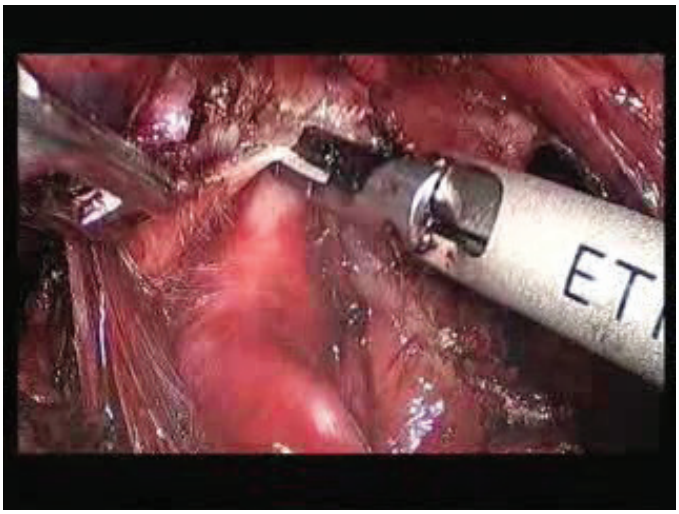

Figure 3: Laparoscopic Separation of Median Arcuate Ligament.

To conclude, definitive angiographic findings, along with clinical impression, are needed to reach the confirmative diagnosis of MALS. The laparoscopic dissection of the MAL from below upward is more beneficial than the same procedure from above downward since in the latter case, the aorta is at risk of injury. We recommend a multidisciplinary team with a holistic approach to care for patients with this complex and rare disease.

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An enigmatic right iliac fossa mass

Eosinophilic colitis (EC) is an extremely rare disease in the spectrum of Primary Eosinophilic Gastrointestinal Disease (EGID), which also includes Eosinophilic Esophagitis (EE), Eosinophilic Gastritis (EG) and Eosinophilic Gastroenteritis. In all the above, there is significant tissue eosinophilia causing chronic inflammation. However, the common causes of tissue eosinophilia (parasitic infestation, drug reaction and malignancy) must be ruled out first.[1] The disease can affect the entire gastrointestinal tract and its etiology is stillunclear. Bimodal age distribution is observed, affecting infants and young adults. Chronic diarrhea leading to malabsorption and significant weight loss is the classical presentation while intestinal obstruction is very rare.

Case Report

A thirty one year old male patient presented to the emergency department with complaints of sudden onset abdominal distension and constipation. He was found to have a distended abdomen with features suggestive of acute intestinal obstruction without signs of peritonitis. X-ray abdomen revealed dilated bowel loops with few air fluid levels. His blood investigations were within normal limits. The cause remained obscure and hence a CECT abdomen was done. It showed a growth in the caecal region with pulled up caecum and cut off at ileocaecal junction **(Figure1)**. The patient improved over the next few hours with conservative management and was planned for further evaluation. Repeat examination of abdomen revealed a palpable mass in the right iliac fossa. Subsequent colonoscopy revealed anulceroproliferative growth with narrowing in the caecal region, the picture suggestingan ileo-caecaltuberculosis. Multiple biopsies were taken which were reported as inconclusive. PCR analysis of the tissues was also not contributory. Meanwhile, as the patient developed signs of intestinal obstruction, informed consent was obtained and the patient was taken up for surgery with the possible diagnosis of ileo-caecal tuberculosis. A right transverse abdominal laparotomy was performed. Intra-operatively, there was a palpable lesion in the caecum with serosal infiltration. There were few lymphnodes in the mesocolon. A classical right hemicolectomy was done **(Figure 2)** as the diagnosis was still unknown and the possibility of Ileo-caecal tuberculosis or a malignancy could not be ruled out intraoperatively. The patient recovered uneventfully in the post operative period. Interestingly, the final histopathological report revealed eosinophilic colitis **(Figure 3)**. Subsequently, patient's serum IgE levels were measures and found to be raised to 415 IU/ml (Normal: 150 IU/ml). The patient is currently on follow up without any recurrence of symptoms.

Discussion

Eosinophilic colitis (EC) was first described by Kaijserin 1937.[2] Studies have shown that the infantile form is associated with cow's milk and soy protein allergy while there is no such association in the adult form.[2] Peripheral eosinophilia (5-35%), segmental tissueeosinophilia and alteration of function are considered as the hallmarks of the disease.[2] The incidence of the disease has remained static over many decades.

Klein et al. classification correlates the physical symptoms and the pathological findings. The disease confined to mucosa will likey present with chronic diarrhoea, malabsorption and weight loss. Intestinal obstruction occurs if the disease involves the muscular layer, while predominant serosal involvement will present as eosinophilic ascites.[3] In our patient there was a transmural involvement leading to intestinal obstruction.

