sponded to steroid therapy. [Indian J Gastroenterol 2003;22:192-193]

Key words: Thrombocytopenia, viral hepatitis

Hematologic manifestations following hepatitis B and C virus infections are commonly reported in literature. But the association of hepatitis A virus and thrombocytopenia has been described rarely. Most of the cases have been reported in adults and older children. Immune thrombocytopenic purpura, to our knowledge, has not been reported in children less than 5 years.

A 4½-year-old girl was brought with hematuria, hematemesis and skin bleed. She did not have fever or any other illness prior to the onset of these bleeding manifestations. On examination she was pale, mildly icteric, and had purpuric rash all over the body and subconjunctival hemorrhage. There was no lymphadenopathy. Abdominal examination revealed mild hepatomegaly; spleen was not palpable and there was no ascites. Rest of the systemic examination including fundoscopy was normal.

Investigations: hemoglobin 10 g/dL, white cell count 6,500/ mm³ (N 62%, L 38%), and platelet count 5,000/mm³. Serum bilirubin 4.0 mg/dL (direct 2.6), total protein 7.0 g/dL (albumin 3.7), AST 2070 U/L, ALT 2150 U/L, alkaline phosphatase 299 U/L. Prothrombin time, partial thromboplastin time and serum creatinine were normal. Bone marrow aspiration showed increased number of megakaryocytes, consistent with peripheral platelet destruction. Serologic studies were positive for anti-HAV IgM antibodies and negative for viral hepatitis B, C, E and HIV. dsDNA and complement levels were normal.

Serial monitoring of platelet count revealed falling platelet counts and hemoglobin. Since she was symptomatic she received pulse doses of dexamethasone 0.8 mg/Kg/day for 4 days, after which she was discharged on oral prednisolone 1 mg/Kg/day in divided doses. Her platelet count after 4 days of dexamethasone was 70,000/mm³. She was followed up after 4 weeks and after 3 months. Her platelet counts were normal and she did not have any bleeding or jaundice clinically.

Extrahepatic immune manifestations are rare with hepatitis A virus infection although it is commonly associated with hepatitis B virus infection. Hematological manifestations in hepatitis A can be severe, independent of the severity of liver damage. Thrombocytopenia can follow 6 weeks after an attack of jaundice or rarely as initial presentation.

Several mechanisms have been postulated for the development of thrombocytopenia, which include bone marrow depression, hypersplenism secondary to splenomegaly, disseminated intravascular coagulation, and a liver regulating factor that depresses platelet release. Some patients undergo spontaneous resolution; if not, corticosteroid therapy can be given.

References

Association of ulcerative colitis with pulmonary sarcoidosis, subcutaneous lipomatosis and appendiceal adenocarcinoma

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We report a 52-year-old man with left-sided ulcerative colitis for 5 years and pulmonary sarcoidosis diagnosed 3 years back. He presented with subcutaneous lipomatosis and a right iliac fossa mass, which was diagnosed histologically as appendiceal adenocarcinoma. He was treated with right hemicolectomy, followed by chemotherapy. [Indian J Gastroenterol 2003;22:192-94]

Key words: Appendix, idiopathic ulcerative colitis

Primary appendiceal adenocarcinoma developing in a patient with left-sided idiopathic ulcerative colitis (IUC) is rare. Its association with pulmonary sarcoidosis and subcutaneous lipomatosis has not been reported in English literature.

A 53-year-old man presented with low to moderate fever associated with chills for two months, weight loss of 8 Kg, and a palpable mass in the right iliac fossa for three weeks. He had been diagnosed to have IUC for the last 5 years, and was on mesalamine. He had one or two relapses every year, and these were controlled with short courses of prednisolone. Two years later, he developed cough and breathlessness on exertion. Chest X-ray revealed nodular-reticular shadows in both lung fields, with hilar and mediastinal lymphadenopathy. Transbronchial lung biopsy showed non-caseating epithelioid cell granuloma with Langhan's type of giant cells, which was negative for acid-fast bacilli. A diagnosis of pulmonary sarcoidosis was made, and he was treated with 40 mg of prednisolone per day. He became asymptomatic by the fourth week. Prednisolone dose was subsequently tapered off. There has been no recurrence of
the pulmonary problem.

