She had had total colectomy and ileostomy 8 years previously for ulcerative colitis. She had had her ileostomy refashioned 3 times for parastomal hernia, parastomal abscess and retraction.

Several unsuccessful attempts were made to reduce the 'prolapse' of her ileostomy. Examination under anaesthesia revealed proximal ileum intussuscepting through the stoma. The intussusceptum was about 15 cm from the most distal part of the ileostomy spout. The ileum was slightly congested with no other pathology. Retrograde reduction was unsuccessful and laparotomy was carried out.

At laparotomy it was noticed that there was herniation of one wall of the ileum through a defect in the abdominal wall next to the stoma. This part of the ileum went on to prolapse through the spout and was followed by more ileum to form the intussusception. Reduction was achieved by gentle traction, the lateral space to the stoma was closed and the ileum was attached to the anterior abdominal wall with absorbable sutures. She was managed post-operatively on ritodrine hydrochloride, a myometrial relaxant.

She went into labour at 35 weeks gestation and had emergency lower segment Caesarian section for fetal distress. Both babies were normal.

A case of intussusception in ileostomy in a pregnant woman has been described by Priest et al. and in a patient with loop colostomy by Keane and Whittaker. In both cases and in the case presented above, there were no aetiological factors and the patients all survived. Diagnosis is easily confused with prolapse, which is easily reducible and for which local revision is usually adequate. Surgical management was different in the 3 cases. In the case described by Priest et al., the patient was managed by revision of her ileostomy and in the case of Keane and Whittaker, by resection and refashioning of the colostomy.

Intussusception as a complication of stomata is not described in textbooks and should be considered if an apparent prolapse proves difficult to reduce or manage locally.

Olufunso Adedeji
W.A.F. McAdam
Department of General Surgery,
Airedale General Hospital,
Skipton Road,
Keighley BD20 6TD,
West Yorkshire, UK.

Gastric leiomyoma: an unusual presentation

Sir,

Leiomyoma is the commonest benign tumour of the stomach found at autopsy. Clinically significant gastric leiomyomas are rare. We report the case of an elderly patient in whom an extraluminal gastric leiomyoma presented with symptoms and signs suggestive of large bowel pathology.

An 84 year old woman presented with a 3 month history of left-sided abdominal pain and altered bowel habit, principally increasing constipation. General examination was normal with, however, suspicion of a palpable upper descending colon. Haematological and biochemical investigations were normal and a barium enema demonstrated only mild diverticular disease of the sigmoid colon. She was commenced on mebeverine and discharged from further review.

She was re-referred 3 months later on account of persistence of the abdominal pain and constipation, accompanied now by a new symptom of anorexia. She had lost 3 kg in weight, and a definite mass was now palpable in the left hypochondrium. Flexible sigmoidoscopy to 50 cm was normal as was a repeat barium enema which again showed only mild sigmoid diverticulosis. Abdominal ultrasound confirmed a left hypochondrial mass (8 cm in diameter), consistent with a tumour arising from either the stomach or pancreas. Both barium meal and upper gastrointestinal endoscopy showed the posterior wall of the stomach to be deformed by extrinsic compression.

An abdominal CT scan demonstrated the mass to be arising from the posterior wall of the stomach. Biopsy under CT guidance yielded only small fragments of tissue from which histology was initially reported as being consistent with a nerve sheath tumour. Laparotomy revealed a large spherical extraluminal tumour (10 × 10 cm across) attached by a narrow pedicle to the posterior gastric wall; histology showed a benign gastric leiomyoma. Two months later she was asymptomatic and had gained over 4 kg in weight.

We could not find a published case similar to ours of an elderly patient with a gastric leiomyoma presenting in such a manner. Anorexia and weight loss are usually early rather than late presenting symptoms, and abdominal pain is more a feature of intestinal than gastric tumours. Our patient's initial palpable 'fullness' must have been the leiomyoma in its early stage, and compression of her left hemicolon most likely explains her altered bowel habit. Although double-contrast barium meal has been the 'gold standard' for many years in the diagnosis of gastric leiomyoma, the value of abdominal CT is now well established, especially in cases of extraluminal extension of tumour.

Gastric leiomyoma is worth considering in the differential diagnosis of unexplained abdominal pain, altered bowel habit and a left hypochondrial mass in an elderly patient, as early diagnosis can lead to a successful clinical outcome.

I. Gillanders
M. Lafferty
B. Danesh
Department of Geriatric Medicine and
The Gastroenterology Unit,
Stobhill General Hospital,
133 Balornock Road,
Glasgow, G21 3UW, UK.

