was demonstrated on CT scan. Macroscopic haematuria was later noted. Intravenous urography confirmed the suspicion of bladder carcinoma and biopsy proved it to be a poorly differentiated TCC. CT scan of the pelvis revealed infiltrating bladder tumour with enlarged bilateral external iliac glands. Bone scintigram proved negative. Pelvic and cranial external beam irradiation, and steroid therapy were started. However, the patient developed massive metastatic pulmonary lesion and died 9 weeks later.

We have only been able to find one other published case in which a brain metastasis presented as the first manifestation of a bladder carcinoma. Similarly, we have already reported another unexpected presentation of urinary bladder carcinoma in the form of a retro-orbital mass. We therefore stress the importance of wide differential diagnoses regarding metastatic disease of the brain. Physicians should be aware of and investigate occult urological symptoms in a patient with neurological signs of an intracranial mass.

Javier C. Angulo
Jose I. Lopez
Miguel Unda-Urzaiz
Nicolas Flores
Servicios de Urología y Anatomía Patológica,
Santo Hospital Civil de Bilbao,
Avd Montevidio 18,
48013 Bilbao, Spain.

References


Campylobacter jejuni – an unusual cause of infectious arthritis

Sir,

We wish to report what we believe to be the first published case of acute infective arthritis due to Campylobacter jejuni.

A 51 year old woman was admitted with acute arthritis of her left knee. She had rheumatoid arthritis and common variable hypogammaglobulinaemia, for which she was treated with corticosteroids and intravenous gammaglobulin respectively. She was afebrile, but the left knee was swollen, red and hot, and had been so for a few days prior to admission.

An arthrocentesis yielded 30 ml of purulent fluid. The Gram stain showed many polymorphonuclear cells and no bacteria; culture was negative during the first 72 h of incubation. At that time the patient became febrile.

Blood and joint aspirate culture were taken again and intravenous ceftriaxone 2 g per day was started, and 20 mg of triamcinolone was injected in the affected joint. The temperature returned to normal within 2 days while the acute arthritis symptoms persisted.

Twelve days after admission C. jejuni was identified in cultures from the joint fluid as well as from the blood. In vitro sensitivity tests showed that the strain was resistant to ceftriaxone, cephalothin, cotrimoxazole, penicillin, aztreonam and ceftazidime, and sensitive to ciprofloxacin, pefloxacin, nalidixic acid, norfloxacin, ampicillin and erythromycin. Ceftriaxone was discontinued and intravenous ciprofloxacin 200 mg three times a day was administered.

The patient showed rapid improvement of local signs with negative blood cultures 72 h after treatment with ciprofloxacin started, and negative joint aspirate 96 h after treatment with ciprofloxacin started. A 4 week course of intravenous ciprofloxacin was given.

C. jejuni is an uncommon cause of infective complications apart from acute enteritis. Bacteraemia has been reported in less than 1% of patients with C. jejuni infections; it appears to be more common at extremes of age. Meningitis and endocarditis have been rarely reported and acute cholecystitis, pancreatitis, and cystitis caused by C. jejuni appear to be the result of local spread of the micro-organisms from enteric foci rather than from haematogenous seeding.

A reactive arthritis has been reported after C. jejuni enteritis (2% of HLA B27 positive antigen patients) but acute infective arthritis has not been documented before to our knowledge.

In this particular patient the infectious event could have been favoured by gamma-globulin deficiency, steroid therapy, and moderately impaired renal function. The gastrointestinal tract might have been the primary site of the infection though symptoms of enteric disease were not reported by the patient even after specific questioning. Stool culture proved negative for C. jejuni, but it was taken 72 h after ciprofloxacin was started.

M.B. Pasticci
E. Baratta
A. Del Favero
A. Gillio
F. Baldelli
S. Pauluzzi
Institute of Infectious Diseases,
1 Institute of Internal Medicine,
2 Department of Orthopaedics,
Policlinico Monteluce,
University of Perugia,
06100 Perugia, Italy.

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Hydatid cyst of the neck

Sir,

Only a few cases of hydatid cyst occurring in the neck area have been reported – the biggest series being 9 cases reported by Touhami et al.¹ This prompted us to report a further case.