On examination, he had pallor. He also had multiple soft subcutaneous swellings measuring 7 mm to 12 mm, which were confirmed to be lipomas on biopsy. The right iliac fossa mass measured 8 cm x 8 cm; it was firm on palpation with irregular surface and fixed to the posterior iliac fossa wall. Colonoscopy showed granularity, friability and scattered small ulcers involving the rectum, sigmoid and descending colon. Transverse and ascending colon appeared normal. The cecum showed unhealthy mucosa with indentations around the ileocecal valve. Microscopy revealed features of chronic active IUC in the rectum, sigmoid and descending colon; ascending colon and hepatic flexure showed mild increase in chronic inflammatory cells in the lamina propria. Biopsy from the indurated cecal mucosa showed features of adenocarcinoma.

Ultrasoundography showed a 6 cm x 5 cm ill-defined, heterogeneous, lobulated, hypochoic mass in the right iliac fossa. Contrast-enhanced CT scan showed a soft tissue mass medial to the cecum and ascending colon (Fig). Barium enema showed changes suggestive of left-sided IUC up to the splenic flexure. Barium meal follow-through demonstrated the mass producing an eccentric impression on the cecum, displacing adjacent small bowel loops and ascending colon.

With a pre-operative diagnosis of carcinoma cecum, right-sided hemicolectomy was done. On the serosal aspect of the cecum, corresponding to the area of the appendix, there was a large multi-lobulated tumor measuring 6 cm x 5 cm x 3 cm and protruding into the cecum as a nodule measuring 15 mm in diameter with a small central pit. Serial slicing revealed a whitish nodular tumor having a narrow base, 2 cm long, adhering to and infiltrating surrounding soft tissue, terminal ileum and ileocecal junction. The mass appeared to have replaced the appendix completely. Microscopy showed features of well-differentiated adenocarcinoma with focal mucin production. Heavy chronic inflammatory cell response was noted in the background. There was infiltration of the cecal wall, terminal ileum and ileocecal junction, with extension to periosteal fat. Surrounding cecal mucosa did not show any evidence of colitis. Nine lymph nodes dissected from the paracolic area were free of tumor.

Postoperatively, he received 6 cycles of chemotherapy comprising cisplatin, oxalaplatin and 5-fluorouracil. Follow-up ultrasonography was normal. Colonoscopy showed healthy anastomotic site. Nine months later, he is doing well. Other family members of this patient do not have any of the above diseases.

There are a few case reports of primary appendiceal adenocarcinoma arising in a patient with IUC. In most of the reported cases, the appendix showed features of involvement by ulcerative colitis and malignancy. Similar to the present case, Kashani et al. reported a patient with left-sided ulcerative colitis with a mass in the right iliac fossa, which on resection showed primary appendiceal adenocarcinoma with bilateral Krukenberg metastases to the ovaries. In the present case, the tumor possibly had involved the whole length of the appendix. Hence involvement of the appendix by ulcerative colitis could not be commented on, though there was heavy inflammatory cell infiltration. Other studies have reported appendiceal involvement as skip lesion in left-sided IUC.

The association of IUC with sarcoidosis and other autoimmune disease conditions has been reported in a few cases. This association has been explained on the basis of HLA-linked genetic susceptibility. Association of IUC and appendiceal adenocarcinoma with subcutaneous lipomatosis has not been reported before.

References

Fig: Contrast-enhanced CT scan showing soft-tissue lesion located medial to ascending colon and anterior to ureter.

Torsion of the greater omentum with inguinal hernia

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Torsion of the greater omentum is an uncommon...