

carcinoma with lymphocytic stroma. Several studies have reported the presence of similar tumor in several extrapharyngeal sites such as lungs, stomach, salivary glands and thymus.³ There are multiple recent case reports describing lymphoepithelioma-like carcinoma (LLC) of the biliary tract with intra-hepatic bile duct being the most common site of origin.² To the best of our knowledge, only two cases of extrahepatic LLC have been reported, one in the gall bladder and another in the distal bile duct.^{1,4} Extra-nasopharyngeal LLC are also associated with EBV infection.² The prognosis of biliary tract LLC is generally considered better than adenocarcinoma.⁵ This case has been reported for its rarity and lack of association with EBV infection.

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Ultrasound-guided glue injection of ileocolic artery aneurysm

Introduction

Visceral artery aneurysm (VAA) is often asymptomatic and discovered incidentally. Reports on ileocolic artery aneurysms (ICAA) are rare and mostly anecdotal. Therapeutic options include surgery or radiology-guided endovascular measures. We report a case of spontaneous ICAA where N-butyl cyanoacrylate (NBCA) glue was used to achieve embolisation percutaneously under ultrasound guidance.

Case report

An 81-year-old gentleman presented with two weeks history of lower abdominal pain. The pain was dull aching, continuous with no radiation or aggravation by food. There were no associated systemic symptoms like fever, loss of appetite or weight loss. Bowel and bladder habits were unaltered. He had chronic obstructive pulmonary disease and Parkinson's disease. He was treated successfully by Heller's cardiomyotomy for achalasia in 2008, with difficult endotracheal intubation prior to anaesthesia.

On examination, the patient was afebrile with other vital parameters being normal. On deep palpation tenderness was noted in the hypogastrium. There were no signs of gut obstruction or any palpable mass. Hemogram, urine examination, renal and liver function tests were normal. Ultrasound abdomen with Doppler (**Figure 1A**) showed a 3×3 cm pulsatile aneurysm. The origin of the aneurysm was unclear. The abdominal aorta, its bifurcation, the celiac and superior mesenteric arteries at their origins were all normal with no evidence of thrombosis. CT angiography (**Figure 2**) performed to identify the origin of the aneurysm, showed a 4.5×4 cm aneurysm filled with a partial thrombus originating from the ileocolic branch of superior mesenteric artery (SMA), with no other aneurysms elsewhere in the abdomen. The afferent artery was 2 mm in size. 2 ml NBCA was injected into the aneurysm percutaneously under ultrasound guidance with no complications. The patient improved symptomatically within 24 hours post-procedure. At 4 weeks follow-up the patient was asymptomatic and Doppler ultrasound showed complete embolisation of the aneurysm (**Figure 1B**).

Discussion

VAA are intra-abdominal aneurysms that affect the celiac, superior and inferior mesenteric, renal arteries and their

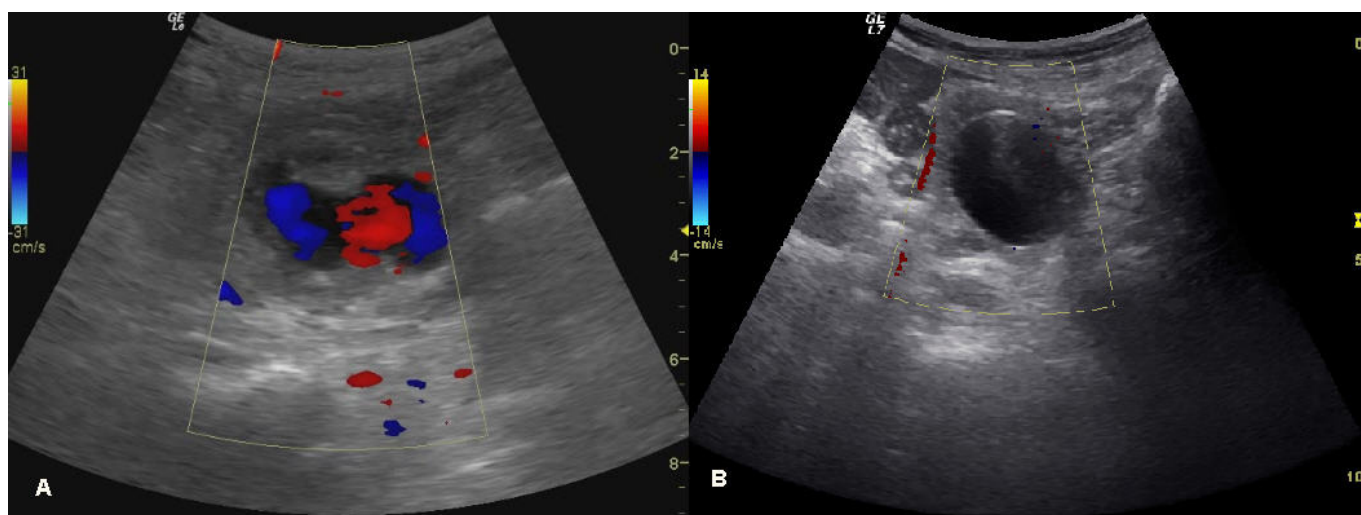


Figure 1: US Doppler of ICAA: A) before glue injection and B) 4 weeks after the procedure