References
References


Fatal cardiac failure after a single dose of doxorubicin in myeloma-associated cardiac amyloidosis

Sir,

While the cardiotoxic effects of cumulative doses of doxorubicin are well recognized,1,2 the potential that this drug has for causing acute cardiac dysfunction is less well recognized. This is likely to be particularly important where there is pre-existing cardiac disease. We report a case where exposure to a single dose of doxorubicin resulted in fatal deterioration in cardiac function.

A 53 year old male presented with nephrotic syndrome and was found to have lambda light chain myeloma. Renal biopsy showed amyloid. Before treatment was started he developed acute pancreatitis which was complicated by renal impairment and severe fluid overload, with radiological evidence of pulmonary oedema. At this time blood pressure was 90/60 mmHg; electrocardiography showed low voltage complexes. Calculated echocardiographic ejection fraction was 47%; there was evidence of septal thickening (1.9 cm) but no chamber dilatation and no evidence of valvular disease or tamponade. Machine haemofiltration was instituted with correction of fluid overload and good biochemical control: there was no cardiovascular instability despite fluid removal of up to 3 kg per treatment. Five days later, treatment with doxorubicin 9 mg/m2, vincristine 0.4 mg, and methylprednisolone 1 g/m2 was given. Twenty-four hours after the initial dose he became hypotensive (70/50 mmHg) despite adequate filling pressures. Thermoludation cardiac output was 5.5 l/min despite treatment with dobutamine 28 µg/kg/min. Despite addition of adrenaline, dopamine, and enoximone there was continued haemodynamic deterioration and cardiac arrest occurred 4 h after transfer. At post mortem there was extensive amyloidosis involving the liver, spleen, kidneys and heart. The coronary arteries were patent and there was no evidence of infarction.

There are 3 previously published cases of fatal cardiac failure after low dose anthracycline administration; one case of fatal cardiac failure without evidence of coronary disease after 3 x 70 mg/m2 daunorubicin (total dose 420 mg),3 and 2 cases of fatal cardiac failure following 50 mg and 80 mg; one of these patients had pre-existing coronary disease.4 In addition, there is one report of non-fatal myocardial infarction following each of 2 doses of doxorubicin5 although this is not the usual mechanism of anthracycline cardiotoxicity. In the present case there was no evidence of ischaemic heart disease or sepsis and the patient was stable although hypotensive until the drug was administered. We conclude that doxorubicin toxicity, superimposed on pre-existing cardiac impairment caused by amyloidosis, was responsible for the patient's death. Caution is required in the administration of anthracyclines to patients where there is pre-existing myocardial disease. This has particular relevance to myeloma, where, as in this case, cardiac amyloid is a potential complication.

Acknowledgements

We thank Dr J. Feehally and Professor J. Walls for their permission to report on the clinical findings and Dr J. Mercer for her permission to report on the post mortem findings.

M.A.B. Devoy
C.R.V. Tomson
Department of Nephrology,
Leicester General Hospital,
Gwendolen Road,
Leicester, LE5 4PW, UK.

References


Intra-operative bumetanide in cadaveric renal transplants

Sir,

In cadaveric renal transplants, one aims to achieve primary function with diuresis on restoring the circulation, to make post-operative management much easier and obviate the need for dialysis. According to our protocol, a central venous pressure (CVP) line is placed in each recipient and intra-operatively they receive cyclosporine A infusion (2.5 mg/kg), methylprednisolone (15 mg/kg) and 100 ml of 10% mannitol. CVP is maintained between 10 – 15 cm of water. Following the revascularization of the graft, we hope to see diuresis within 5 – 10 min. If this does not occur, we have been encouraged by the use of intravenous bumetanide (2 mg) as a bolus. This has resulted in immediate diuresis and continued primary function of the graft in 6 patients.

Bumetanide is a potent 'high-ceiling' diuretic with a number of features which make it desirable for use in renal transplant patients. After intravenous injection, the diuresis starts within a few minutes with sharp peak and short duration of action.1,2 The principal site of action is the thick ascending limb of Henle's loop where it inhibits the active reabsorption of Na+ and Cl—. There is evidence to suggest that it also has minor action at the proximal tubules via carbonic anhydrase inhibition. Bumetanide enhances glomerular filtration rate and renal plasma flow.

group.bmj.com on June 20, 2017 - Published by http://pmj.bmj.com/
Gastric leiomyoma: an unusual presentation.

I. Gillanders, M. Lafferty and B. Danesh

doi: 10.1136/pgmj.68.795.68

Updated information and services can be found at:
http://pmj.bmj.com/content/68/795/68.citation

These include:

**Email alerting service**
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/