

However, with unresectable or metastatic disease, it is advisable to attempt a trial of chemotherapy. The most frequently used agents are doxorubicin and cisplatinum.⁵

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Extra-osseous Ewing's sarcoma presenting as obstructive jaundice

Introduction

Tefft et al first described a soft tissue tumor in five young children, which was indistinguishable from Ewing's sarcoma (ES) of bone, on light microscopy.¹ To the best of our knowledge there are less than 10 case reports of intra-abdominal Ewing's sarcoma, and there are no case reports of intra-abdominal Ewing's sarcoma presenting with obstructive jaundice. We therefore report the first case of intra-abdominal Ewing's sarcoma and obstructive jaundice due to compression of the retro-pancreatic bile duct and review the literature. This case

also illustrates the difficulties in diagnosis and management.

Case report

A 50-year-old male patient presented with back pain of 1 month's duration. Abdominal examination revealed a palpable mass located in the lower abdomen. Routine laboratory tests were normal. USG abdomen was performed that showed multiple hypoechoic and heterogenous nodules in the peri-aortic and para-aortic regions. CT abdomen revealed a large lobulated solid mass (6.8 cm x 9.4 cm x 13.5 cm) in the right lumbar region extending into the right iliac fossa, multiple lymph nodes in the paraaortic, paracaval and retroperitoneal regions. Lymphoma was suspected and FNAC report was inconclusive. Biopsy showed round to polyhedral cells arranged in rosette pattern suggestive of cellular tumor mass and advised histological assessment. After 15 days he again presented to us with jaundice and worsening abdominal distention. Lab reports suggested obstructive jaundice. Repeat CT abdomen (**Figure 1**) showed large lobulated soft tissue mass (20 cm x 17 cm x 16 cm) and there was enlargement of all groups of retroperitoneal and mesenteric lymph nodes, which was non-discrete. CBD was dilated (10 mm) and displaced anteriorly and compressed in its retro pancreatic segment by a large lymph nodal mass. Histology (**Figure 2**) was suggestive of malignant round cell tumor. Immunohistochemical studies included CD99 (+), synaptophysin (+), and LCA (-). In the context of clinical and



Figure 1: CT scan showing intraabdominal mass with compression of bile duct.

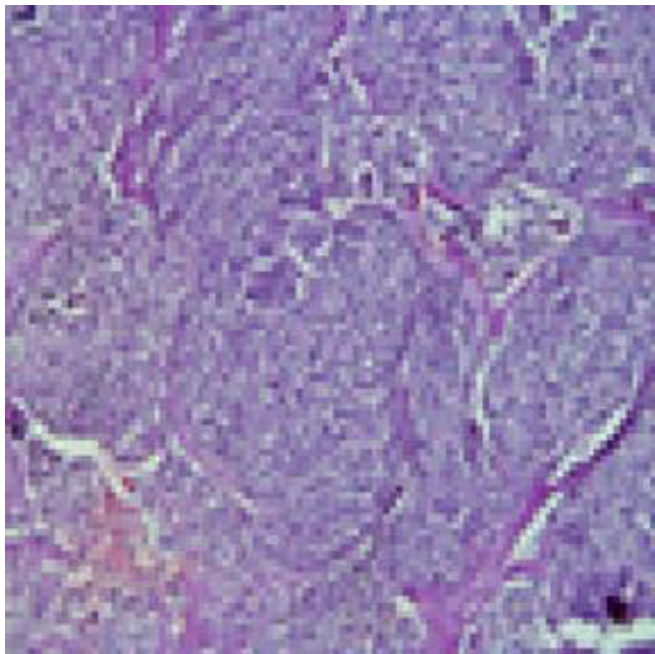


Figure 2: HE showing malignant round cell tumor (10x magnification).

histopathological evidence Ewing's sarcoma was diagnosed in this patient.

Duodenoscopy showed duodenal encasement of tumor. Biopsy reported non-specific infiltration. Palliative chemotherapy with ifosfamide and etoposide was started.

Discussion

Extraosseous Ewing's sarcoma (EES) occurs in the soft tissues (5%), often immediately adjacent to bones and is histologically indistinguishable from Ewing's sarcoma.² Distinct membranous CD99 expression is characteristic and highly but non-specific reliable positive marker for EES.³ ES, rhabdomyosarcoma, neuroblastoma, round cell liposarcoma are subcategories of small blue round cell tumors. Our first differential was lymphoma but biopsy revealed small round cell tumor, suggestive of EES. The mainstay of treatment should include multi-agent chemotherapy and aggressive surgical treatment.⁵

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Isolated retrovesical hydatid cyst presenting with obstructive uropathy and bilateral lower limb edema

Introduction

Isolated retroperitoneal retrovesical hydatid cyst is extremely rare with an incidence of 0.1/100,000 persons.¹ Hydatid cyst in the retrovesical area usually presents with pressure effects on adjacent organs such as urinary bladder and rectum.² We report a case of isolated retrovesical hydatid cyst (RVHC) presenting with obstructive uropathy and bilateral lower limb oedema. This type of presentation is extremely rare.

Case

A 36-year-old male patient presented with fullness and pain in the lower abdomen, and difficulty in passing urine of 3 weeks duration. There was straining and a sense of incomplete voiding. He also had bilateral lower limb edema, which had progressed over the same duration. There was no history of fever, trauma or any chronic illness. He was a farmer who kept livestock. The patient was in agonizing pain on arrival. His vital parameters were normal. Per abdominal examination showed fullness of lower abdomen with mild tenderness. Digital