Figure 2: Coronal maximum intensity projection showing ICAA (white arrow) on contrast-enhanced CT scan

branches. Identified mostly in older people (age >60) of either gender, aneurysms of jejunal, ileal and colic arteries put together account for only 3% of all VAAs. Aneurysms of the ileocolic branch (ICAA) of SMA are very uncommon and usually anecdotal.¹ Although predominantly asymptomatic and detected incidentally, ICAAs can present with abdominal pain or nausea. Aneurysm rupture may manifest with pain, gastrointestinal blood loss or intra-abdominal haemorrhage.² The only previous Indian report on ICAA was by Sharma et al who described a case following minor trauma which resolved spontaneously.³ The pathogenesis of ICAAs is unclear but most occur due to septic emboli,^{4,5} vasculitis, trauma, dissection, fibromuscular dysplasia or degeneration.⁶ The last two causes

were most likely responsible for the aneurysm in our patient.

Doppler ultrasound is the diagnostic modality of choice for suspected SMA aneurysms, but localization becomes difficult when one of its branches is involved.⁷ Hence confirmation of the actual site and detection of other concomitant aneurysms is always performed by CT angiography,⁸ as was done in our case. With the risk of rupture approaching 50%, treatment is indicated for most SMA aneurysms.⁵ Treatment options include surgery or endovascular interventional techniques, depending on the patient's hemodynamic status and surgical risk. Surgical options include aneurysmectomy, aneurysmorrhaphy or ligation (with or without arterial reconstruction). In view of the previous difficulties encountered at endotracheal intubation in our patient and his age, we decided against surgical intervention in this case. Endovascular measures involve stenting ("endovascular exclusion") or using coils, thrombin or glue to embolise the aneurysm sac. Lagana et al⁹ report a 10% reperfusion at one month after a single endovascular intervention (29 VAAs, 18.7 months mean follow-up), and no reperfusion after a second endovascular procedure. An American follow-up study¹⁰ on 48 VAAs reported NBCA use in 19% procedures for persistent flow or multiple branches yielding good results. The choice of endovascular intervention is dictated by size of the vessel, presence of multiple feeders and local experience. We chose NBCA in our patient due to the small size of the efferent artery (not ideal for stenting), its lower cost and ease of preparation compared to thrombin. The percutaneous route was selected based on the estimation that the aneurysm was accessible through a safe, avascular plane under ultrasound guidance. While our patient's abdominal pain resolved within 24 hours, total embolisation of the aneurysm

was confirmed 4-week follow-up.

To the best of our knowledge this is the first Indian case report of spontaneous ICAA treated by ultrasound guided percutaneous primary glue embolisation. We suggest this treatment option as a feasible and effective modality for aneurysm embolisation in patients where surgery is deemed unsuitable and local expertise for endovascular stenting or coil embolisation are unavailable.

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Retrieval of an impacted foreign body in the oesophagus by combined endoscopic-surgical approach

Introduction

Impaction of a wide range of foreign bodies in the oesophagus has been described in the literature. These are retrieved either by endoscopy or surgery. We report impaction of an unusual foreign body (mango seed) in the oesophagus which could not be extracted endoscopically. A thoracotomy/oesophagotomy would have been too morbid for the elderly patient. A rendezvous approach using endoscopy and surgery successfully retrieved the foreign body avoiding a thoracotomy.

Case report

An 80-year-old man presented to the All India Institute of Medical Sciences, New Delhi with a 10 day history of dysphagia and chest pain. He was able to swallow liquids with difficulty. On further questioning he gave history of accidental ingestion of a mango seed 10 days ago. There were no other complaints. His physical examination was unremarkable. Chest and abdominal X-rays were normal. An upper gastrointestinal endoscopy revealed a large mango seed impacted at 30 cm from the incisors (**Figure 1a**) but it could not be extracted (**Figure 1b**). An attempt to retrieve it using a snare and a gentle push also failed. Forceful dislodgement was not attempted given the long duration of impaction, the size of foreign body and the possibility of a distal lesion. A surgical extraction was planned but as the patient was elderly, it was decided to avoid a thoracotomy and oesophagotomy. At laparotomy, the seed could not be felt at the gastroesophageal junction. A gastrotomy was made in the upper body of the stomach and after placing retractors within the stomach, the tip of the seed was just visible. Endoscopy from below showed no evidence of any narrowing or growth in the distal oesophagus. An attempt to grasp the seed was unsuccessful. An upper gastrointestinal endoscope was passed through the oesophagus and the seed was pushed with the endoscope. This manoeuvre succeeded in prolapsing a part of the seed along with the oesophageal mucosa into the gastroesophageal junction allowing the seed to be grasped at its widest part with a long Allis forceps. The seed was then gently dislodged with a to-and-fro motion and extracted from