Letters to the Editor

Massive gastric dilatation and acute pancreatitis – a case of the ‘Ramadan syndrome’?

Sir,

The association of acute pancreatitis and massive gastric dilatation has previously been reported in this journal^{1,2} and elsewhere.³ A further case is described here.

A 14 year old Muslim boy presented with a 24 hour history of epigastric pain, vomiting and progressive abdominal distension developing 5 hours after breaking the traditional Ramadan fast. On examination he was dehydrated and tachycardic (120 per minute) with marked abdominal distension but no signs of peritonism. A supine abdominal X-ray showed gross gastric dilatation. Routine blood tests revealed an amylase of 751 IU/l, an elevated urea 14.2 mmol/l and hypokalaemia (2.8 mmol/l). Despite initial management with nasogastric aspiration and intravenous fluids, the patient’s condition deteriorated with development of hypovolaemic shock. His abdomen became rigid with absent bowel sounds and a repeat film showed progression of gastric dilatation. Amylase had risen to 2,428 IU/l.

Following resuscitation, laparotomy was performed as a perforated viscus could not be excluded. An enormously dilated stomach was confirmed, but in addition oedema of the pancreas and retroperitoneal tissues was evident. A gastrostomy was fashioned. The patient required total parenteral nutrition postoperatively but otherwise made a complete and uneventful recovery.

Although the association of acute pancreatitis with massive gastric dilatation is well recognized, the aetiological mechanism remains obscure. The case reported here is similar to others^{1–3} and the primary diagnosis appears to be acute gastric dilatation with secondary pancreatitis. The former may mask diagnosis of the latter, which of itself requires vigorous early management to avoid complications. Fluid sequestration and reduction in plasma volume is common in acute pancreatitis and, when this condition co-exists with gastric dilatation, such potential hypovolaemia is exacerbated by fluid sequestration in the dilated stomach.²

Whatever the precise physiological mechanism(s) involved, reflux of duodenal contents up the pancreatic duct is the most likely mechanism for initiation of pancreatitis secondary to gastric dilatation associated with a rise in intraduodenal pressure.⁴ Such a rise could result from gastric dilatation with duodenal ileus. Alternatively pancreatitis *per se* could result from direct stimulation of the pancreas by the presence of food in the stomach via release of cholecystokinin–pancreozymin (CCK-PZ).⁵

Two of these recorded cases have been described in patients with anorexia nervosa and refeeding appears to trigger the condition. A parallel may therefore be drawn between anorexia nervosa and the food restriction which is customary in Ramadan (variable period of food deprivation – from dawn to dusk over a month in a lunar calendar). Gastric dilatation may occur as a response of the stomach to food intake following a period of deprivation, perhaps mediated via a gastrointestinal hormone. This association is important clinically as fluid replace-

ment and efficient nasogastric aspiration must be initiated early if laparotomy is to be avoided.

The simultaneous occurrence of acute pancreatitis and massive gastric dilatation under circumstances of food restriction followed by refeeding could perhaps appropriately be called ‘Ramadan syndrome’, a term familiar to clinicians in Muslim societies but scantily documented in the literature.

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Urinary bladder carcinoma initially manifested as brain metastases

Sir,

Angulo *et al.* have recently reported two cases of bladder carcinoma, the clinical presentation of which was due to brain metastases.¹ We describe a further patient with transitional cell carcinoma of the bladder who presented with ophthalmoplegia and diabetes insipidus due to pituitary fossa involvement by secondary tumour. This brings to four the number of reported cases of primary bladder carcinoma presenting with neurological symptoms caused by brain metastases.^{1,2}

A 45 year old woman presented with a 4 week history of headache and right-sided facial numbness and a 2 day history of polyuria, polydypsia and dysuria. Multiple right-sided cranial nerve palsies (III, V, VI, VII and XII) and a left pelvic mass were detected on clinical examination. Examination of the urine revealed red blood cells and a significant growth of *Escherichia coli*. Cranial computerized tomography demonstrated a lesion in the sella turcica with erosion of the right sphenoid bone. Ultrasound of the pelvis indicated a mass in the region of the right ovary. The patient was deemed unfit for

diagnostic laparotomy and an empirical trial of BEP (Bleomycin, VP16, Cisplatinum) chemotherapy was commenced. She subsequently developed pancytopenia at which time a bone marrow examination revealed focal infiltration by malignant epithelial cells. After an initial improvement the patient died.

