CC-001 AN INCIDENTAL PRE-OPERATIVE FINDING UNMASKS A RARE DIAGNOSIS

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Introduction A 70-year-old lady presented for an elective repair of an umbilical hernia and was incidentally noted to be hypoalbuminaemic on routine bloods. Her past medical history included recurrent urinary tract infections and chronic lymphoedema. An unexpected finding of chylous ascites during the laparotomy prompted further investigations. A malabsorptive picture was noted from history.
Methods On initial presentation, low albumin was investigated by routine bloods, an auto-immune screen and 24 h urine protein excretion. Malabsorption was investigated by haematinics, serum protein electrophoresis, tissue transglutaminase antibody, stool culture, tuberculin skin test, barium follow through, hydrogen breath test and faecal elastase test. Imaging involved chest radiograph, ultrasound abdomen, gastroscopy, colonoscopy and capsule endoscopy.
Results Blood tests revealed panhypogammaglobulinaemia and microcytic anaemia with low iron and vitamin B_{12} but normal intrinsic factor levels. Gastroscopy and colonoscopy were normal and a capsule endoscopy revealed features consistent with lymphangiectasia throughout the small intestine and jejunum. Protein losing enteropathy was confirmed with faecal α-1 antitrypsin level which was 10 times greater than normal.
Conclusion A diagnosis of primary intestinal lymphangiectasia or Waldmann's syndrome was made. This is a rare disorder characterised by dilated intestinal lacteals resulting in lymph leakage into the small bowel lumen and responsible for protein-losing enteropathy leading to lymphopenia, hypoalbuminaemia and hypogammaglobulinemia.[1] The patient was commenced on low fat diet medium chain tri-glyceride (fatty acid) supplementation.

Competing interests None.

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CC-002 A RARE CAUSE OF DYSPEPSIA

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Introduction We present a rare case of dyspepsia in a 61-year-old man, in which we hope to highlight the multitude of possible differentials and the pathophysiology behind his unusual diagnosis.
Methods Case presentation.

A 61-year-old man was referred with a 2 month history of intermittent bilateral leg oedema and dyspepsia associated with weight loss. Initial examination was unremarkable; JVP was not raised, there was no abdominal tenderness, organomegaly or ascites and no palpable lymph nodes.
Results Oesophagogastroduodenoscopy was performed showing large gastric folds. Biopsies of the stomach showed eosinophilic infiltration of the mucosa. Initial bloods showed a peripheral eosinophilia of 1.7 (0.0–0.4). CT showed Supraclavicular lymph nodes, thickening of the stomach wall and ascites which may have been indicative of malignancy, however repeat biopsies confirmed inflammation of the gastric wall only. This evidence of marked eosinophilic infiltration of the stomach and peripheral eosinophilia in the absence of parasite infection, atopy, exposure to toxic chemicals and nothing to suggest a primary eosinophilic syndrome from a myeloproliferative disorder meant this is a case of true eosinophilic gastritis.
Conclusion Eosinophilic gastritis is a rare disorder that is, protean in its presentation due to its variable site and depth of involvement. It is characterised by (a) the presence of gastrointestinal symptoms (b) biopsies showing eosinophilic infiltration of one or more areas, and (c) no evidence of parasitic or extra-intestinal disease.[1–5] It affects any age group or race.[6] There are currently a variety of treatments used however none have been proven effective in clinical trials and this is an area in need of further research.

Competing interests None.

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CC-003 AN UNUSUAL CAUSE OF JAUNDICE

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Introduction We report the case of a 45-year-old gentleman who initially presented 12 years ago with abdominal pain. A CT scan of his abdomen showed him to have a portal vein thrombosis. A thrombophilia screen confirmed a G20210 prothromin gene mutation. He was initially anticoagulated with warfarin although this had to be subsequently discontinued following an oesophageal variceal haemorrhage. He then underwent periodic gastroscopy with repeated bandings over the next 11 years. He remained well over this time. However, at a recent clinic review it was noted that he had become jaundiced. Further imaging with CT, plus trans abdominal and endoscopic ultrasound showed extensive intra-abdominal varices with encasement of the common bile duct. At ERCP a plastic stent was inserted across a distal common bile duct stricture. This resolved his jaundice. The stent was removed 3 months later. To date his jaundice has not returned. Based on his history and radiological findings, a diagnosis of portal biliopathy secondary to a portal vein thrombosis was made. This is a rare but important cause of jaundice. We discuss the prevalence, investigation and management of this condition.
Methods N/A.
Results N/A.
Conclusion N/A.

