This case was similar to previous reports except for the large tumour size and the necessity for amputation as primary treatment. The breast mass was interesting since the breast is phylogenetically an apocrine sweat gland. Although other eccrine tumours are similar to breast carcinomas[10], there are no reports associating breast lesions with porocarcinoma[8].

In conclusion, eccrine porocarcinoma is a rare, curable malignancy of eccrine sweat gland origin. However on review of the literature metastasis or death occurred in 25% of cases. Close follow-up to detect local recurrence and lymph node metastasis is recommended since further surgery may be curative[9,11]. In more advanced cases there is no treatment of proven benefit.

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Closed loop large bowel obstruction secondary to pancreatitis

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Keywords: large bowel obstruction; pancreatitis

Case presented to Clinical Section, 8 December 1989

We report a patient with pancreatitis, in whom closed loop colonic obstruction resulted in caecal necrosis. Pancreatitis is an unusual cause of large bowel obstruction. The first case was described in 1927 by Forlini[1]. We were unable to find a similar case in the literature.

Case report

A 43-year-old male painter and decorator presented as an emergency with a 2-week history of abdominal pain. Over the previous 48 h this had become more severe and localized to the right iliac fossa. It was associated with absolute constipation and abdominal distension. There was a 3-year history of diabetes controlled with metformin. The patient was a heavy drinker, consuming 10 pints of Guinness a day. On admission he was flushed with a temperature of 37.8°C, a pulse of 96/min and a blood pressure of 130/80 mmHg. The abdomen was distended and tender with guarding in the right iliac fossa. Rectal examination showed an empty rectum. Bowel sounds were absent.

Investigations revealed: haemoglobin 13.2 g/dl, whole blood count 15.1×10^9/l, glucose 15.3 mmol/l and amylase 113 u/l (electrolytes, urea and liver function tests were within the normal range). Plain abdominal X-rays (Figure 1) showed a distended caecum in the right iliac fossa. At laparotomy a grossly distended and necrotic caecum was found. There was a large mass arising from the lesser sac and root of the transverse mesocolon, involving the hepatic flexure of the colon, the gallbladder and the duodenum. The mass was mobilized revealing free pus in an abscess cavity within the lesser sac. The abscess was drained and a right hemicolectomy was performed. The patient made a good postoperative recovery, apart from a minor chest infection which responded to antibiotics and physiotherapy. Histology revealed areas of fat necrosis and calcification consistent with pancreatitis. An ultrasound performed 2 weeks postoperatively showed no evidence of gallstones.

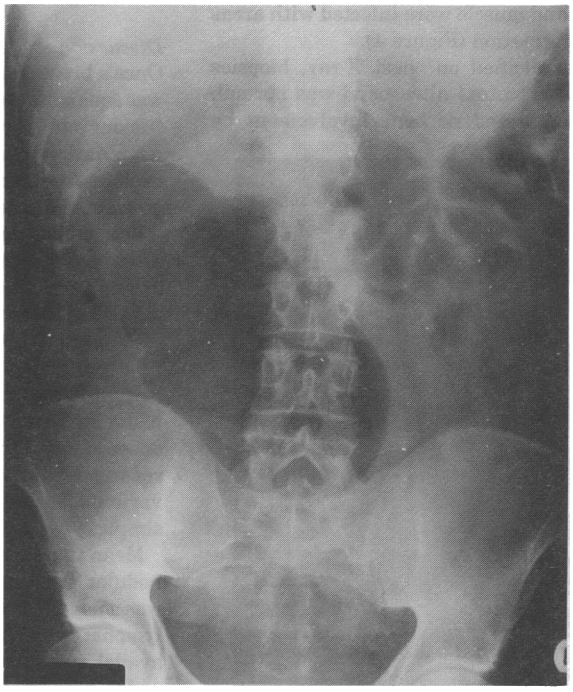

Figure 1. Supine abdominal X-ray demonstrating distended caecum

Discussion

Large bowel obstruction caused by pancreatitis has been reported before; obstruction is usually incomplete[2,3].

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We believe this is the first case to present with a closed loop obstruction, producing caecal necrosis.

