iciency is the result of impaired triglyceride secretion (despite normal synthesis) by the hepatocytes.² ²

Cirrhosis of liver in homozygous ALB deficiency has been attributed to medium-chain triglyceride diet, and is not found in heterozygous subjects.¹² Since the prognosis of chronic liver disease with heterozygous ALB deficiency is excellent, it is important to differentiate this condition from other causes of persistent transaminase elevation resulting in cirrhosis. If heterozygous ALB deficiency is confirmed on lipid profile and ALB levels, an invasive procedure like liver biopsy can be avoided in an asymptomatic subject.

We suggest that a lipid profile, including ALB levels, should be performed in subjects with unexplained persistently elevated transaminases.

References


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Mesenteric lipoma: an unusual cause of small intestinal volvulus
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Mesenteric lipoma as a cause of small intestinal volvulus has not been reported before. We report a middle-aged man with this entity. [Indian J Gastroenterol 1997; 16: 159]

Key words: Small intestinal obstruction

Small intestinal volvulus is rare in adults. Although bands, adhesions and diverticulitis can sometimes explain its pathogenesis, in most cases its cause remains obscure. We encountered a patient with small intestinal volvulus in whom a large mesenteric lipoma was the predisposing factor.

A 46-year-old man presented with features suggestive of acute intestinal obstruction. Per rectal examination was normal. The patient had relief in the left lateral decubitus, a sign suggestive of small intestinal volvulus.

Routine blood and urine investigations and skilogram of the chest were normal. Plain X-ray abdomen revealed multiple air-fluid levels without gas under the diaphragm. After resuscitation, the patient was explored by a right paramedian incision. Volvulus of the small intestine around a large mesenteric mass (approximately 25 cm x 15 cm) was found. The mass lay on the left side turned upon itself, along with a twist in the adjoining loop, resulting in volvulus. Around 60 cm of small intestinal loop involved in the volvulus was relatively ischemic. Warm packs around the ischemic gut and 100% oxygenation brought back the color of the intestine. The mass was excised (Fig); histology confirmed it to be a lipoma.

Volvulus of the small intestine is rare beyond the neonatal age.² Volvulus involving several feet of the small intestine without an underlying cause has been reported in Africa; a large meal of maize and vegetables is said to be responsible.³ Literature does not mention mesenteric lipoma as a predisposing factor for small intestinal volvulus.

References


Tracheo-bronchial remnants: a rare cause of dysphagia
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A 14-year-old girl presented with dysphagia since the age of one year. Investigations revealed two
strictures at the lower esophagus. Endoscopic mucosal biopsy from the strictures showed pseudostratified columnar epithelium suggesting that tracheobronchial remnants was the cause of the stenosis. Esophageal dilatation failed to relieve her symptoms. [Indian J Gastroenterol 1997; 16: 159-160]

Key words: Congenital esophageal stenosis

Congenital stenosis of the lower esophagus due to intramural tracheobronchial remnants is a rare entity. Till 1991, less than 50 cases had been reported. Because of its rarity, the diagnosis is often overlooked in infants and young children presenting with feeding problems. We describe a girl with congenital esophageal stenosis due to tracheobronchial remnants.

A 14-year-old girl presented with non-progressive dysphagia, more for solids than liquids since the age of one year. She denied history of nasal regurgitation, aspiration or recurrent bronchopneumonia. There was no history of chest pain, corrosive ingestion, trauma, previous surgery or intubation. Her growth and developmental milestones were normal.

Barium esophagogram showed two benign appearing strictures in the lower esophagus with mild dilatation of the segment in between. There was no mucosal irregularity or shouldering. Gastroesophageal reflux was not observed, even in the Trendelenburg position. Flexible fiberoptic esophagogastroduodenoscopy (XQ-30: Olympus, Japan, outer diameter 9.8 mm) revealed two strictures in the esophagus at 27 cm and 30 cm from the incisors. The mucosa over the strictures and at the gastroesophageal junction was normal. The strictures were dilated with Savary-Gillot dilators (up to 12.8 mm) and endoscopic mucosal biopsies were taken from both the stricture sites. Mucosal biopsy showed pseudostratified ciliated columnar epithelium suggestive of respiratory-type epithelium, confirming that tracheobronchial remnants was the cause of the stenosis (Fig). As endoscopic dilatation failed to relieve her dysphagia, surgical resection of the stenotic segment with end-to-end anastomosis was advised; the child is yet to report for surgery.

Congenital esophageal stenosis due to tracheobronchial remnants was first reported in 1936 by Frey and Duschtel in a 19-year-old girl who died with the diagnosis of achalasia. Esophageal atresia is the most frequently associated anomaly, followed by ano-rectal abnormalities.

Symptoms usually start early in life, after solid food is introduced into the diet. Radiographic contrast studies typically show a narrow stricture in the lower esophagus; the esophagus above the stenotic segment is dilated and often has poor peristaltic activity. Endoscopic examination shows stenosis of the lower esophagus with normal overlying mucosa, a useful distinguishing feature from peptic stricture secondary to reflux esophagitis. Though it was successful in our case, endoscopic biopsy is usually not thick enough to show heterotopic tissue lying deep under the normal mucosa.

Dilatation of the stricture results in only transient relief of dysphagia. Surgical resection of the stenotic segment with end-to-end anastomosis is the treatment of choice.

Though rare, congenital esophageal stenosis due to tracheobronchial remnants should be considered in young patients with esophageal stricture resistant to standard therapy.

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