Competing interests None.

CC-004 A COMPLICATED CHOLECYSTECTOMY

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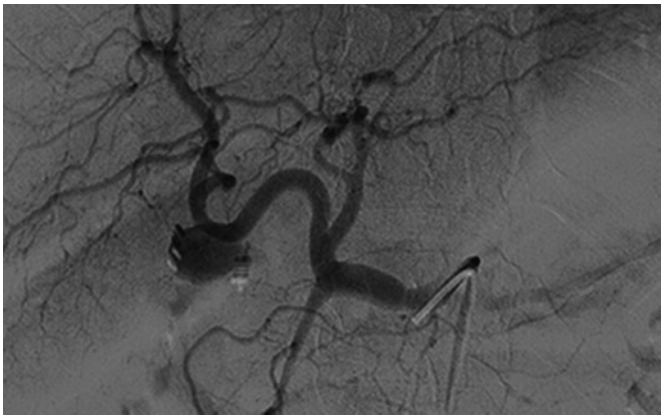
Introduction Laparoscopic cholecystectomy has all but replaced open techniques due to its superiority in terms of length of stay,



Abstract CC-004 Figure 1

preoperative morbidity, and time to return to normal activities. However, it is associated with increased risk of bile duct injury.[1] Here we present a case in which a technically difficult laparoscopic cholecystectomy resulted in both common and uncommon complications.

Methods A 41-year-old morbidly obese female presented with abdominal pain 6 days after undergoing an elective laparoscopic cholecystectomy for gallstones. The timing of the presentation, together with evidence of free abdominal fluid on abdominal CT led to suspicion of a biliary leak, which was confirmed at ERCP. The patient returned with acute upper gastrointestinal haemorrhage, right upper quadrant pain and deranged liver function. Emergency OGD revealed a soft nodular swelling in the first part of the duodenum, but no source of bleeding. A CT angiogram revealed an iatrogenic right hepatic artery false aneurysm. This was treated initially with coil embolisation, but subsequently required surgical excision of the right hepatic artery. The aneurysm was found to have fistulated into the common bile duct.

Results Cystic duct leak is often encountered after laparoscopic cholecystectomy, occurring in between 0.3 and 0.9% of cases.[1] Diagnosis of biliary leak can be challenging, as free abdominal fluid is a common finding after uncomplicated laparoscopic surgery.[2] Right hepatic artery false aneurysm resulting from laparoscopic cholecystectomy has been previously reported.[3] In this case, fistulation into the common bile duct led to haemobilia and acute upper gastrointestinal haemorrhage. An angiogram showing the aneurysm and its relation to the surgical clips is shown below.

Conclusion Bile leaks are a common complication of laparoscopic cholecystectomy and typically present with abdominal pain and nausea around the fourth post-operative day.

MRCP, ERCP and hepatobiliary scintigraphy are helpful in evaluating bile duct injuries post laparoscopic cholecystectomy.

Consider haemobilia in patients with a combination of right upper quadrant pain, deranged LFTs and upper GI bleeding with no overt source of blood loss on OGD.

Competing interests None.

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CC-005 CAN YOU HELP PLEASE? A YOUNG WOMAN WITH ASCITES, BOWEL OBSTRUCTION AND INTESTINAL FAILURE

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Introduction Presenting complaint A 39-year-old woman of Jamaican descent presented to her local hospital with a 6-week history of worsening vomiting, general cramping abdominal pain, diarrhoea, and two stone weight loss. Initial investigations had not confirmed a diagnosis. She was subsequently transferred to the regional nutrition centre with high naso-gastric tube losses, for further investigation and parenteral nutrition support.

Previous medical history Past medical history included an episode of unexplained weight loss and a pericardial effusion 4 years ago. She had also suffered with a mild anaemia, thrombocytopaenia and an associated calf DVT. Her sister was treated for pulmonary tuberculosis as a child.

On examination The patient looked unwell and cachectic (weight 30.9 kg, BMI 12.4). She was tachycardic and hypotensive (98/65 mm Hg), with a temperature of 37.4°C. Respiratory examination was normal. Her abdomen was soft, distended and generally tender, with normal bowel sounds. There was evidence of ascites but no peripheral oedema. There were no rashes or skin changes. Her fingers showed swan neck deformity. A Hickman line was in situ.

