and had gained 12 kg weight.

CASE 2

Another patient 69 years old woman had repeated abdominal pain and lower gastrointestinal bleeding for one and half year. She was anemic (Hb 4g %) and had lost 8 Kg weight. Angiography showed an occlusion of SMA and formation of a huge Riolan's arch. During surgery, intestinal wall was found thin like layers of paper in some areas, light of colonoscopic illumination could easily be seen from the lumen of thin layer intestine. After aorto-SMA bypass, the SMA pulsation could be felt and seen. Postoperative recovery was uneventful. She became asymptomatic, gained 5 Kg weight. Hemoglobin rose to 10G% at 4 weeks and was discharged.

DISCUSSION & CONCLUSION

Arterial insufficiency or ischemia produces the target tissue or organ hypoplasia even necrosis as in our case of mesenteric insufficiency and remarkable hypoplesia of the intestinal wall[1].

The variable vessels involved. Location of bowel affected, and different levels of acuity of illness all result in multiple possible presentations. The detection of such a serious condition can be a diagnostic and therapeutic dilemma[2]. The varied presentation seen in the two cases where in one had hypoplasia and the other had hyperplasia is rather perplexing. Could this be related to the rapidity of onset, duration and degree of ischemia? Could it be that different layers or parts of layers of intestine behave differently to ischemic insult?

Embolic occlusion of the superior mesenteric artery occurs in more than half of all cases[3]. Most emboli originate in the heart and are potentiated by cardiac arrhythmias or depressed systolic function due to ishaemic heart disease. In our case, unnecessary delay increased morbidity of the patient though this patient was lucky to have uneventful recovery after surgery.

Mesenteric ischemia most often results from SMA embolization or thrombosis, and less commonly, venous occlusion or nonocclusive process. Remobilization of the SMA accounts for nearly 50% cases, with thrombosis responsible for another 25% of cases[4, 5]. In our case, perhaps atrial emboli were responsible.

Conservative treatment with thrombolytic therapy did not help our patient. In fact, unnecessary delay could have jeopardized patient's survival. In most cases, as in our both cases surgical exploration was emergently performed to restore intestinal arterial flow and resect irreparably damaged bowel. Very thin ischemic bowel in second case is in contrast to the first case where ischemic bowel segment was remarkably thickened or hypertrophied with smooth and normal serosa without any other lesions. We fail to understand as to why is two cases where same etiology of mesenteric ischemia could lead to different pathological processes?

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Case Report

Ileal Carcinoid Tumor mimicking Carcinoma Cecum.

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Abstract*: We report a 28-year old female admitted to the surgical ward with pain and lump in right lower abdomen; on careful examination and inhertigation a presumptive diagnosis of carcinoma caecum was made. A standard right hemicolectomy was done. However, the histopathological report demonstrated carcinoid tumor in the ileum with free resection margins. Immunohistochemistery confirmed the diagnosis of carcinoid tumor ileum.* ***Keywords:*** *Carcinoid tumors, carcinoid syndrome, 5HIAA.*

INTRODUCTION

Historically, the term carcinoid was first coined by Oberndorfer in 1907[1]. The prevalence of carcinoid tumors is expected to be around 0.5 per 100,000, although autopsy studies suggest that it may be as high as 2 per 100,000[2]. In the great majority of cases, carcinoids remain silent. Symptomatic carcinoids declare either through their mass effect (pain, luminal obstruction) or secretary products. Carcinoid syndrome consists of a constellation of symptoms which arise as a result of massive release of serotonin and neuropeptides directly into the systemic system[3]. It has been observed that patients with carcinoids have an increased risk of developing secondary neoplasms[4]. Urinary 5-HIAA measured in a 24-hour urine sample is the most frequently applied test in the endocrine work-up of the carcinoid tumors[5]. Chromogranin A, a glycoprotein secreted y the neuroendocrine cells, has 80% sensitivity to carcinoids and serves as a valuable marker in the early detection of recurrences and during follow-up after the primary treatment[6]. Carcinoids frustrate the physicians by the complex symptoms and varied biochemical affections and demand a high index of suspicion. Surgery is the treatment of choice for such lesions, and patients should be follow-up with serial urinary 5-HIAA assays and somatostatin receptor imaging, where available.