A 25 year old male presented with a swelling on the left side of the neck, gradually progressive in size for one year. The swelling was 10 x 8 cm, situated partially under the left lower part of the sternocleidomastoid and was soft in consistency. Oral and ear, nose and throat examination were normal. Fine needle aspiration was carried out which revealed clear fluid and the cytology report was inconclusive. The cyst was excised and the histopathology confirmed it to be echinococcal disease.

During follow-up the patient was evaluated for any other site of hydatid, but radiology of chest and ultrasonography of liver, spleen and kidney were normal.

Hydatid cyst develops most commonly in liver (60%), lungs (20%) and rarely in brain, eye, heart, bone or other internal organs.²

The disease presents as a slow growing benign tumour with pressure symptoms according to its site of occurrence. Immuno-electrophoresis is a highly specific test for diagnosis. In the neck area it is very difficult to diagnose hydatid cyst. Even fine needle aspiration cytology is inconclusive unless one submits it for microscopic examination with a high suspicion index. In endemic areas, one should keep in mind the possibility of hydatid cyst when presented with a cystic lump in the neck.

Kundan Kumar
Ajay K. Khanna
Mahendra K. Misra
Department of Surgery,
Institute of Medical Sciences,
Banaras Hindu University,
Varanasi 221 005,
India.

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Chilaiditi's syndrome presenting as unexplained tender hepatomegaly

Sir,

Hepatodiaphragmatic interposition of intestine (HDI; Chilaiditi's syndrome) is a condition when part of the intestine is interposed between the liver and the right dome of the diaphragm. It is a rare condition, the incidence varying between 0.006% to 0.2%, depending on the age and sex of the patients.³ Recently, we have come across an unusual case of HDI mimicking amoebic liver abscess.

A 46 year old labourer was admitted with moderate to severe, throbbing, non-radiating pain in the right upper quadrant of the abdomen of 8 days duration, low grade, intermittent fever and anorexia. Physical examination revealed a firm, smooth and tender liver palpable 1.5 cm below the subcostal arch in the right midclavicular plane. The percussion note over the liver was tympanic in character which merged with the note over the chest. The patient was diagnosed as having an amoebic liver abscess, and was treated with metronidazole.

Complete haemogram and liver function tests were normal. The routine stool examination for *Entamoeba histolytica* was negative. The plain X-ray of the abdomen taken in the erect position revealed gas under the right diaphragm with a horizontal fluid level. Ultrasonography and contrast enhanced computed tomography confirmed the colonic interposition between the liver and the right dome of the diaphragm. The liver was normal and was pushed downward and medially by the colon. During his hospital stay, he remained afebrile, although the tender hepatomegaly persisted.

HDI is generally described as an asymptomatic and clinically silent syndrome. However, it is of interest to radiologists since it has to be differentiated from the various causes of 'air under the diaphragm'.³ This condition may occur transiently (sliding type), however, adhesions may cause persistence of the interposition.³ The interposed organ is hepatic flexure of the colon in most cases but small intestine and omentum may also be present. Multiple factors, discussed at length in an earlier report,⁴ are implicated in the causation of interposition.

This condition may not be entirely clinically irrelevant, as symptoms such as diffuse abdominal pain, nausea, vomiting, flatulence, constipation, shortness of breath and pain in the substernal area may occur.³ Various authors have emphasized that abdominal tenderness and displacement of the liver to the left side of the abdomen may be observed. However, a moderately large palpable liver of 15.0 cm with tenderness over the right hypochondrium, as observed in the present report, has not been previously described. Since Chilaiditi's syndrome is relatively frequent in the rural population and those consuming a vegetarian diet, for example, the Mediterranean region³ and Siberia,⁶ it should theoretically be more prevalent in the Indian subcontinent, though no such epidemiological study has been reported from this area. Hence, it is rational to suspect HDI, when unexplained hepatomegaly (with or without tenderness) is encountered.

D.K. Mukhopadhyay
S. Srikant
A. Misra
B. Bhatla
R. Uppal
Department of Medicine and ¹Radio-Diagnosis,
All India Institute of Medical Sciences,
New Delhi-110029,
India.

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