdomen showed a 10 cm x 6 cm firm, immobile mass in the right lower quadrant. There was no hepatosplenomegaly. A small bowel series (Fig) showed an extrinsic mass effect on the ileal loops. In addition, there was a classical ileocecal intussusception.

At exploration, a large mass of lymph nodes in the right lower quadrant was subtotally excised. Since the intussusception was irreducible, a right hemicolectomy was performed. The patient recovered uneventfully. Histology of the dissected specimen showed a lymphoblastic lymphoma.

Beyond the pediatric age, lymphoma as a cause of intussusception has been reported only on seven previous occasions. To our knowledge, this is the first report in Indian literature. The clinical presentation is extremely variable, often manifesting as an abdominal lump with or without signs of obstruction. In view of the non-specific symptoms, a small bowel series rather than a barium enema is often the initial radiological examination. In spite of the rarity of this lesion in adults, we were prompted to make a preoperative diagnosis of lymphoma in our patient in view of the association of a lymph node mass with the intussusception.

Complete surgical excision with chemotherapy using two or more cytotoxic drugs produces best results in these patients.

References

Trichobezoar: A Rare Cause of Gastric Perforation

Sir,

Patients with bezoars may be asymptomatic or have mild upper gastrointestinal symptoms. Complications reported with bezoars include intestinal obstruction,
ulceration, hemorrhage, gastric perforation and obstructive jaundice. Although we have operated on ten cases with gastric trichobezoar in the last 20 years, this was the only case with associated gastric perforation.

J S, a 15 year old male, was admitted with complaints of pain in the abdomen and high fever for five days and absolute constipation for two days. The pain started suddenly in the epigastrium and later became diffuse all over the abdomen. There was no history of vomiting or gastrointestinal bleeding nor in the past. On examination, he was poorly built and nourished, with pulse 120/min, BP 120/70 mmHg and respiratory rate 36/min. His abdomen was distended, with boardlike rigidity and tenderness all over, and was silent on auscultation. The chest and cardiovascular system were essentially normal.

Investigations: Hemoglobin 13.0 g/dl; WBC 13,000/mm; blood urea 60 mg/dl; random blood sugar 110 mg/dl. Plain X-ray abdomen revealed multiple dilated loops of bowel with air-fluid levels and pseudopeptic ulcer. He was diagnosed to have perforation due to hollow viscus perforation and was prepared for emergency surgery.

At laparotomy, he was found to have generalised peritonitis, with two litres of sero-purulent fluid in the peritoneal cavity and flanks all over. There was an oval perforation 8 mm x 6 mm in the body of the stomach anteriorly. There was a hard intragastric foreign body which could be moved only along the long axis of the stomach. A strand of hair was removed through the perforation. A gastroscopy incision encircling the perforation was made and a trichobezoar measuring 15 cm x 10 cm x 8 cm was removed. The gastric muscosa had multiple ulcers. The stomach was washed and the gastroscopy incision closed in two layers. The abdomen was closed after a thorough peritoneal lavage. The patient recovered uneventfully. Histopathology of the gastric perforation revealed chronic granulomatous tissue. A psychiatric evaluation revealed mild mental subnormality. Endoscopy performed five months later revealed normal stomach and the patient is asymptomatic.

Gastric perforation due to trichobezoar is an extremely uncommon complication. Mechanical irritation of the gastric mucosa in association with peptic gastritis due to the trichobezoar leads to gastric ulceration, which has been observed in 9-6% of the patients. Removal of the trichobezoar results in healing of these ulcers. However, the presence of bezoar for a long period may lead to progression of the ulcer to perforation. Our patient did complain of epigastric pain for four years. A similar case of gastric perforation due to trichobezoar in a mentally retarded child has been reported earlier.

History of trichophagy is often not forthcoming in these patients. Our present patient, and eight of our previous ten patients, denied any such history. However his subnormal mental status may have been responsible for trichophagy.

References

Villous Adenoma of Duodenum

Sir,

We report a case with villous adenoma of the duodenum. These tumors are uncommon; only about 55 cases have been reported in the world literature.

A 35 year old female patient presented with two months' history of vague upper abdominal pain. She had been having vomiting off and on for one month. There was no history of hematemesis or melena. Physical examination was unremarkable. An upper gastrointestinal examination with barium (Fig) showed a polypoid tumor in the first and second parts of the duodenum. The tumor had a soap-bubble appearance with smooth margins. Endoscopy showed a papilliferous tumor and biopsy revealed this to be a villous adenoma. At surgery, the tumor was resected completely. Histopathological evaluation showed no evidence of malignancy. The patient made an uneventful recovery.

Relative to their length, the duodenum and the proximal jejunum account for the largest number of tumors (benign or malignant) of the small bowel. Benign tumors of the duodenum comprise 15% to 42%

Fig: Spot film showing well-defined soap-bubble mass (arrows) occupying the first and second portions of the duodenum.