Large Brunneroma presenting with bleeding

GAJANAN D WAGHOLIKAR, SADHANA DHINGRA,* NARENDRA KRISHNANI,* VINAY K KAPOOR

Departments of Surgical Gastroenterology and *Pathology, Sanjay Gandhi Postgraduate Institute of Medical Sciences, Raebareli Road, Lucknow 226 014

Brunner’s gland adenoma (Brunneroma) is a rare entity. We report a patient who presented with severe anemia due to bleed from a large Brunneroma arising from the duodenal bulb, and was managed successfully by surgical excision of the tumor. [Indian J Gastroenterol 2002;21:201-202]

Key words: Brunner’s gland hyperplasia, duodenal polyp

Brunner’s gland adenoma (Brunneroma) is a rare entity. We report a patient with a large Brunneroma who presented with melena and severe anemia due to bleeding from the tumor.

A 35-year-old man presented with a 3-month history of intermittent episodes of melena. There was no history of hematemesis or any history suggestive of acid-peptic disease, portal hypertension or intake of NSAID. There were no significant findings on clinical examination apart from severe pallor. Laboratory investigations revealed severe anemia with hemoglobin of 6 g/dL and hematocrit of 20%. Other hemotological and biochemical investigations were within normal limits. Upper gastrointestinal endoscopy revealed a large polyp in the duodenal bulb projecting into the second part of the duodenum with hyperemic and friable overlying mucosa. As the stalk was quite broad, endoscopic polypectomy was not possible.

At surgery, after preparative transfusion of two units of blood, there was a large polypoidal lesion arising from the duodenal bulb and extending into the second part of the duodenum. After Kocherizing the duodenum an inferior duodenotomy was made over the superior duodenal flexure and a large reddish brown polyp, 5 cm x 4 cm in size with a 2 cm wide stalk, was delivered out. Excision was done after transfixing the base and duodenotomy closed in two layers. A nasojejunal tube was placed at surgery to initiate early enteral alimentation. The postoperative period was uneventful. Histology of the resected polyp showed Brunner’s gland adenoma (Fig).

Brunner’s glands are acinar tubular mucus-secreting glands in the submucosa of the duodenum. These glands are more numerous in the juxtapyloric part of the duodenum; distally they decrease in size and number until they disappear around the duodeno-jejunal flexure. Their alkaline secretion buffers the acidic gastric contents entering the duodenum.1 Recently they have been shown to synthesize the polypeptide hormone urogastrone which
Rectal botryomycosis mimicking carcinoma

SHUBHA N. RAO, KALPANA SRIDHAR, RAMCHANDRA PAI, ARTHI RAO

Departments of Surgery and Pathology, K M C, Mangalore

Botryomycosis is a granulomatous disease that was first recognized in horses. The lesion is infective with fungus-like grains similar to the sulfur granules in actinomycosis. We report a 54-year-old woman with a strong suspicion of rectal carcinoma that turned out to be rectal botryomycosis. She responded to erythromycin. [Indian J Gastroenterol 2002;21:202-203]

Key words: Actinomyces, rectum cancer

Human botryomycosis is usually a localized granulomatous infection of the skin or mucous membrane. We report a woman with rectal botryomycosis that was suspected to be malignancy.

A 54-year-old woman presented with left-sided lower abdominal pain since 1 year. There was no history of vomiting, constipation, or bleeding per rectum. She gave no history of loss of weight or of appetite. Her past medical history was not significant. On physical examination, there was a hard mass in the left iliac fossa. Per rectal examination revealed an annular growth 6-7 cm from the anal verge.

Ultrasonography revealed wall thickening in the rectal region with diverticulum of the urinary bladder. CT scan revealed circumferential thickening of the rectal wall with infiltration of adjacent fat, the left pelvic wall, and abdominal wall muscles, suggestive of stage III-B rectal carcinoma. Carcinoembryonic antigen and CA 125 levels were within normal limits. Percutaneous FNAC as well as biopsy showed no tumor cells. Colonoscopy showed extrinsic compression at 10 cm and 44 cm. Colonoscopic biopsy did not show any tumor cells. HIV serology was negative.

At laparotomy, a tumor was found to arise from the pelvis, adherent to the omentum and pelvic wall; the organ of origin could not be ascertained. Multiple biopsies were taken. The mass consisted of multiple abscesses, some with organizing granulations. The patient was treated with antibiotics, and the mass resolved.

References

Correspondence to: Dr Kapoor, Professor and Head. Fax: (522) 44 0017, 44 0973. E-mail: vkkapoorn@sngpl.ac.in
Received January 28, 2002. Accepted February 10, 2002