The normal tissue eosinophilia varies considerably between different segments of colon and most authors accept > 20 eosinophils/High power field (HPF) as the cut off value.[4] Peripheral eosinophilia is too variable to beused as a screening tool. In our case,

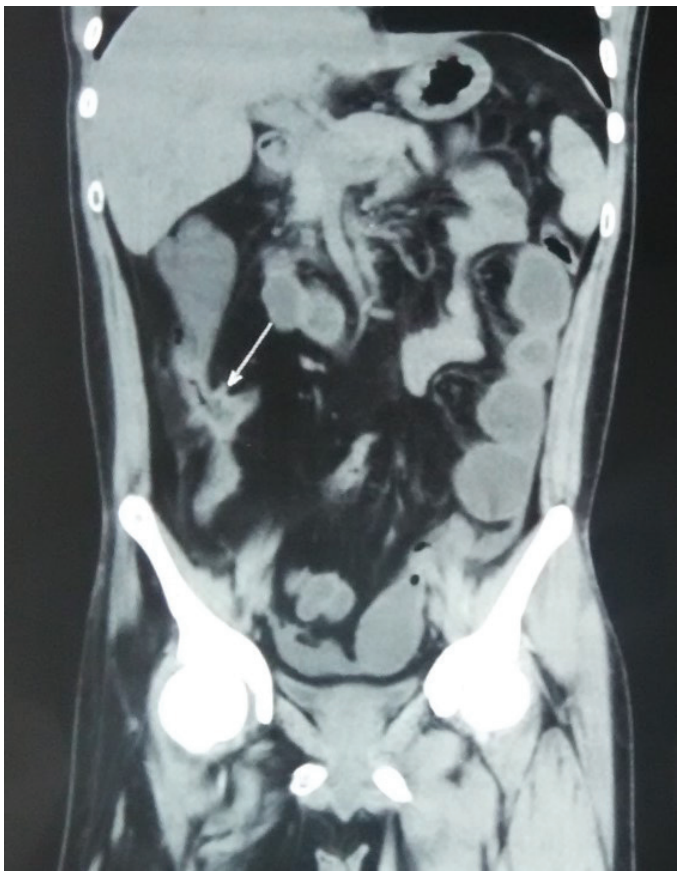

Figure 1: Abdominal CECT showing caecal growth with pulled up caecum and narrowing at the ileo-caecal region.

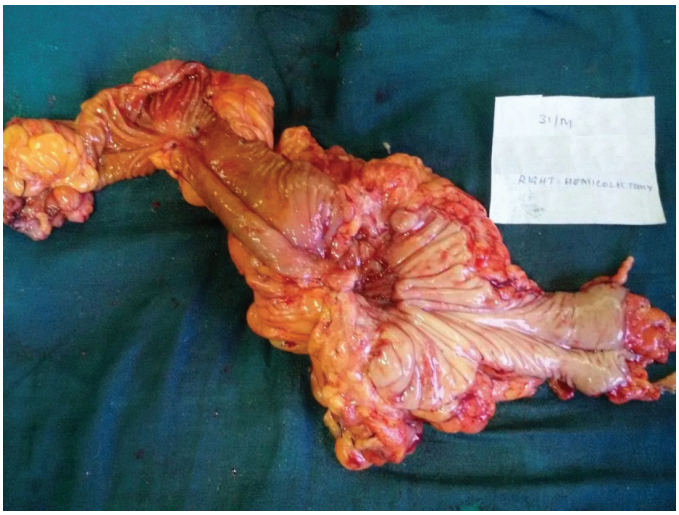

Figure 2: Resected specimen showing an ulceroproliferative lesion in the caecum.

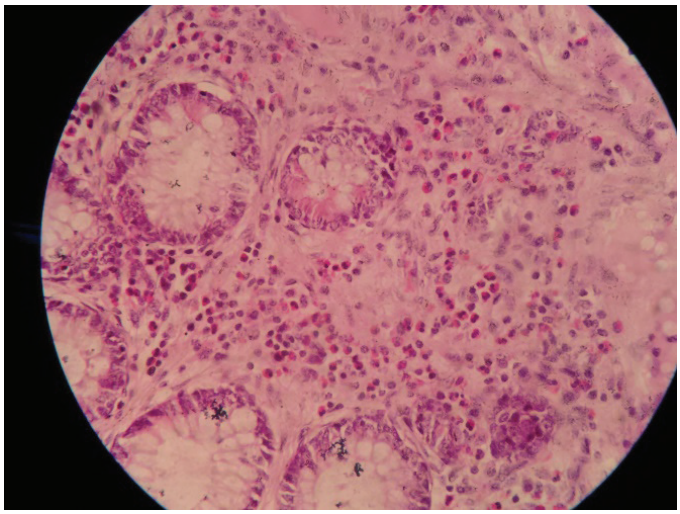

Figure 3: Photomicrograph showing dense eosinophilic infiltrate in the caecal wall.

the tissue eosinophilia was >20/HPF and the differential eosinophilic count in blood was 16%.

The differential diagnoses include Crohn's colitis, drug induced colitis (Rifampicin, NSAID, Carbamazepine), connective tissue disorders and allogenic bone marrow transplant.[4,5] Tolosa-Hunt syndrome (high serum IgE levels>1300IU/ml) and Idiopathic Hypereosinophilic syndrome (marked peripheral eosinophilia > 1500cells/µL) also need to be considered.

The management differs for infants and adults. In the former, withdrawal of the allergic trigger is sufficient while in the later corticosteroids are the main stay of therapy. The initial steroid dosage of 1-2 mg/Kg/day for 8 weeks is gradually tapered over the next 8 weeks.[5] Relapse and steroid dependence are also reported. Budesonide (6 mg/day) is found to be useful in right sided colitis. The most important precaution before starting medical therapy is to rule out parasitic infestation beyond doubt.

Our patient had a right iliac fossa mass that caused acute intestinal obstruction. To our knowledge, this is the first docemented report of such a presentation.

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