

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

examination of rectum revealed a large, smooth, spherical mass anterosuperior to the rectum. The prostate was normal. Bilateral lower limb edema was pitting in nature. Distal pulsations were intact. The patient was immediately catheterized. Approximately 1300 ml of clear urine was drained. On reassessment, there was a smooth, non-tender immobile mass reaching almost up to the umbilicus.

Lab parameters revealed normal hemoglobin with TLC-8300/ mm^3 (eosinophil-4%). Plain X ray chest and abdomen was normal. Retrograde urethrogram showed distended urinary bladder (UB). Ultrasound abdomen and pelvis showed a large cyst (14 cm \times 10 cm \times 14 cm) in the pelvis and hydronephrosis

on the right side. CECT scan showed a large, non-enhancing, hypodense cystic lesion in the pelvis extending up to the coccyx and displacing the urinary bladder anterosuperiorly, compressing the rectum posterolaterally (**Figure 1**). Bilateral ureters were dilated with delayed contrast excretion.

On laparotomy, there was a large cyst in the pelvis which lay beneath the pelvic peritoneum, displacing the rectum posteriorly and UB anterosuperiorly (**Figure 3**). The diagnosis of retroperitoneal retrovesical cyst was made. Cyst densely adhered to the adjacent retroperitoneal connective tissue and rectum. It was aspirated. Clear fluid was seen. Cytological examination demonstrated the presence of hooklets, confirming

