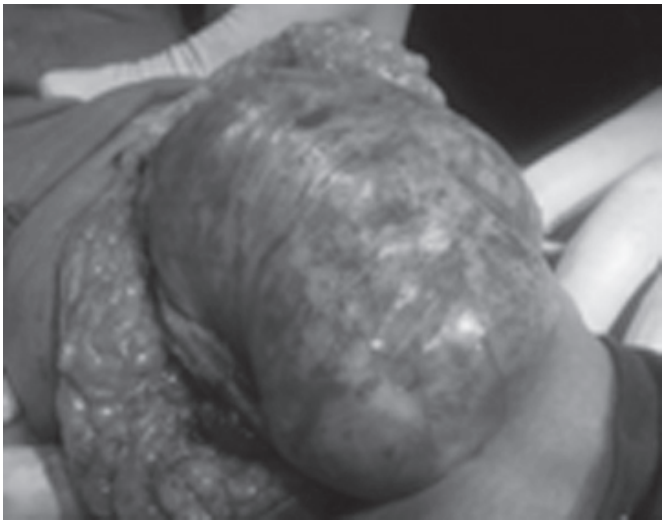

Figure 2: Intra operative photograph of giant choledochal cyst.

postoperative day.There was no evidence of malignancy on histopathological examination. The patient is presently doingwell at 1-year follow up.

Discussion

Choledochal cysts are rare congenital cystic dilatations of the biliary tract that can involve the intra- or extrahepatic bile ducts. The size of choledochal cyst varies, and the maximum diameter of cyst can reach upto20 cm.[4]

The classical triad of abdominal pain, jaundice and a right hypochondrial mass (as was in our case) is seen in less than 20% of patients. The main diagnostic tool for detection of a choledochal cyst, especially in childhood, is ultrasonography. Magnetic resonance cholangiopancreatography (MRCP) is the best method for noninvasive imaging of bile duct cysts. Surgery is the treatment of choice for a choledochal cyst. Complete excision of all cystic tissue is recommended because of the risk of recurrent cholangitis and the high risk of malignant degeneration. The risk of malignancy ranges from 3.2% to 39.4%.The risk of cancer in patients who had choledochal cyst diagnosed in the first decade is 0.7%, 11 to 20 years is 6.8% and more than 20years is 14.3%.[5] Robot-assisted resection of choledochal cysts and hepaticojejunostomyis therecently introduced modality in cyst management.

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Duodenal Leishmaniasis Mimicking Celiac Disease

Introduction

Visceral leismaniasis is considered as opportunistic infection in immunosuppressed patients particularly HIV infected. However, in the endemic areas like India, South America, Northeast Africa, and the Mediterranean basin it is quite common in immunocompetent persons as well. The atypical presentation of leishmaniasis is usually in association with HIV coinfection. [1-3] We present a case of atypical presentation of leishmania infection in a non immunocompromised patient who came with clinical symptoms mimicking celiac disease.

Case report

A 32 year old female presented in gastroenterology OPD with complaints of chronic diarrhea and weight loss for one year and fever for one month. Blood tests revealed normocytic normochromic anemia and leucocytosis. Anti transglutaminase

