ileum without underlying adenoma, inflammatory disease, or duplication. As far as pathogenesis is concerned, we cannot exclude any of the four basic mechanisms proposed above. Clinical presentation of SCC of the ileum is similar to that of other ileal tumors. Optimal treatment and the prognosis are illusive because of the rarity of this condition. Surgery is the corner stone in the management ofthe disease.[10] Due to the small number of cases available in the literature the effects of chemotherapy and radiotherapy on the survival and recurrenceare unknown.

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Mediastinal pseudocyst mimicking pseudoachalasia

Pseudocyst is a well-recognized complication following acute or chronic pancreatitis. Most of these are pancreatic or peri-pancreatic in location. Mediastinal pseudocyst is rare, and can present with symptoms like chest pain and breathlessness due to pressure effect.

We report a case of recurrent acute pancreatitis with recent onset of dysphagia for both solids and liquids.

Case Report

A forty-year-old male presented with difficulty in swallowing for both solids & liquids for previous one and half months. He also had associated retrosternal discomfort, regurgitation, cough and significant weight loss (15% of body weight). He had a history of recurrent episodes of acute pancreatitis (alcohol related)which were conservatively managed. Over a period, patient developed abdominal pain and was found to havea pancreatic pseudocyst 3 years back. He was planned for laparoscopic cystogastrostomy but due to inadvertent rupture of cyst wall during the surgery, external drainage was performed.

On evaluation for the present symptoms, a barium swallow study showed a dilated esophagus with smooth distal narrowing giving a ‘bird’s beak appearance’ suggestive of achalasia cardia (**Figure 1a**). Upper GI endoscopy showed fluid stasis in the esophagus with

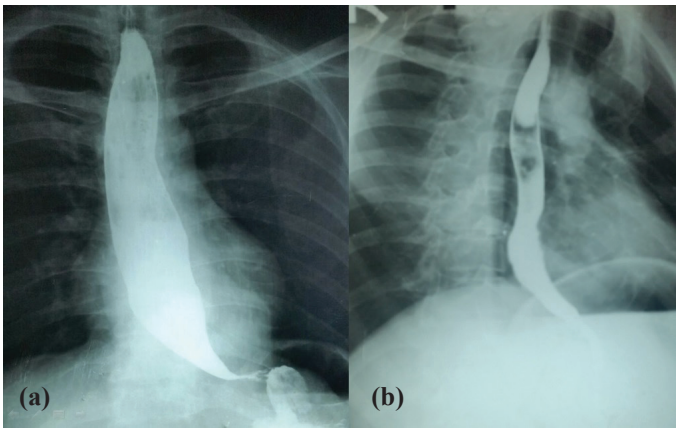

Figure 1 (a,b): Barium swallow: Before and after cystogastrostomy and drainage.

proximal dilatation and scope could not be negotiated through the esophagogastric junction. Under fluoroscopic guidance, guide wire was passed into the stomach and nasogastric tube was placed to provide enteral nutrition. CECT scan showed alarge pancreatic pseudocyst in the lesser sacextending into the mediastinum through hiatus upto the level of left atriumcausing compression of the gastroesophageal junction (**Figure 2**). After optimizing the nutrition of the patient, laparotomy was performed with upper mid line incision. A 15x15 cm pseudocyst was noted in lesser sac. After ananterior gastrostomy was performed, needle aspiration through posterior wall of stomach into the cyst confirmed the location of the cyst. Common wall of stomach and cyst was opened and 1200 ml of cola-coloured cyst fluid was drained. Lastly, a cystogastrostomy drain was established (**Figure 3**) and the anterior wall of stomach closed. Post-operative period was uneventful. Oral fluids were started, and patient was gradually able to tolerate semi solid and solid diet without any difficulty. Cyst fluid amylase was 10,400 IU/L and cyst wall biopsy showed granulation tissue. Barium swallow repeated on day 12 was normal (**Figure 1b**). Endoscopy repeated on day 14 showed that scope passed freely into GE junction and stomach.

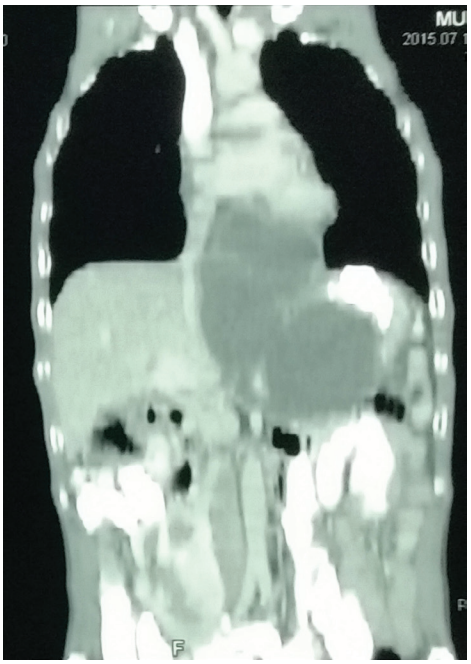

Figure 2: CT chest coronal view showing mediastinal pseudocyst.

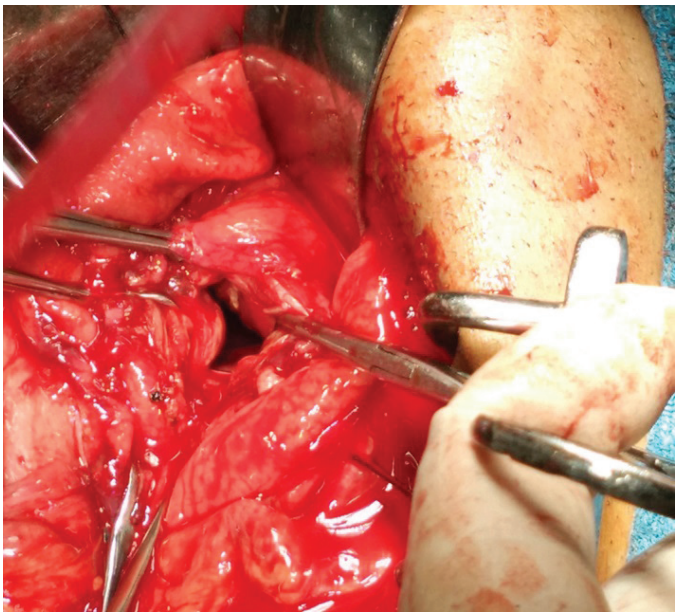

Figure 3: Intra-operative photograph of cystogastrostomy.

Discussion

Mediastinal pancreatic pseudocyst is a rare complication first described in 1951.[1] In adults it is commonly due to alcoholinduced pancreatitis and rarely it can also occur following trauma.[2] Mediastinal pseudocyst develops as the pancreatic fluid enters the mediastinum through

the esophageal or aortic hiatus following rupture of pancreatic duct posteriorly into the retroperitoneum.[3] These pseudocysts cause compression symptoms which include breathlessness, chest pain, back pain, cardiac tamponade and cough.[1,4]

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