DISCUSSION

The awareness of cutaneous Kaposi’s sarcoma as a diagnostic possibility helps in the work-up of nodulo-ulcerative skin lesions. In this case we did not include Kaposi’s sarcoma in the initial clinical differential diagnosis. The rarity of isolated limb involvement in Kaposi’s sarcoma and the past history of malignant schwannoma of the same limb contributed to the absence of Kaposi’s sarcoma as a diagnostic possibility in the work-up of the patient. Our first clinical diagnosis was recurrent malignant schwannoma because of his past history and because the lesions appeared to be along the distribution of cutaneous nerves. Malignant melanoma was considered in the differential diagnosis because of the pigmented nodules, pigmentation in the ulcers and because the distribution of lesions looked like intransit metastases. Kaposi’s sarcoma was considered in the differential diagnosis only when he tested positive for HIV-1. To avoid bias in reporting, the specimen had been sent to three different pathologists, all the pathologists reported it independently as Kaposi’s sarcoma.

Several different treatments have been used for Kaposi’s sarcoma including surgical excision, radiation therapy, Highly Active Anti-Retroviral Therapy (HAART) and intralesional chemotherapy. The initial treatment of patients with Kaposi’s sarcoma in HIV positive cases is an effective anti-retroviral regimen. If Kaposi’s sarcoma does not regress despite a reduction in HIV viral load and an increase in CD4 cell count, alternative treatments may be considered. Localised lesions may be treated with cryotherapy, laser or surgical excision. But in this case, in view of multiple lesions and involvement of lungs this patient has been put on HAART.

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Benign pneumoperitoneum following road accident: A case report

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ABSTRACT

A 42-year-old male patient a victim of road accident developed pneumothorax which was successfully treated with an intercostal drainage. On the third day he developed sudden abdominal distension with rigidity. X-ray abdomen revealed free gas under both domes of the diaphragm. At laparotomy a thorough search did not reveal any hollow organ injury.

KEY WORDS

Spontaneous pneumoperitoneum, Benign pneumoperitoneum.

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A 42-year-old male patient was admitted to the casualty department with history of road accident. At the time of admission, the patient was semiconscious and in severe respiratory distress. On examination, the patient was severely anaemic and dehydrated. The pulse was feeble, blood pressure 90/50 mm Hg, with
cold and clammy extremities. Examination revealed left-sided fracture shaft femur, right-sided Colle’s fracture and an 8-cm linear scalp wound over the right temporal region. There were numerous cuts and grazes all over the body. His Glasgow coma scale was 10/15. Chest examination revealed resonant percussion note with tracheal deviation to the right and diminished breath sounds of the left chest. The abdomen was soft and bowel sounds were audible. The examination of the other systems was within normal limits.

The patient was resuscitated with intravenous fluids, blood and broad-spectrum antibiotics. X-ray chest revealed left-sided pneumothorax. CT scan of the brain was within normal limits except scalp haematoma over the right temporal region. USG abdomen did not reveal any significant abnormality. The haematological and biochemical examination were within normal limits.

An emergency left intercostal drain was inserted, the scalp wound was repaired and POP back slab and Thomas splint was applied to the fractured bones. The patient was shifted to the surgical intensive care unit and was kept under continuous monitoring. The patient recovered. Chest drain was removed after 48 hours following complete lung expansion on check X-ray and the patient was shifted to the surgical ward. On the third day after admission he developed sudden abdominal distension with board-like rigidity. There was no history of vomiting. Classical rebound tenderness was absent and bowel sounds were audible. Liver dullness was obliterated. His general parameters were stable. Straight X-ray abdomen revealed free gas under both domes of the diaphragm (Figure 1). A diagnosis of hollow viscous perforation was made and the patient was put up for operation. At laparotomy, barring a “pop” sound of gushing air, no evidence of any hollow viscous perforation or peritoneal fluid was evident. A thorough search after mobilizing the duodenum and colon also did not reveal any significant abnormality. The solid abdominal organs were normal.

Leaving a drain in the pelvis the abdomen was closed in layers. There was no drainage from the abdominal drain, which was removed on the third postoperative day. The patient recovered without any complications and was discharged on the seventh postoperative day after stitch removal with advice to attend orthopaedic outpatient department (OPD) for further management and surgical OPD for follow-up. At one year follow-up the patient is well without complications.

DISCUSSION

Spontaneous pneumoperitoneum occurs as a result of perforation of a hollow viscous. Rarely, true pneumoperitoneum without hollow viscous perforation may result from diffusion of thorax-derived air through a phrenic defect or along sheaths of mediastinal blood vessels.\(^1\) The female genital tract represents another route for intraperitoneal air penetration.\(^2\) Other aetiologies include iatrogenic pneumoperitoneum (after abdominal surgery and digestive endoscopy) and pneumatosis cystoides intestinalis, when the subserous intraparietal gaseous bubbles rupture into the peritoneal cavity.\(^2\) The finding of pneumoperitoneum without perforation of the digestive tract is a relatively rare finding. About 10% of the radiological pneumoperitoneums occur without hollow viscous perforation.\(^3\) It creates a diagnostic perplexity. Pneumoperitoneum, preceded by a reasonable incident cause in a patient with adequate abdominal examination, may warrant continued observation thus avoiding an unnecessary laparotomy.

Though in most cases the standard treatment is surgical, one should keep in mind this rare condition and adopt a more rational treatment approach avoiding unnecessary operation in case of “benign” pneumoperitoneum.\(^4\)

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