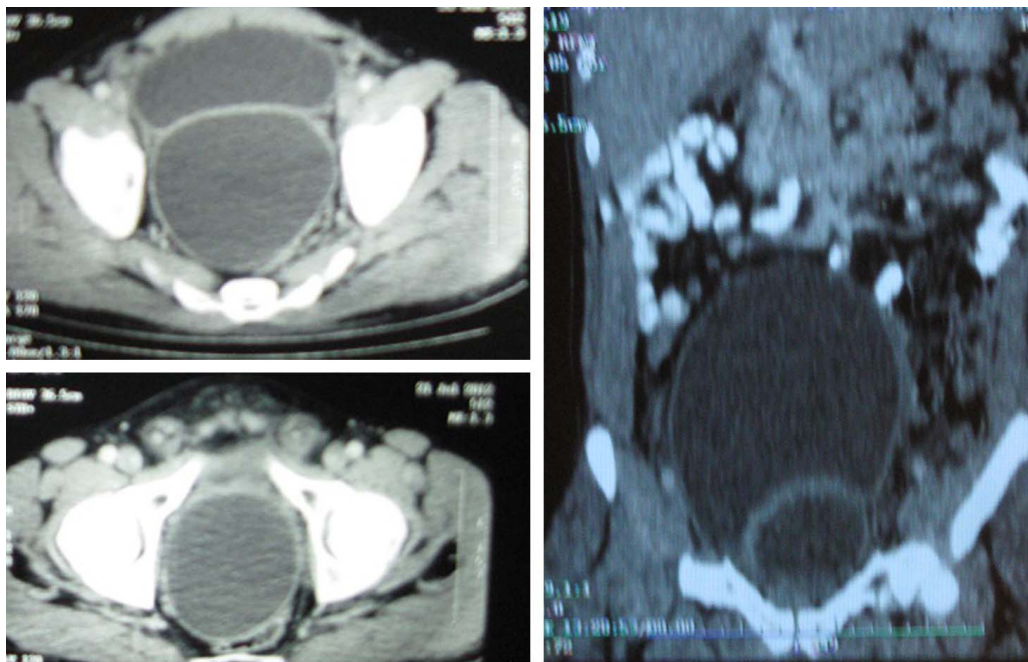


Figure 1: CECT showing retrovesical hydatid cyst

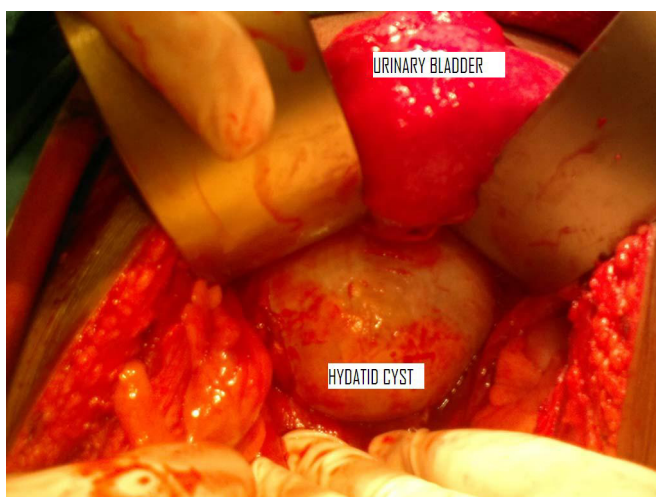


Figure 2: CECT showing dilated ureter on both sides

a hydatid cyst. 20% hypertonic saline was instilled into the cyst. After a few minutes, the fluid was reaspirated. An incision was made over the pericyst. The entire germinal layer of the hydatid cyst was removed. The pericyst was completely excised and sent for histopathological examination, which confirmed the diagnosis (**Figure 3**). The postoperative period was uneventful. Lower limb oedema subsided drastically immediately postop. He was discharged on the 5th postoperative day and advised a 4-week course of albendazole therapy (15mg/kg/day). Follow up ultrasonography after 15 days showed normal kidneys with no back-pressure changes. A total of 3 cycles of albendazole therapy was given with at 2-week intervals. The patient is symptom free after 15 months.

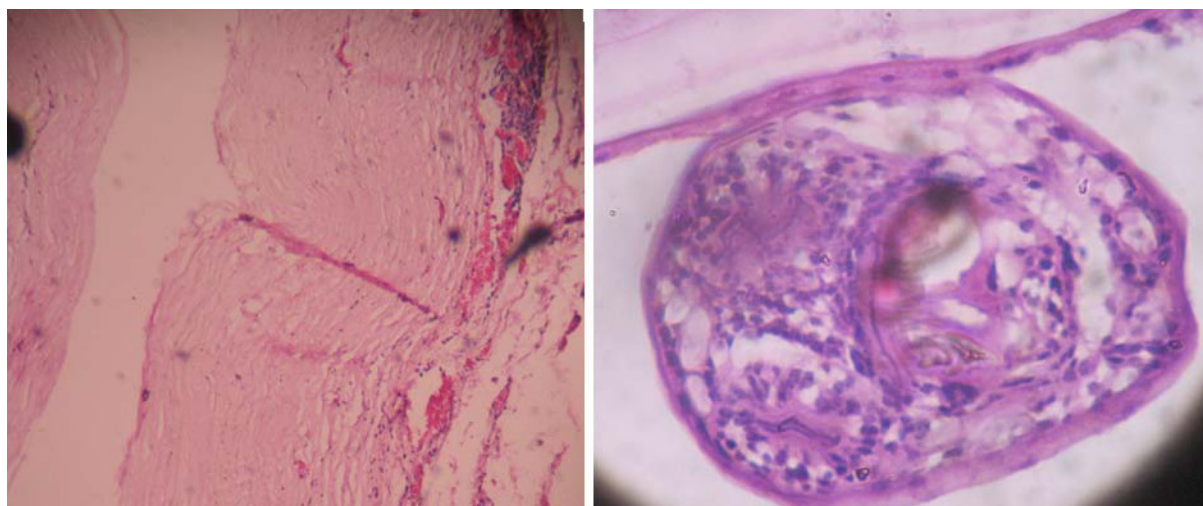


Figure 3: Intraoperative view of retrovesical hydatid cyst displacing UB anterosuperiorly and rectum posterolaterally

Discussion

Isolated retrovesical hydatid cyst (RVHC) is an exceptional occurrence. Aydinli et al from Turkey retrospectively analyzed 653 surgically treated patients of intraabdominal hydatid cysts in 25 years (1979 to 2004) and found only one case in the retrovesical space.³

The challenge in managing these patients is the accurate preoperative diagnosis of hydatid disease. The sensitivity of ultrasonography and CT are 93-98% and 97% respectively. The sensitivity of serological test (Indirect hemagglutination test) is 87.5% only⁴.

Treatment is primarily surgical i.e. complete removal of the entire cyst without contamination of the field. Robotic assisted laparoscopic surgery is the most recently introduced modality in the treatment of retrovesical hydatid cyst.

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Duplication of transverse colon in an adult presenting as chronic diarrhea

Introduction

Duplications of the gastrointestinal tract (GIT) are infrequent in the general population with an incidence of two or three cases per year in referred pediatric hospitals and more often discovered in the first two years of life.¹ This case study highlights tubular duplication of the transverse colon in an adult presenting with chronic diarrhea.

Case report

A 48 years old male came to our outpatient department with the chief complaint of chronic diarrhea for last 6 months. Clinical