

report revealed the presence of malarial pigment in the ruptured spleen (**Figure 4**).

## Discussion

Malaria is a parasitic infection caused by *Plasmodium* species. In India, *P. vivax* accounts for approximately 55% of cases whereas 40%–42% of cases are caused by *P. falciparum* which is most frequently associated with severe complicated malaria.<sup>1</sup> Infections by other two species are often subclinical and associated with fewer complications. However, splenic complications are commonly associated with non-falciparum species especially *P. vivax*. They occur in up to 2% of cases.<sup>3,4</sup> Patients may present with left hypochondriac pain which may be due to infarct in an enlarged spleen, trauma to an enlarged spleen and rarely rupture of the spleen. Most cases of splenic rupture occur during acute infection. Although there is considerable splenomegaly in chronic malaria, rupture is uncommon as excessive fibrosis acts as a protective barrier against rupture. In cases with acute disease, there is rapid enlargement and stretching of splenic capsule secondary to vascular congestion and cellular hyperplasia, and the lack of fibrosis predisposes to splenic rupture. Diagnosis should always be suspected in a patient from an endemic region who presents with rapid onset of hypotension and severe left hypochondrial pain. Abdominal USG is a rapid bedside modality for assessing the severity of splenic rupture, amount of subcapsular and intraperitoneal haematoma. It also helps to exclude other causes which may present with left hypochondrial pain such as left-sided pleural pathology, pancreatitis and renal calculi. In haemodynamically stable patients, CT scan can be performed to delineate the findings and a better assessment of their severity.<sup>2-5</sup>

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# Enteral stenting using the rendezvous technique

## Introduction

We report a rare case of management of metastatic carcinoma colon with postoperative recurrence in a patient who had presented with anastomotic stricture and acute intestinal obstruction. She underwent combined percutaneous fluoroscopic insertion of guidewire and rendezvous insertion of fully covered self-expanding metallic stent (SEMS) and achieved palliation.

## Case report

A 67-year-old woman, a known case of carcinoma colon (post-right hemicolectomy), presented with a history of jaundice for the past 6 months due to lymph node metastases at the porta hepatis. Percutaneous stenting (Luminexx Bard) of the right anterior, right posterior and left biliary system was done (as endoscopic retrograde cholangiopancreatography failed) to palliate jaundice. No further treatment was opted because of her poor performance status. The patient was largely asymptomatic for 6 months after which she presented with acute intestinal obstruction (**Figure 1**) due to recurrence of tumour at the anastomotic site. After initial resuscitation, stenting was

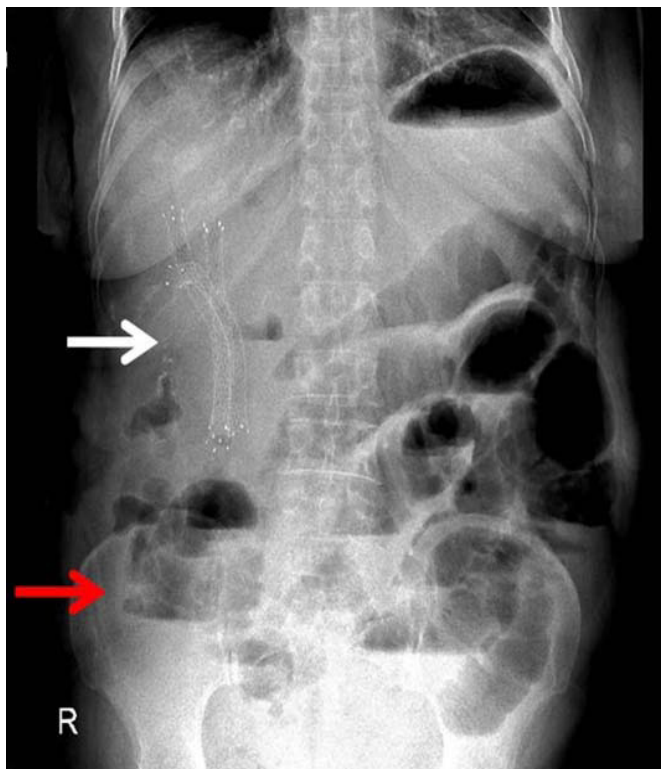


Figure 1: Abdominal X-ray showing previously placed biliary metallic stents (black arrow) and multiple air-fluid levels (red arrow).

attempted to relieve obstruction using colonoscopy. However, guidewire could not be negotiated across the site of anastomotic stricture. As the patient was moribund and the success of spiral enteroscopy-assisted SEMS deployment was questionable due to terminal ileal location of the stricture;<sup>1</sup> the rendezvous technique was preferred over other methods.

