Health-related quality-of-life

Dear Editor,
The author has covered this upcoming subject in a very concise and comprehensive manner. It has been clearly mentioned that surgical by-pass is still relevant in the palliation of malignant obstructive jaundice, in the better interest of the patient, especially in the underdeveloped countries.

Although the endoscopic stenting is a desired palliative procedure, the paucity of technical expertise, non-availability of adequate set up, and cost factor remain the limiting factors. In these circumstances, cholecysto-jejunostomy, gastrojejunostomy, and jejuno-jejunos-

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REFERENCE

Gallbladder tuberculosis

Dear Editor,
We read the article ‘Tuberculosis of the gallbladder without associated gallstones or cystic duct obstruction’ by Tanwani et al. with interest. It is indeed remarkable that apart from the nodes the only other intra-abdominal visceral focus was found in the gallbladder. We however have a few reservations about the management of the case.

1. Why was an ultrasound guided FNAC/biopsy of the nodes not attempted?
2. Could an extraperitoneal approach to the iliac nodes for biopsy have avoided a laparotomy?
3. If laparotomy were required, wouldn’t a laparoscopic biopsy be a better option?

4. We do not find a reasonable indication to do a cholecystectomy in this case, as tuberculosis was high on the cards and medical therapy is the main stay of treatment.

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Authors’ reply

Sir,

We appreciate the chance to respond to comments/queries made by our colleagues about our paper. We work in a modestly equipped institution where laparoscopy is not available and our radiological colleagues are not very confident, vis-à-vis, various invasive interventional procedures. Perhaps surgeons working in elite institutions do not realize that many of us are working in hospitals where good quality imaging or expertise to use it is either not available or if available in private sector is beyond the patient’s financial constraints. Hence the decision to go for an “Exploratory laparotomy”, which remains not only the final court of appeal but also a very (if not the most) important ‘investigation’ for surgeons working in sub-optimal working conditions. Cholecystectomy was performed because hard nodule of 0.5 cm. X 0.5 cm. was palpable at the neck of gall bladder, gave an impression of impacted stone in the neck (this point has already been made in our paper). Ironically, (as mentioned in our paper) post-operative histopathological confirmation becomes the greatest tragedy of diagnosis because a condition that is curable medically has to follow surgery unavoidably. We thank our colleagues for their interest in our paper.

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Extramedullary hematopoiesis masquerading as malignant neoplasm in a known case of plasmacytoma

To the Editor,

Extramedullary hematopoiesis (EMH) is the presence of hemopoietic precursors outside the bone marrow. Usually, it is noted in patients with myeloproliferative disorder and congenital hematological diseases. The organs most commonly involved are the spleen, liver, and lymph nodes, but EMH has also been reported in a number of unusual sites such as, mediastinum[1] and even breast.[2] Although cases of myeloid metaplasia presenting as masses within various sites have been reported, to the best of our knowledge, no case of EMH masquerading as malignant neoplasm of neck in a case of plasma cell neoplasm has been documented. We hereby present such a case, where the diagnosis was made by fine-needle aspiration (FNA) cytology.

A 50-year-old man presented with a complaint of a huge neck swelling. The patient was a known case of plasmacytoma, diagnosed in 1988, for which he received chemotherapy and radiotherapy. The patient underwent remission and the follow-up hemogram was within normal limits for the last 15 years. On examination, a nontender and bony hard neck swelling measuring 15 x 10 cm was detected. Hemogram and serum electrophoresis were within normal limits. Bone marrow examination revealed myelofibrosis in trephine biopsy. X-ray and computed tomography (CT) scan revealed a well-defined homogenous mass above the left clavicle extending posteriorly. Clinical and radiological possibilities of malignant neoplasm of neck were considered and FNA was done. The smears were stained with May-Grunwald Giemsa (MGG) and Hematoxylin and Eosin (H&E). Smears were moderately cellular comprising lymphocytes, polymorphs, immature granulocytic precursors such as myelocytes and metamyelocytes, nucleated red blood cells, and larger binucleated to multinucleated cells with fine granular cytoplasm representing megakaryocytic lineage of cells. The diagnosis of EMH was offered.

In the index case, the patient presented clinically with a neck mass masquerading as malignant tumor of the neck. Differential diagnosis included plasmacytoma, paraganglioma, fibrohistiocytic lesions, rhabdomyosarcoma, and metastatic carcinoma on clinical grounds. Fine-needle aspiration findings were obvious enough to clinch the diagnosis. Even on cytomorphology, megakaryocytes with hyperchromatic nuclei and marked nuclear membrane irregularity may be misinterpreted as atypical or malignant cells. The presence of blasts in EMH may lead to difficulty in distinguishing the entity from granulocytic sarcoma or lymphoma. The presence of mature polymorphs, erythroblasts and megakaryocytes is helpful to the diagnosis of EMH in contrast to the homogenous leukemic infiltrates occurring in granulocytic sarcoma.[3] Multiple myeloma is a known cause of secondary myelofibrosis. Also, cyclophosphamide causes fibrosis of ovary, bladder, and lungs but there are no well-documented reports of bone marrow fibrosis. Fine-needle aspiration has been a modality to diagnose EMH in cases presenting as tumors.[4] Our case demonstrates the unusual finding of EMH presenting as soft tissue tumor of the neck in a known case of plasma cell neoplasm and diagnosed successfully by FNA findings.

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