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Letters to the Editor

Duodenal adenocarcinoma: uncommon cause of chronic blood loss in the elderly

Sir,

Iron deficiency anaemia is a common problem in the elderly population which requires both upper and lower gastrointestinal investigations to exclude treatable pathology.[1,2] We report two elderly patients who presented with iron deficiency anaemia and weight loss.

Case 1

An 87-year-old man presented with malaise, anorexia and loss of weight for three months. Initial investigations showed a haemoglobin of 5.1 g/dl, mean corpuscular volume (MCV) 62 fl and serum ferritin 10 µg/l. Upper gastrointestinal endoscopy revealed an apparently benign duodenal ulcer. Biopsies were taken and revealed a poorly differentiated duodenal adenocarcinoma. The patient refused any further investigations or invasive treatment. He was transfused and discharged home 14 weeks after his initial symptoms. He died of post-operative pneumonia following a repair of a non-pathological hip fracture 14 weeks after being discharged.

Case 2

A 76-year-old woman presented with loss of weight and poor appetite for four weeks. She was anaemic with a haemoglobin of 7.8 g/dl, MCV 70 fl and serum ferritin 18 µg/l. γ-Glutamyl transaminase, alanine transaminase and alanine phosphatase were within normal limits. Upper gastrointestinal endoscopy showed a large duodenal ulcer. She was treated with anti-H_2 receptor drugs and blood transfusions without much improvement in her systemic symptoms. Barium enema and abdominal ultrasound were normal. A duodenal ulcer biopsy was taken at repeat endoscopy and the histology showed a poorly differentiated duodenal adenocarcinoma. Peritoneal and hepatic metastases were present at laparotomy. She was discharged to hospice 12 weeks after her first hospital admission. She died of carcinomatosis four weeks later.

Duodenal adenocarcinoma is rare but is the commonest duodenal malignancy. Its incidence increases with age, having its peak at the seventh decade of life.[3] Chronic blood loss occurs in the majority with over 66% of the patients testing positive for faecal occult blood.[3] Upper gastrointestinal tract endoscopy with direct vision biopsy is the mainstay diagnosis.[3] Extensive surgical resection (Whipple's procedure) is the only curative treatment, although surgery and chemotherapy have been used as palliative treatment.[4]

Summary/learning point

Duodenal ulcer biopsy should be considered part of the investigations of iron deficiency anaemia in the elderly if systemic symptoms (e.g. weight loss) are present

We agree with Kaminski *et al*[5] that the diagnosis of duodenal adenocarcinoma tends to be delayed due to its relative rarity and non-specific systemic symptoms and therefore advise to investigate the entire gastrointestinal tract, including the small bowel if abdominal symptoms are present.[5] We would like to add that patients with systemic symptoms may have malignant disease and that duodenal ulcer is not always benign as our two cases have shown. Ulcer biopsy offers a rapid histological diagnosis and could avoid unnecessary and unpleasant gastrointestinal tract investigations.

CARLOS TRESCOLI-SERRANO
MAR GARCIA-ZARCO
Department of Geriatric Medicine
OLUFUNSO A ADEDEJI
Department of General Surgery,
Kings Mill Hospital,
Sutton in Ashfield, Nottinghamshire, UK

Correspondence to C Trescoli-Serrano, Department of Health Care of the Elderly, Queens Medical Centre, University Hospital, Nottingham NG7 2UH, UK

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Persistent discharging wound sinus from retained gallstone fragments following laparascopic cholecystectomy

Sir,

For patients with symptomatic gallstones, laparoscopic cholecystectomy is now the procedure of choice.[1] As a relatively new procedure, however, many complications not seen with open cholecystectomy are now being reported.[2,3] We describe a persistent discharging sinus from the epigastric wound, resulting from retained gallstone fragments, following gall bladder extraction at that site.

A 47-year-old woman with symptomatic gallstones was admitted for laparoscopic cholecystectomy. This was performed using a standard four-port technique at which the gall bladder, which contained several large stones, was removed via the epigastric port under vision but with some difficulty as the stones had to be fragmented and the epigastric wound enlarged to facilitate removal. Her postoperative recovery was uneventful and she was discharged at 48 hours. Eight weeks after discharge, the epigastric wound became infected and spontaneously discharged pus and several gallstone fragments. Two weeks following this the wound was explored under anaesthesia when further gallstone fragments were discovered. The wound was curetted and thoroughly lavaged. Four weeks following her second operation she still complained of a persistently discharging wound and a further four weeks later (now six months following laparoscopic cholecystectomy) the wound was re-explored under general anaesthesia. A granulation-lined cavity was found together with a blind ending track laterally (one either side) at the bottom of which was a gallstone fragment. These were removed, the cavity curetted and thoroughly lavaged and the wound closed. Six months following this final procedure she is asymptomatic and the wound has healed.

Learning point

In a thin-walled gall bladder with multiple stones it is important to prevent spillage of gallstone fragments in the wound at laparoscopic cholecystectomy

Of 6076 laparoscopic cholecystectomies in the Dutch series, wound sepsis was documented in only 79 cases (1.3%)[2] and therefore appears to be relatively uncommon. More recent concerns have focussed on the development of abdominal wall metastases.[4] In our patient, a persistent discharging sinus resulted from retained gallstone fragments in the wound at which gall bladder extraction was performed. To our knowledge there has been only one similar reported incidence of this complication.[5] The introduction of retrieval devices in which the gall bladder may be placed prior to removal almost certainly would have prevented this particular complication and is to be recommended when there are numerous stones in a soft or thin-walled gall bladder. An awareness of this potential complication may in itself help in prevention.

N WILLIAMS
J HILL
M SHAFIQ
Department of Surgery,
North Manchester General Hospital,
Crumpsall, Manchester M8 6RB, UK

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