attention and intervention to prevent the complications. Aim should be restoration of blood supply and micturition with least discomfort to the patient. Long term follow up with Micturating Cysto-Uretherogram (MCU), Uroflowmetry etc. is necessary. These patients should also undergo a psychosexual assessment to prevent further episodes of such genital auto-mutilation.

REFERENCES

Distal ureteric atresia presenting as an abdominal lump in an adult

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ABSTRACT

A 26-year-old female, presented with discomfort and a lump in the left side of abdomen. Examination showed a non-tender cystic mass in the left lumbar region extending down to the pelvis, the lower limit being palpable through the left fornix. Investigations revealed a cystic mass extending from the left renal area to the pelvis and a non-visualized left kidney. Cystoscopy could not identify the left ureteric orifice. Surgical exploration showed a blind ending left ureter as a cystic mass, containing clear fluid capped by a hypoplastic left kidney. The mass extended from the left renal area to the pelvis. Left sided nephroureterectomy was performed.

KEY WORDS

Ureter, Atresia

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INTRODUCTION

Ureteric atresia is a rare congenital abnormality. In distal atresia the ureter fails to communicate with the bladder and terminates close to it as a cul-de-sac. The proximal canalized ureter generally presents as a cystic mass. It may present in the infancy or childhood as an abdominal mass. But because of the relatively greater increase in the size of the abdominal cavity it is less apparent in adults and may remain unnoticed through out life. It may be incidentally discovered as a mass during investigations of persistent fever. One such case of distal ureteric atresia in an adult is reported because of its rarity.

CASE REPORT

A 26-year-old female, presented with vague discomfort in the left side of the abdomen for 18 months and a lump in the left side of the abdomen noticed for 8 months. Bowel and bladder habits, appetite, menstrual cycle were normal. On examination the patient was thin built, weighing 34kgs, afebrile and slightly pale. There was a non-tender, soft, cystic mass, measuring 5” x 6”, extending from the left costal margin down into the pelvis. It was fixed and had a well defined upper margin; the lower margin was not palpable. The mass showed no movement with respiration. The peristaltic sounds were normal. Per rectal examination revealed the lower limit of the cystic mass to lie...
anteriorly and to the left. Routine examination of blood revealed hemoglobin 10.1 gm% with normal total and differential counts. Blood urea and creatinine were 28mg% and 1.1 mg% respectively. Urinalysis was normal. Plain x-ray of abdomen showed a soft tissue shadow extending along the left flank of the abdomen down towards the pelvis. USG revealed a cystic mass extending from the left lumbar region to the pelvis with improperly delineated left kidney. IVU showed a well functioning, larger than normal right kidney and non-visualized left kidney. Later films of the series showed smooth extrinsic indentation of the dome of the bladder. Isotopic renogram also showed normal perfusion of the tracer on the right and a completely nonfunctioning left kidney.

Retrograde pyelography was attempted, however, cystoscopy failed to identify the left ureteric orifice. Patient was explored with the provisional diagnosis of a nonfunctioning hydronephrotic left kidney.

Exploration revealed a cystic mass situated retroperitoneally on the left side. Proper mobilization of the left colon revealed it to be hugely dilated left ureter extending from the left renal region down to the pelvis, ending blindly by indenting the dome of the bladder but without communicating with it. Left kidney was small and atrophic (Figure 1) and the dilated ureter contained large quantity of clear fluid. Opposite kidney and ureter were larger than normal in size due to compensatory hypertrophy but were otherwise normal and no other congenital abnormalities were detectable. Left sided nephroureterectomy was performed. Post operative recovery was uneventful.

Histopathology report of the atrophied kidney showed rudimentary glomeruli and tubules suggestive of dysplastic kidney.

DISCUSSION

It has been observed that in higher vertebrates the development of the kidney and ureter is a complicated multistep process that involves genes like Wilms’ tumour (WT1), c-ret oncogene, Wnt4 and forming. Ureteric atresia results from failure of canalization of a segment of ureter because of ischemic damage to that portion during the process of elongation of the ureteral bud. It may be unilateral or even bilateral and can involve any portion of the ureter. It is commonly associated with ipsilateral or contralateral, renal or ureteric duplication.

In distal ureteric atresia the terminal portion of the ureter ends blindly before establishing a communication with the bladder, a point to be remembered while differentiating it from a clinically similar condition of obstructed megaureter. In the latter there is a functional stenosis or narrowing of distal part of the ureter in the presence of ureterovesical communication.

Ureteric atresia is difficult to diagnose preoperatively. Conditions with which it is likely to be confused clinically are hydronephrosis, megaureter, retroperitoneal cysts, tumors, and ovarian tumors. Magnetic resonance imaging and laparoscopy, when available, are important aids in preoperative diagnosis.

When ureteric atresia presents in the infancy and childhood, the presentation is that of an abdominal mass, due to huge cystic dilatation of the ureter proximal to the atretic segment. It has been reported in a 9 years old child with multicystic dysplasia in half of horseshoe kidney with lower ureteric atresia. On the other hand a blind ending ureter with a noninfected, dysplastic kidney may remain unnoticed through out life. It may be accidentally discovered as a mass or during investigation for persistent fever (when the content gets infected).

In this reported case, the lean and thin stature of the lady probably brought the cyst to her notice and prompted her to seek medical advice. Though laparoscopy was certainly an important option both for diagnosis and treatment, it could not be used in this patient because of its non-availability at the time of surgery. Since her left kidney was atrophied and

Case report

Figure 1: The specimen of hugely dilated blind ending ureter capped by an atrophied left kidney
nonfunctioning while the opposite kidney was functionally normal a left sided nephroureterectomy was decided upon.

REFERENCES


Lipoma of the stomach

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ABSTRACT

Lipomas are benign tumours of adipose tissue. They are rare in the stomach, but when present, may produce haematemesis, pain or dyspepsia. A case of gastric lipoma is reported and relevant management options discussed.

KEY WORDS

Lipoma, Stomach, Excision, Gastrectomy

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INTRODUCTION

With the widespread use of endoscopy and improvements in radiological techniques, more and more gastric lesions are being picked up. It is often difficult to differentiate benign neoplasms (<2% of all gastric tumours) from low grade sarcomas, and although lipomas form only 3% of benign gastric tumours, they can be the cause of much diagnostic confusion, vis-à-vis, gastric cancer.

CASE REPORT

A 44 year old female was admitted with history of upper abdominal pain only. General and systemic examination was unremarkable. Except an elevated ESR (39 mm 1st hour-Wintrobe’s method), all laboratory investigations were normal.

Ultrasound examination of the abdomen was normal. On fibreoptic endoscopy, a 3 x 3 cm smooth, elevated area with normal overlying mucosa was present along the greater curvature at the fundus. Endoscopic punch biopsy was inconclusive. Contrast enhanced abdominal CT revealed a smooth, rounded, homogeneous, polypoidal lesion along the posterior wall of stomach (Figure 1).

On laparotomy, a bulge was visible over the posterior aspect of fundus, without any breach of the overlying serosa. Gastrotomy was done here and a 3 x 3 cm soft, smooth submucosal mass was found with normal overlying mucosa. Frozen section examination revealed lipoma, so a wedge resection with 2 cm margin was performed. The post operative period was uneventful. The patient is well one year post surgery. Histopathology confirmed it to be a sub mucosal lipoma of the stomach.

DISCUSSION

Lipomas are rare in the gastrointestinal tract, where