Initial investigations Blood tests, abdominal x-ray, and ct scan of the chest, abdomen, and pelvis. Gastroscopy and flexible sigmoidoscopy were normal.

Methods A differential diagnosis was drawn up and parenteral nutrition started. Gynaecological malignancy, tuberculosis, and intestinal pseudo-obstruction (IPO) were investigated. A CA125, quantiferon test, ascitic tap with microscopy, culture and sensitivity, and an auto-immune screen were requested. Review at gynaecological MDT was undertaken.

Results Gynaecological malignancy, tuberculosis, and pseudo-obstruction were ruled out. A diagnosis of gastro-intestinal SLE was made.

Conclusion SLE is a chronic inflammatory autoimmune disease of unknown aetiology, with variable manifestations. Gastrointestinal manifestations of SLE include lupus mesenteric vasculitis and SLE-related IPO. Lupus mesenteric vasculitis occurs in 0.2–0.9% of patients worldwide with SLE, and IPO is a rare syndrome, the pathogenesis of which is unknown.

Dilation of the bowel, ureters and common bile duct, with ascites makes a possible diagnosis of early SLE megaviscus syndrome, a very rare generalised pseudo-obstruction syndrome.

Competing interests None.

CC-006 NOT ALL YELLOW IS LIVER

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Introduction We present an interactive case report of a 34-year-old Caucasian male presenting to our hospital with abdominal pain and jaundice. On initial investigation he was found to have a cholestatic jaundice with no ductal dilatation on Ultrasound scan.

Methods On presentation he was found to have no risk factors for chronic liver disease and a comprehensive liver screen revealed no cause. Liver biopsy was subsequently performed and on the basis of this a diagnosis of cholestatic jaundice secondary to hyperthyroidism was suggested. Thyroid function testing confirmed

hyperthyroidism and there was rapid resolution of the jaundice after starting Carbimazole.

Results Thyrotoxicosis is associated with various abnormalities in liver function. These abnormalities are usually mild, but can, as in this case, cause profound cholestasis. We discuss the incidence, the histological findings, possible aetiologies and clinical outcome of thyroid induced liver dysfunction together with a broader overview of the interactions and associations between the liver and thyroid gland.

Conclusion Thyroid function should be included in the assessment of any patient with cholestasis. Drug histories for culprit medications need to go back many months. Anti-thyroid medications treat thyroid induced cholestasis in the short and long term by inducing a euthyroid state, but can themselves cause hepatotoxicity.

Competing interests None.

CC-007 UNUSUAL ASSOCIATION OF TWO GRANULOMATOUS DISEASES

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Background Granulomatous diseases in tropics are usually due to infective causes while noninfective causes are rare. Erythema nodosum could be a manifestation of either type. When two entities co-exist, to ascertain the contributory cause is extremely difficult and causes therapeutic dilemmas.

Methods A 19-year-old Sri Lankan trainee mechanic presented with a history of low-grade fever of 5 months duration and asymmetrical migratory polyarthropathy since 1 month prior to admission. He had developed recurrent mouth ulcers and tender subcutaneous nodules in both upper and the lower limbs. He also admitted that he had episodic loose stools, anorexia and weight loss. Past medical history, social and family histories were unremarkable. He had being treated before with several courses of antibiotics and steroids without a definitive diagnosis.

Examination revealed a distressed febrile male, having a vasculitic rash resembling erythema nodosum, mouth ulcers, swollen left knee and ankle joints, a proximal muscle weakness and soft exudates in right fundus.

Results The results of important investigations were as follows. A persistent neutrophil leucocytosis (highest 32000/cmm with neutrophils 82%), an anaemia (lowest haemoglobin 9.8 g/dl, MCV-74fl),a thrombocytosis (highest 649 000/ccmm^3), elevated ESR 91 mm and CRP 241 mg/dl respectively. elevated Alp, raised ferritin. CPK, renal functions, remaining liver functions, urine analysis abdominal ultrasound scan, 2D echoe, chest x-ray, Mantoux test, hepatitis B, C, HIV screens all were negative. Blood picture revealed anaemia of chronic disease and inflammatory or infective process. He also underwent colonoscopy and gastroscopy examinations, the histology of which was suggestive of a granulomatous disease.

