caused by Madurella Mycetomatis. Hence below elbow amputation of the left forearm was done followed by histopathological confirmation of the specimen for Mycetoma. The post operative follow up for 6 months showed no recurrence. All the above 3 cases had Fluconazole 50 mg per day for 3 months postoperatively.

DISCUSSION

Mycetoma was first recognised as a clinical entity in Madurai (South India) as madhura foot, but now it is known to be prevalent in other countries also. Foot continues to be the commonest site followed by the upper extremity. Involvement of the perineum as the third in order of frequency and the fourth commonest site was scalp. The aetiological factors involved in causation are multiple in the form of thorn prick, trauma leading to ulceration, blunt trauma and the wicks. The clinical picture of Mycetoma is almost uniform irrespective of the causative fungi. Histology of Mycetoma has achieved a reasonably good standard in identification of species, that more sophisticated tests are not desired as a routine as they are cumbersome and time consuming and it is evident that Madurella Mycetomi is the prevalent fungus. Radiological examination was done in suspected cases of bone involvement. The radical cure can be achieved by local excision followed by antifungal therapy for 3-6 months and by amputation of the affected part, in case the bones were affected.4

REFERENCES


A rare presentation of primary hydatid cyst

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ABSTRACT

Hydatid cyst affecting a muscle is very rare. The clinical diagnosis of which requires high index of suspicious. The diagnosis can be made by careful history, physical examination and simple investigation like ultrasonography and fine needle aspiration. Surgical excision of cyst remains the mainstay of management.

KEY WORDS

Hydatid cyst, Muscle, Echinococcus granulosus.


INTRODUCTION

Hydatid disease is endemic in developing countries and cattle rearing regions of the world. It may affect wide range of organ or tissue. Here we present a case of hydatid cyst of muscle which according
to contemporary literature is a relatively rare occurrence.

CASE REPORT

A 20-year-old female from the family of shepherds was admitted with a painless swelling over left side of back since 3 months. There was no history of trauma, fever or weight loss. Physical examination revealed a diffuse, non-tender cystic swelling of 20 x 12 cm in size over the left infra scapular region with fixity to deep muscles.

On blood examination the Total Leukocyte Count was 5000 cells ul⁻¹ and 1% eosinophils. Routine chest radiograph and abdominal ultrasound was normal. A plain radiograph showed a large soft tissue mass in infra scapular region of left back with normal underlying bones. Ultrasound of local part show cystic lesion with some echogenic material inside it. Fine needle aspiration from the cyst was performed to differentiate hydatid cyst from cold abscess, which yielded clear fluid and microscopic examination of fluid was inconclusive. Based on these findings, a working diagnosis of hydatid cyst arising from muscle was made.

On exploration, a hydatid cyst deep to lattissimus dorsi muscle and attached to serratus posterior inferior muscle was found. The cyst was excised and soft tissue washed with 0.5% cetrimide solution. When the specimen of cyst cut opened, multiple scolices were found inside it (Figure 1). Histopathology confirmed our working diagnosis of hydatid cyst. Post operatively the patient was put on medical treatment in form of Tablet Albendazole 400 mg daily and follow up of the patient till today is uneventful.

DISCUSSION

Hydatid disease is caused by the larval tapeworm of the genus Echinococcus granulosus, Echinococcus multilocularis and Echinococcus oligarthrus. Echinococcus granulosus is the most common cause of hydatid disease.¹ The incidence¹,² of involvement of various organs and tissues by hydatid disease in descending order is mentioned in Table 1.

Hydatid disease of muscle is rare. Classically the patient presents with a long history of cystic lump with muscle fixation.