At necropsy the pituitary fossa was extensively infiltrated by tumour with erosion of the right sphenoid bone and extension into the right orbit. The bladder was markedly thickened by tumour with diffuse mucosal ulceration and an intact serosal surface. No other primary neoplasm was identified. Microscopy of the bladder tumour and of the pituitary infiltrate showed a poorly differentiated transitional cell carcinoma with focal squamous differentiation.

This is the first reported case, to our knowledge, of a patient with transitional cell carcinoma of the bladder whose clinical presentation was due to pituitary fossa involvement by secondary tumour. Metastatic disease of the pituitary fossa usually develops late in the course of disseminated malignancy.³ Previously reported cases of pituitary involvement by bladder carcinoma were incidental findings at autopsy.⁴

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Bilateral tubercular psoas abscess mimicking bilateral hydronephrosis – the role of computerized tomography in the management

Sir,

A 16 year old boy presented with gradually increasing kyphosis since childhood, pain in the right flank, decreased urine output and intermittent swelling of feet, face and abdomen of 6 months duration. On examination he had kyphoscoliosis, pectus excavatum and palpable masses in both flanks. Intravenous urogram did not show functioning kidneys even in delayed films. Abdominal ultrasonography showed fluid-filled spaces in the renal fossa and a diagnosis of bilateral hydronephrosis due to ureteropelvic junction obstruction was suggested. Ultrasound-guided needle aspiration yielded creamy pus from both cavities and a pigtail catheter was left for drainage. The smear examination and culture of the pus

was positive for *Mycobacterium tuberculosis*. The dye study done subsequently through the catheter gave an impression that the catheter was extra renal in a psoas abscess. Computed tomography then demonstrated bilateral psoas abscesses, destruction of vertebral bodies, with the presence of normal functioning but displaced kidneys on both sides.

A total of 1000 ml of pus was drained from the right side and 750 ml from the left. Therapy for tuberculosis was given for 9 months and the patient has made an uneventful recovery with complete resolution of both psoas collections and the kidneys returning to their normal positions.

It is well known that spinal disease may present with abdominal symptoms but review of urological, radiological and orthopaedic literature emphasizes the rarity, delayed presentation, diagnostic difficulty, and non-specific radiological features of tubercular psoas abscess and late diagnosis of all forms of tuberculosis especially spinal tuberculosis.^{1,2}

Improved methods of visualizing the anatomy and pathology of the retroperitoneum and the psoas muscle now exist with the development of ultrasonography. Still one can wrongly diagnose a psoas abscesses as bilateral hydronephrosis, if one does not specifically look for the kidneys when they no longer remain in their normal positions and are displaced by the fluid collection, as happened in our case. The complementary use of computed tomography with its exquisite organ specificity and the advantage of density discrimination helps to clinch the diagnosis early and resolve the confusion. Recent reports document the successful treatment of psoas abscesses by percutaneous drainage which seems to be preferable to formal surgical drainage.³

We conclude that there should be heightened clinical awareness of the condition. This high index of suspicion coupled with early CT evaluation and judicious use of ultrasonographically guided aspiration will lead to an early recognition of the disease, and its cure.

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***Enterobius vermicularis* live adult worms in the high vagina**

Sir,

I present an unusual case of *Enterobius vermicularis* adult live worms recovered from the high vagina. To my knowledge no such case has been reported in the literature.