Mair in 1976[4] reviewed the then world literature and noted three main modes of presentation for large bowel obstruction following pancreatitis. Fifty per cent are discovered on barium enema during an attack of acute pancreatitis. In 25% the diagnosis is made at laparotomy for large bowel obstruction. The final 25% present with an acute abdomen.

Obstruction usually occurs at the splenic flexure, perhaps reflecting the close anatomical association with the tail of the pancreas. Of the 36 cases reviewed by Lazarou in 1984[5] the hepatic flexure was involved in only six cases. The aetiology of the stenosis probably varies. Compression and oedema associated with an inflammatory mass may lead to narrowing. Pericolic fibrosis may then lead to a more permanent stricture[6]. Hunt and Mildenhall have postulated that mesenteric ischaemia associated with a severe attack of pancreatitis may play a role leading in the longer term to fibrosis with stricture formation[7].

Barium enema may be valuable in the chronic presentation demonstrating a stenotic lesion with normal mucosa. In three cases conservative management and follow-up barium studies have demonstrated resolution[5]. Most patients in the past have undergone laparotomy, and a number of authors have stressed the value of a conservative operative approach using a defunctioning loop colostomy because of the reversible nature of many of the strictures and the poor environment for an anastomosis[4,5]. A conservative operative approach is inappropriate in the presence of caecal necrosis.

Large bowel obstruction associated with lesser sac paracolic abscess may be due to pancreatitis. Conservative surgery is usually appropriate, but in the case reported closed loop obstruction necessitated right hemicolectomy.

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Familial Raynaud's phenomenon and localized scleroderma associated with essential telangiectasia and cytogenetic abnormalities

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Keywords: Raynaud's phenomenon; morphoea; telangiectasia; chromosome breaks

Case presented to Section of Dermatology, 15 June 1989

We report a mother and daughter (aged 39 and 16 years) with a similar history and pattern of cutaneous abnormalities.

Case report

The mother has had Raynaud's phenomenon since the age of 2 years and painful lesions diagnosed as chilblains with recurrent paronychia since childhood. Subsequently, red, blotchy areas on the hands, forearms and feet, a brown patch of abnormal skin on the right shin and thickening of the skin of the toes have developed. She has also complained intermittently of dysphagia but investigations have been normal. She had a bilateral lumbar sympathectomy at the age of 19 years with considerable subsequent relief from chilblains. At the age of 23 years she had ulcers around the ankles and in 1986 osteomyelitis of the left foot. In 1988 she was treated for a chronic sinus involving the right foot.

The daughter noticed the development of red, blotchy areas on the hands, forearms and feet 7 years ago and a cream and brown patch on her right shin 3 years ago. She was investigated for haemoptysis in 1985. She developed Raynaud's phenomenon and chilblains for the first time in the winter of 1987/88.

On examination both present similar appearances with cold hands and feet and profuse telangiectasia of an essential rather than matt type on the face, forearms hands and feet. Both have localized scleroderma on the right lower leg, the daughter's extending onto the right thigh. The mother has sclerodactyly of the toes and sclerosis of the skin of the dorsum of the feet. Several of her nails are dystrophic.

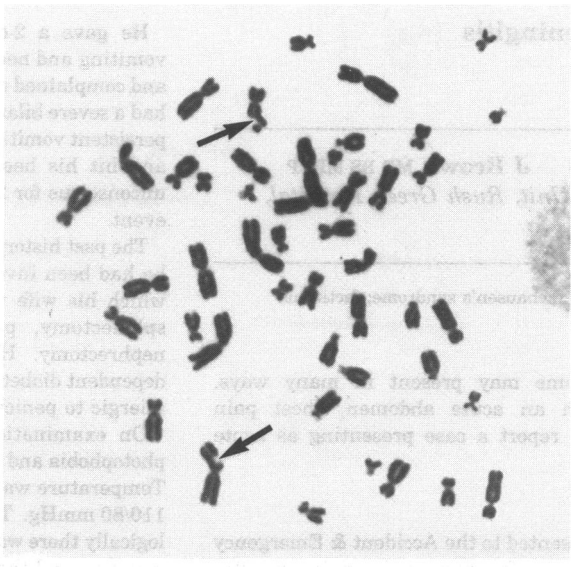

Figure 1. Lymphocyte chromosome preparation from the daughter showing two chromatid breaks (arrowed)

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