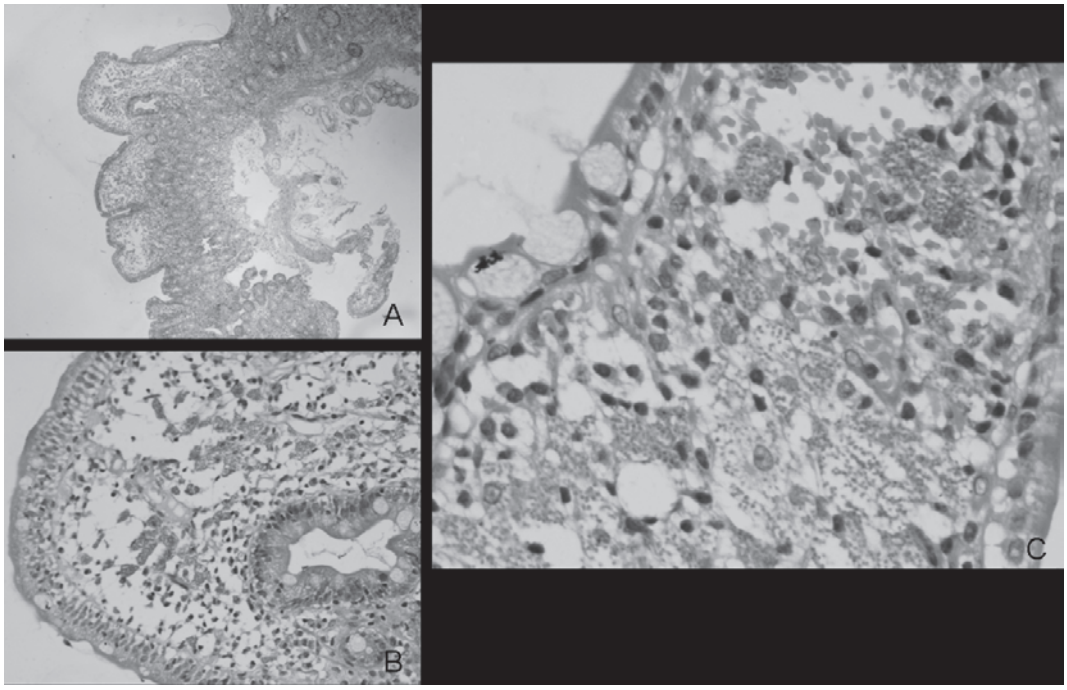

Figure 1: A) Low power photomicrograph showing mild villous atrophy (H&E, X40); B) Medium power showing granular clumps in the lamina propria (H&E, X200); C) High power examination showed abundant macrophages with intracytoplasmic and extracellular bodies of leishmania (H&E, X400)

(TTG) serology was positive. In view of chronic diarrhea and positive TTG, upper gastrointestinal endoscopy was performed and found to be mostly normal except for mild scalloping of duodenal mucosa and non-specific duodenitis. Biopsy was taken from the duodenum (D2) to rule out celiac disease.

Histopathological examination revealed a well oriented adequate biopsy with crypt villous ratio of 1:1 to 1:2. There was mild focal increase in intraepithelial lymphocytes. Lamina propria showed granular clumps under low power. High power examination showed abundant macrophages with intracytoplasmic and extracellular bodies of leishmania in the lamina propria (**Figure 1**). Later, she was tested for human immunodeficiency virus which was negative. Following treatment with liposomal amphotericin B the patient recovered from most of symptoms.

Discussion:

The classical presentation of visceral leishmaniasis is fever, weight loss, hepatosplenomegaly, hypergammaglobulinaemia and pancytopenia.[4] However, few patients show atypical manifestation particularly HIV infected and elderly immune-compromised individuals. Atypicality may be in terms of location, more severe cytopenias, high rate of recurrence and the higher mortality rate.[1]

We report a case of atypical presentation of duodenal leishmaniasis in a non immunecompromised patient who came with clinical symptoms mimicking celiac disease. There was no hepato/splenomegaly or lymph adenopathy, and there was unusual duodenal infiltration. Duodenal presentation of leishmania in patients with AIDS is well documented. In one of the series with 91 patients of AIDS the diagnosis of leismaniasis was established on gastrointestinal biopsies in 12 cases.[1] These patients usually underwent endoscopy and biopsy due to symptoms related to gastrointestinal tract. To conclude, atypical presentation of leishmaniasis should be kept in mind in the patient coming from endemic areas.