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CASE REPORT

A 28-year old female presented to the surgery OPD of Rajindra hospital, Patiala, with pain and lump in the right lower abdomen of 15 days duration. Pain was of moderate intensity, off and on and aggravated after meals. Patient's examination revealed a mass in the right iliac fossa of approximate size of 10 X 10cm. it was nontender, mobile, firm. Non ballotable, with irregular surface and was dull on percussion. Routine blood investigations and abdominal X-rays (erect and supine) were unremarkable. An abdominal/pelvic ultrasounds showed around 180 ml fluid collection in the right iliac fossa, and reported this as appendicular abscess. Ct scan showed a neoplastic mass 8X7.7 cm in size, irregularly marginated, involving ileocaecal junction, cecum and the proximal ascending colon causing luminal narrowing, along with some small areas of necrosis within this. In ultrasound and CT liver was normal; there were no secondaries in liver. Barium enema showed a large filling defect in proximal ascending colon and caecum with mucosal irregularities and this was also reported as growth in the cecum. Operative findings demonstrated a big mass in the cecum. A standard right hemicolectomy was done with removal of 15 cm distal ileum, and an ileotransverse was done. Postoperative period was uneventful.

The histopathology reported carcinoid tumor in the ileum. There was no penetration of the muscular or serosal layer and the resection margins were free of tumor. On immunohistochemisttry, the tumor cells were positive for neuron specific enolase and focally positive for chromogranin, confirming the diagnosis of carcinoid tumor of ileum. The patient was planned to be regularly reviewed in the surgical clinic every 6 months for 3 years with urinary 5-HIAA assays.

DISCUSSION

In the present case there was no feature suggesting carcinoid syndrome. The presentation was with a palpable mass in the right iliac fossa along with CT (Fig-1) and barium finding suggesting the same; it was considered to be like a classical case of carcinoma cecum. Accordingly a right hemicolectomy was carried out. Even the gross specimen of Rt. Hemicolectomy (Fig.2) suggested a cecal tumor. Only on cut section (fig.3) it was found that there was no tumor in the lumens of

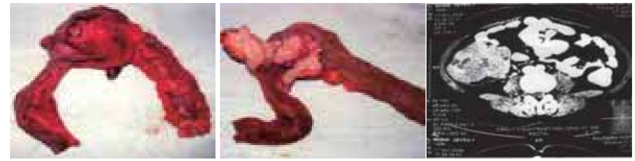

Fig.1 Gross specimen of right hemicolectomy of patient showing big mass in cecum *Fig.2 Cut section of specimen showing ileal carcinoid encroaching the cecal lumen* *Fig.3 CT abdomen of the pt showing cecal mass*

cecum although the lumen was being encroached upon by the big tumour which was actually in the terminal ileum. Histopathology and immunohistochemistery subsequently confirmed this to be carcinoid tumor.

On as exhaustive search of literature about ileal carcinoid clinically mimicking a carcinoma of the cecum, we could not find a single such reference. Hence it was considered fit for this case to be reported for its rare presentation. To conclude it is suggested that ileal carcinoid should also be kept in mind while evaluating a right iliac fossa mass, and should be considered in the differential diagnosis of cecal carcinoma as management is entirely different for both.

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Case Report

Rifampicin Induced Thrombocytopenia:A Case Report.

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Abstract: *Rifampicin is an essential drug in the treatment regimen for tuberculosis. It is generally well tolerated. But very rarely it can cause serious adverse reactions in the form of acute renal failure and thrombocytopenia. A case of acute thrombocytopenia occurring in a patient on Rifampicin for the treatment of pulmonary tuberculosis is being reported here.*

INTRODUCTION

Rifampicin is a crucial drug as well as essential component of the treatment regimen for tuberculosis. Apart from minor adverse effects in the form of nausea, vomiting and rash, very rarely it may cause life threatening side effects like acute renal failure and thrombocytopenia[1, 2].

The first case of Rifampicin induced thrombocytopenia was reported

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