Computed tomography (CT) scan-assisted percutaneous access of the ileal loop was achieved just proximal to the obstruction followed by delineation of stricture details with contrast under fluoroscopic guidance. Fluoroscopy showed two strictures—one at the terminal ileum and the other at the anastomotic site (**Figure 2**). Guidewire was inserted percutaneously and negotiated across the strictures. It was pulled through the colonoscope followed by placement of two stents (Bona stent, Standard Sci-Tech, Seoul, Korea)—first at the anastomotic site and the second at the terminal ileum (**Figure 3**). Subsequently, the small bowel was decompressed (**Figure 4**) and the patient improved. The patient is asymptomatic after 3 months of follow-up.

This case is an illustration of successful palliation of malignant enteral strictures using the rendezvous stent insertion technique in patients with poor surgical risk.

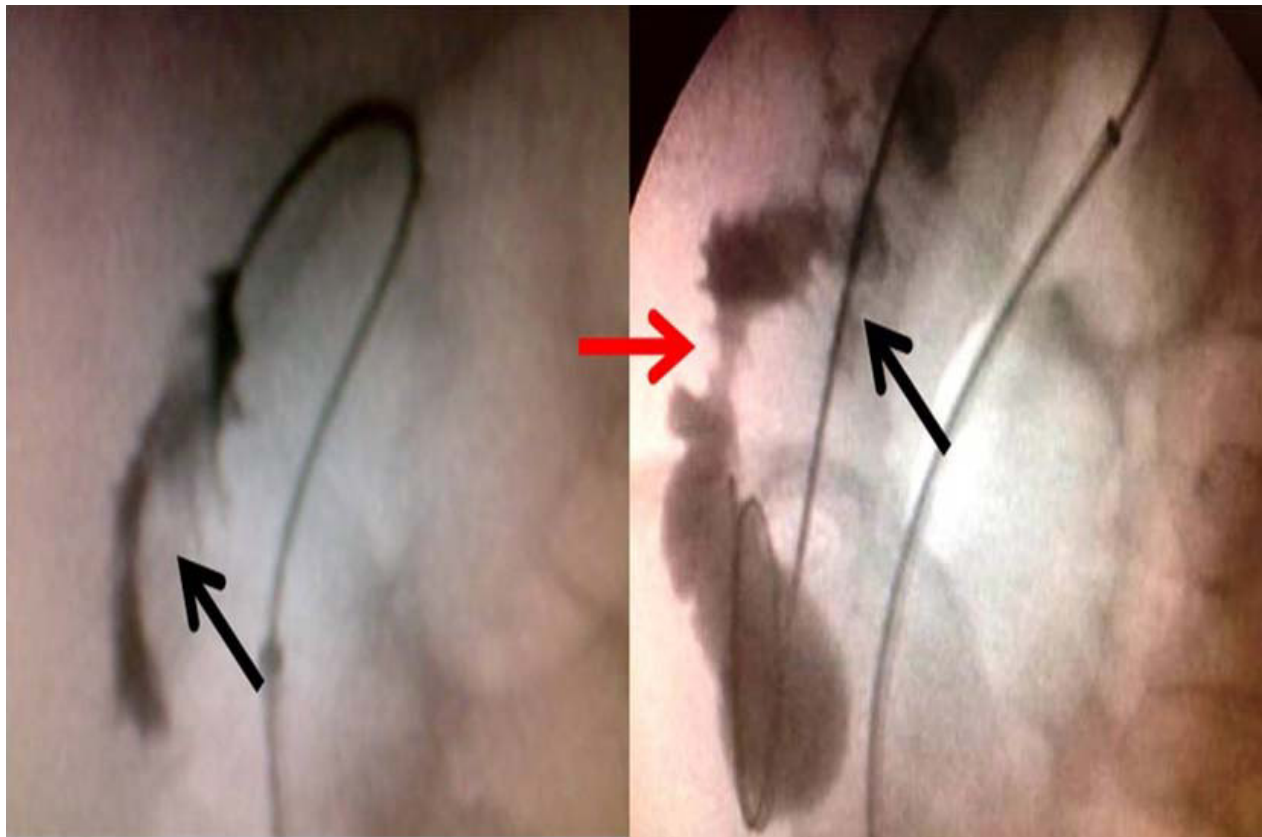


Figure 2: Fluoroscopic image showing terminal ileal stricture (black arrow) and anastomotic stricture (red arrow).