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Transperineal excision: A novel and alternative surgical approach for pelvic recurrence of rectal cancer

Introduction

Colorectalcancer (CRC) is the third most frequently diagnosed cancer in both men and women and the second most fatal cancer.[1] The incidence of CRC is greater in men than in women.[2] CRCs are often seen in the elderly population and approximately 30% of these are localized in the rectum.[2] Distal rectal cancer is a surgical and oncological challenge. Various surgical operations, such as abdomin operineal resection and low anterior resection with total mesorectal excision (TME), are performed in the management of distal rectal cancer. Although recurrence rates have decreased to about 10% after using the method of TME, local recurrence remains an important clinical issue.[3] Surgery is the treatment of choice but it is a difficult procedure, with very poor prognosis. Here, we report a case of pelvic recurrent tumor that was entirely excised by a novel and alternative surgical method, transperineal approach, with CT-guided wire marking.

Case Report

A 71-year-old female patient, who had undergone abdominal operineal resection for a low rectal cancer with T2N0 pathological stage before fifteen months, was admitted to our unit for routine follow-up. She had received a full course of adjuvant chemoradiation following the operation. On blood tests, cancer antigen 19.9 (CA 19-9) level was high (163 IU/mL) with normal carcinoembryonic antigen (CEA) level (5ng/mL). As shown in **Figure 1**, CT scan showed a heterogeneous pelvic mass, 38 mm x 35 mm in size, at the left posterolateral side of bladder. Similar lesion within definite borders was also seen on magnetic resonance imaging. In PET/CT, an increased 18F - FDG uptake (SUVmaks: 5.1), approximately 29 mm x 25 mm in size, at the inferior left para-iliac zone was observed. CT-guided trucut biopsy was performed. Biopsy identified an adenocarcinoma. The pelvic mass was marked with a CT-guided wire and was excised totally by transperineal approach under spinal anesthesia as shown in **Figure 2**. On histopathological examination, an adenocarcinoma, evaluated as a recurrent lesion of the

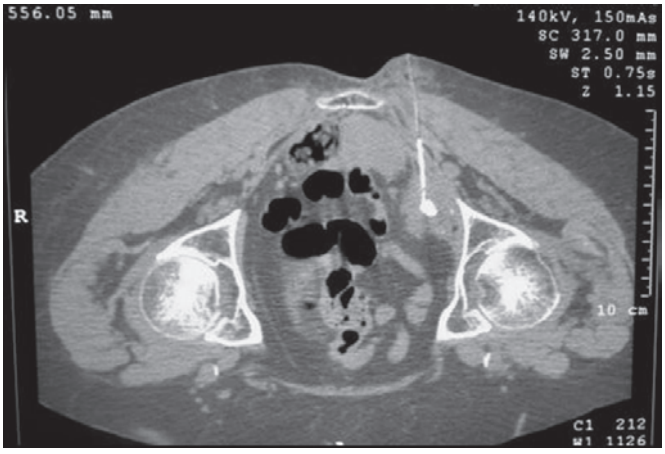

Figure 1: The tomographic appearance of the pelvic mass, marked with a wire, localized at the left posterolateral site of bladder

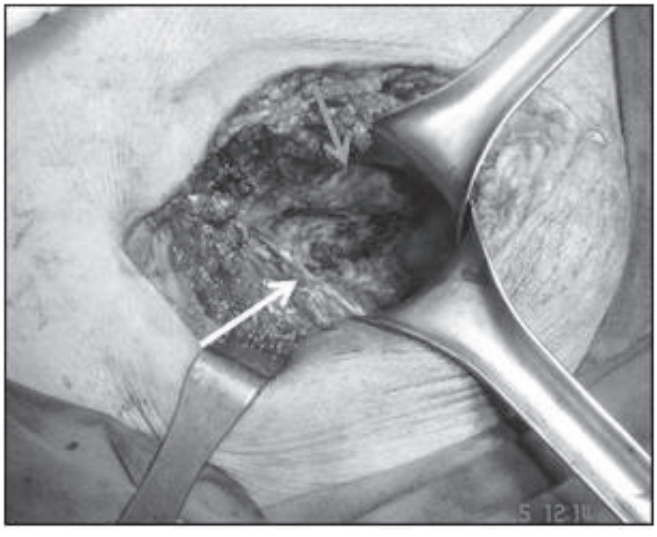

Figure 2: The appearance of the area after excision of the mass, localized between iliac bone (blue arrow) and obturatory vein (white arrow)