He was started on five ASA, antibiotics, steroids and azothiopine with abetment of fever and vasculitis. While on treatment he presented with recurrence of vasculitis, fever and hyper pigmented patches over the back of the legs, bilateral knee joint effusions and a discharging ulcer of right foot. Skin biopsies were done from the appropriate areas. The histology showed, foamy macrophages, positive AFB staining and positive PCR for mycobacterium. Joint aspiration was uninformative with negative serial cultures for TB. Based on the skin biopsy a course of drugs specific for a bacterial granulomatous disease was started.

After several weeks of treatment he presented with fever and vasculitis. He also had a thickened right ulnar nerve; bilateral axillary lymphadenopathy and electrophysiological studies confirmed a sensory motor neuropathy of lower limbs.

Conclusion This case history illustrates a unique rare association of two granulomatous diseases described in literature.

Competing interests None.

CC-008 AN UNUSUAL CASE OF ABDOMINAL PAIN AND DIARRHOEA

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Introduction We present a case of abdominal pain and diarrhoea with an unusual cause.

Methods A 66-year-old male presented with the symptoms of intermittent early satiety, abdominal pain, nausea and vomiting. He also complained of intermittent episodes of diarrhoea with occasional steatorrhoea and a progressive weight loss of 32 kg over the previous 20 years which presented as a poor nutritional state, loss of muscle mass and strength. The patient had previously had treatment for testicular teratoma and multiple small bowel resections following a complicated perforated Meckel's diverticulum. A combination of gastroscopy, water-soluble contrast meal and CT demonstrated superior mesenteric artery (SMA) syndrome. This was as a result of chronic progressive weight loss secondary to a functional short bowel syndrome. Past radiation therapy for the teratoma may also have contributed.

Results The patient was treated with nasojejunal feeding for 9 months and measures to manage the short bowel syndrome. Further contrast imaging showed resolution of the SMA syndrome at 9 months. SMA syndrome can occur as a result of any cause of dramatic weight loss such as catabolic and post-operative states or chronic wasting illnesses. External compression and mesenteric tension have also been described as precipitants of SMA syndrome.[1] SMA-like syndromes also exist and need consideration.[2] Treatment consists of enteral feeding, or parenteral nutrition where indicated, in addition to rectification of the underlying cause. Surgery, such as duodenojejunal bypass or derotation of the duodenum, is considered where treatment fails.

Conclusion SMA syndrome is a rare but treatable cause of duodenal obstruction diagnosed by clinical suspicion and radiology.

Competing interests None.

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CC-009 ABDOMINAL PAIN IN DIABETIC KETOACIDOSIS: SOMETIMES NEEDS MORE THAN INSULIN!

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Introduction Here we present a case of a 17-year-old girl with DKA and an acute abdomen with interesting radiological findings including colonic intramural gas and portal venous gas.
Methods We discuss the case and review the existing literature regarding mechanism and prognosis of these in the format of an interactive case presentation. This is illustrated with radiological and pathology images accompanied by best of five format questions to demonstrate relevant learning points.
Results Images and the full case report can be found in our email submission.
Conclusions Key learning points are as follows. While patients with DKA may commonly present with abdominal pain, those with other features of an acute abdomen require further imaging and clinical assessment. Colonic intramural gas has a characteristic appearance on AXR and may indicate underlying bowel infarction. Portal venous gas may be secondary to iatrogenic causes in which case conservative management is sufficient, however in the context of the acute abdomen it still requires a poor prognosis and urgent surgical assessment is required. In the patient presenting with widespread colonic ischaemia, thrombophilia and use of vaso-constricting medications need to be considered.

Competing interests None.

CC-010 TB OR NOT TB?

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Introduction Making a diagnosis between Crohn's disease and intestinal tuberculosis can be difficult and is often delayed. There is significant overlap in clinical, radiological, endoscopic and histological features between the two diseases.[1 2] Our case shows the difficulties that may be encountered, with a diagnosis only being confidently made nearly a month after initial presentation.
Methods We present an interactive case study of a 40-year-old lady who presented with a 3 month history of abdominal pain and significant loss of weight. Her bowel habit was normal and there were no other upper or lower gastrointestinal symptoms of note.
Results Our interactive case presentation reviews the diagnostic conundrum our patient provided. We review the investigations results, which were often misleading and highlight some of the pitfalls in making an appropriate diagnosis.
Conclusion The resurgence of TB correlates with a rise in cases of abdominal TB in developed countries. Between 1997 and 2000, the incidence of all TB globally increased by 1.8% each year, with approximately 8.3 million new cases being diagnosed in 2000.[3 4]

Abdominal TB accounts for approximately 1% of all reported TB[3 5 6] and intestinal TB is the commonest form of this.[1]

Making a diagnosis between Crohn's disease and intestinal tuberculosis can be difficult.