Routine investigations like complete blood count, x-rays and ultrasonography of abdomen and local part should be carried out first. Aspiration of fluid by fine needle is safe,³ simple and effective means to reach working diagnosis. Serological tests like ELISA and immunoelectrophoresis are important tool in diagnostic workup if diagnostic dilemma persists, provided facility of such tests is available. However all of these may not be conclusive. Hydatid cyst is classically confirmed by direct demonstration of parasitic elements in surgical specimen.¹

The treatment of hydatid cyst is principally surgical. However pre-operative medical treatment should be considered in order to sterilize the cyst, to decrease

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Table 1: Incidence of hydatid cyst affecting various organs/tissues

<table>
<thead>
<tr>
<th>Organs / tissues</th>
<th>Incidence</th>
</tr>
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<tbody>
<tr>
<td>Liver</td>
<td>60%</td>
</tr>
<tr>
<td>Lung</td>
<td>30%</td>
</tr>
<tr>
<td>Kidney</td>
<td>2.5%</td>
</tr>
<tr>
<td>Heart</td>
<td>2.5%</td>
</tr>
<tr>
<td>Spleen</td>
<td>Less than 2%</td>
</tr>
<tr>
<td>Brain</td>
<td></td>
</tr>
<tr>
<td>Bone</td>
<td></td>
</tr>
<tr>
<td>Orbit</td>
<td>Only few cases reported</td>
</tr>
<tr>
<td>Urinary bladder</td>
<td></td>
</tr>
<tr>
<td>Spinal extradural space</td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
</tr>
<tr>
<td>Submandibular gland</td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
</tr>
<tr>
<td>Muscle</td>
<td></td>
</tr>
</tbody>
</table>
the tension in the cyst and thus reducing the chances of spillage and resultant anaphylaxis. Intra operatively, the instillation of 0.5% cetrimide, 15% hypertonic saline or 0.5% silver nitrate solution before opening the cavity tends to kill the daughter cysts and thus prevents further spread and anaphylactic reaction. Post operative medical treatment reduces recurrence rate.  

REFERENCES


Delayed dehiscence of repaired urinary bladder

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ABSTRACT

Delayed dehiscence of a previously repaired bladder rupture in a 12-year-old boy is described. There was no obvious cause except that while in bed the boy had withheld his early morning urge to pass urine. He presented with peritonitis and raised urea and creatinine levels. Retrograde cystography was diagnostic after the urinary catheter had drained 1.2 litres of blood-tinged urine. The rent in the dome of the bladder at the site of previous repair was closed with polyglycolic acid sutures during emergency laparotomy. Though rarely reported, delayed dehiscence is a possibility which can occur in repaired urinary bladder. It emphasizes the need for long-term follow-up.

KEY WORDS
Bladder rupture, Delayed dehiscence, Spontaneous.

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INTRODUCTION

Idiopathic spontaneous urinary bladder rupture is a rare entity. It is neither associated with bladder disease nor with any outlet obstruction.  

Idiopathic delayed spontaneous dehiscence of a previously repaired bladder rupture, though known, has been reported once in the literature. We hereby report a case of delayed idiopathic dehiscence of repaired bladder rupture in a child and postulate possible aetiologies.

CASE REPORT

A 12-year-old boy was hospitalized with a history of generalized abdominal pain of sudden onset and abdominal distension of 24 hours duration. He had no history of fever, vomiting, or constipation, but he had passed very little urine since the onset of pain. Following blunt abdominal trauma 36 months ago, he had undergone an exploratory laparotomy. A splenorrhaphy, primary repair of an ileal perforation and repair of an intraperitoneally ruptured bladder were performed. He had recovered uneventfully following surgery and had maintained good health without any urinary complaints.

On examination, the child was alert and afebrile. He had tachycardia and his respiratory rate was 20/min. Abdomen showed a midline scar and was distended. He had tenderness and guarding all over his abdomen. Shifting dullness was present. Laboratory examination revealed an essentially normal blood count, but his blood urea was elevated to 92 mg/dl and serum creatinine was 5.0 mg/dl. Serum sodium and potassium were 130 meq/l and 5.8 meq/l respectively. Plain X-ray abdomen and chest were within normal limits. Emergency ultrasonography showed intraperitoneal fluid collection.