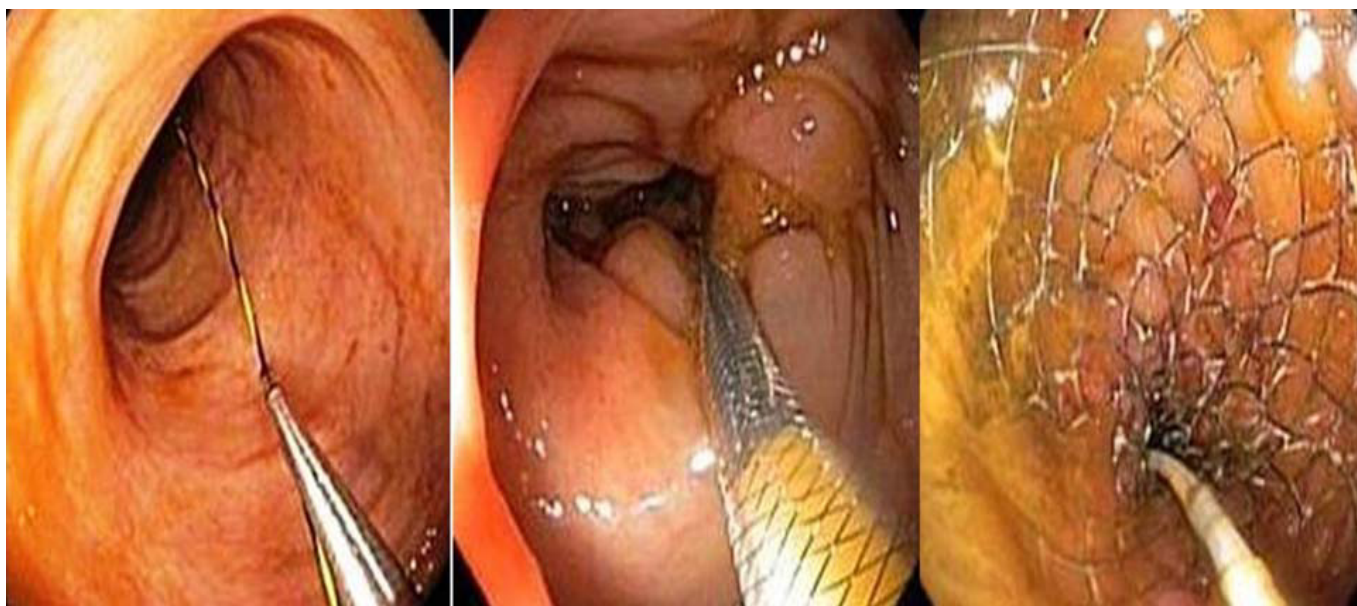


Figure 3: Colonoscopic image showing retrieval of fluoroscopically inserted guidewire through a colonoscope.

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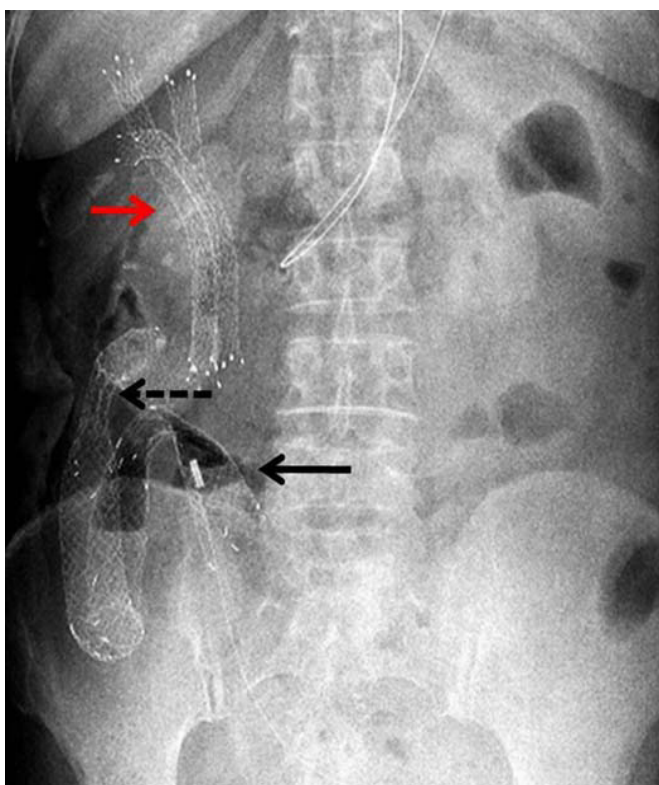


Figure 4: Abdominal X-ray showing biliary metallic stents (red arrow), stents over anastomotic stricture (broken arrow) and terminal ileal stricture (black arrow).

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## Reflux disease in an infant: a twist in the tale

### Case report

A 1-year-old girl child of non-consanguineous parents presented with a history of regurgitation of feeds and poor weight gain lasting for the past 6 months. Initially, she used to regurgitate unaltered solid foods immediately after ingestion. Later she started regurgitating both solid and liquid food and her condition gradually worsened. She also suffered from two bouts of pneumonia in the past 4 months. She had numerous medical consultations and got treated for gastro-oesophageal reflux but with no improvement. There was no significant birth- or neonatal- or family history related to her illness.