Attempts have been made to formulate scoring systems based upon endoscopic[7] or histological appearances.[8 9] Unfortunately, there is no gold standard diagnostic test to distinguish between the two diseases.

Competing interests None.

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CC-011 A VERY SICK COLON

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Introduction The diagnosis and management of fulminant colitis is usually straight forward, with clear diagnostic and management pathways. We present a interactive case that highlights the difficulties and pitfalls in the management of a complex patient when the diagnosis was uncertain.
Methods A 49-year-old lady was admitted via Accident and Emergency with sudden onset severe lower abdominal pain, loose bloody stools and a few episodes of vomiting. There was no previous history of gastrointestinal symptoms and no significant past medical history.

An urgent flexible sigmoidoscopy showed unusual appearances that were at odds with an abdominal CT scan and other investigations. Moreover the patient's clinical progress was also at odds with the unusual investigation results, leading to a clinical conundrum.
Results In our interactive case presentation we follow the patient's progress, which highlights the difficulties in managing a case where the diagnosis and optimal management is uncertain.

Investigations throughout the admission suggested a multitude of possible diagnoses including: ischaemic colitis, vasculitis, fulminant C.difficile and Crohn's colitis, with the final outcome being unexpected based upon the patient's initial progress.
Conclusion In our interactive case presentation we highlight how important it is to keep an open mind to all possible diagnoses, even in light of atypical investigation results. We also illustrate how fulminant colitis can develop rapidly, even if the patient's clinical progress suggests otherwise and possible steps to ensure optimal management of more difficult cases.

Competing interests None.

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CC-012 "DODGING A FLY": AN UNCOMMON PRESENTATION OF A GI CONDITION

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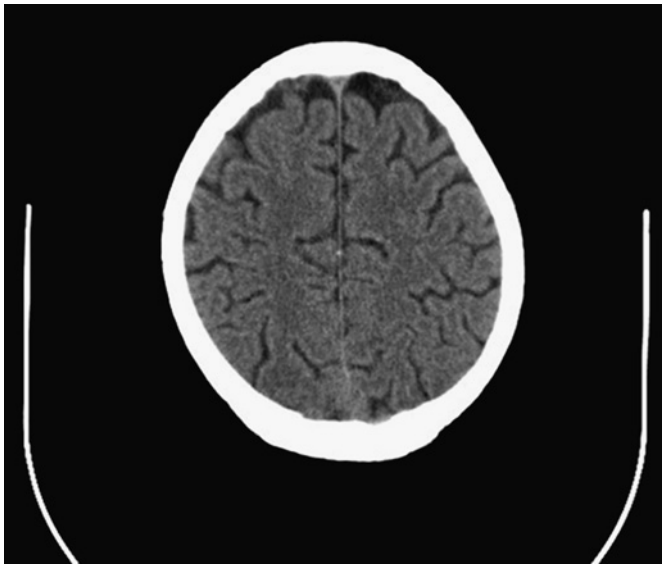
Introduction A 25-year-old male presented with a thunderclap headache which started after a sudden movement of his head to avoid a fly. Six weeks prior he sustained a small traumatic subdural haematoma which was treated conservatively.

Methods Clinical examination was unremarkable, blood tests revealed a microcytic anaemia, raised inflammatory markers and hypoalbuminemia. Imaging confirmed a right transverse and superior sagittal sinus thrombosis. Further questioning revealed a 10 year history of chronic diarrhoea, microcytic anaemia but previously normal imaging.

Results Recent symptoms included mouth ulcers, bloody diarrhoea, abdominal pain, and significant weight loss. CT and colonoscopy confirmed terminal ileal crohns disease. CVT completely resolved with anticoagulation, but IBD required biologic agents.

Conclusion Cerebral venous sinus thrombosis is not often encountered in clinical practice. It is exceptionally rare to be the presenting feature of IBD. His active Crohn's disease and possible venous sinus trauma may have predisposed him to the thrombosis.



Abstract CC-012 Figure 1

Competing interests None.