with ectopic amylase production[11]. It is possible that amylase production in this tumour occurred as a result of interference with the gene expression control following chromosome damage and allele loss associated with malignant transformation.

The finding of a high amylase content should be interpreted with caution especially as the differential diagnosis includes lesions in which accurate preoperative diagnosis is essential.

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Oesophago-gastrectomy for Marie-Bamberger syndrome

A Pallecaros BSc MRCP **B A Ross** FRCS
L Gates MBBS **F W S Webb**
Departments of Medicine and Thoracic Surgery, The Ipswich Hospital, Ipswich IP4 5PD

Keywords: inflammatory fibroid polyp; hypertrophic pulmonary osteoarthropathy

Case presented to Clinical Section, 8 November 1991

The Marie-Bamberger syndrome of hypertrophic pulmonary osteoarthropathy (HPOA) is still ill understood[1]. We report a fascinating case whereby removal of a rare benign oesophageal tumour completely reversed crippling HPOA.

Case report

Until June 1990 Mr PM, 74 years old, had been enjoying his retirement to the full, finding time for gardening and cricket between appointments as a local councillor. He then developed dysphagia for solids. At first he did not worry as similar symptoms had occurred in 1983 when oesophagitis and a sliding hiatus hernia had been diagnosed.

This time a strange lesion was found in the distal oesophagus. The features on barium swallow could not distinguish between an intrinsic oesophageal lesion and an external one pushing in. Endoscopically the lesion stretched for 10 cm and was described as resembling a 'sausage'. Biopsies only showed non-specific inflammatory changes suggesting that the lesion was extramucosal.

Mild clinical HPOA developed in October 1990 confirmed by X-ray (Figure 1). As he was an ex-smoker no investigation was spared to exclude an underlying pulmonary lesion, including sputum cytology and bronchoscopy.

By December 1990 he was bed-bound by crippling HPOA, had lost 2 stones in weight and had progressive dysphagia.

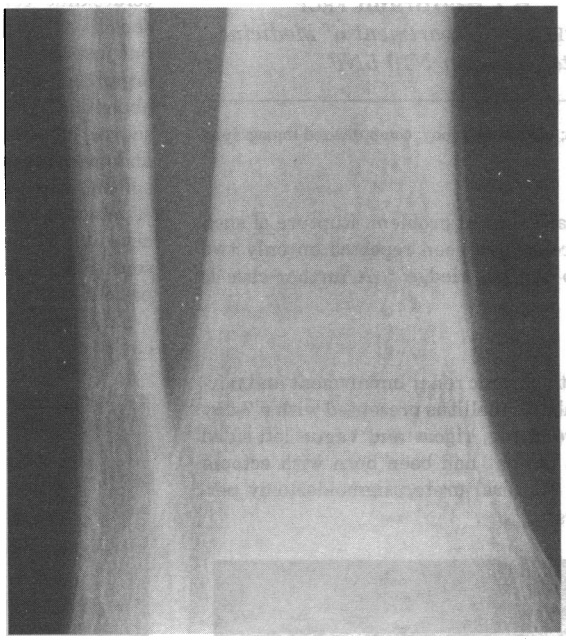

Figure 1. Lower tibial shaft with typical X-ray appearance of HPOA

The oesophageal lesion had not changed endoscopically except that the tip had ulcerated with a consequent drop in haemoglobin from 14 to 10. CT added very little as the mass had a similar attenuation value to surrounding tissue.

An oesophago-gastrectomy was performed on the 23 January 1991. When Mr PM next awoke in intensive care the HPOA had vanished.

Discussion

The oesophageal lesion, an inflammatory fibroid polyp (IFP), is rare. Most of the reported cases have occurred in the stomach or small intestine and none of these have previously been associated with HPOA[2-4]. The neoplasm is benign, mainly consisting of a fibrous and vascular mesh. Characteristic histological features include giant cells and eosinophils[2].

We do not know the significance of a transient eosinophilia retrospectively apparent in this patient's record in 1982-4.

Correspondence to: Dr Anna Pallecaros, 32 Rollscourt Avenue, London SE24 0EA

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A barium swallow in 1983 reported 'a slight indentation in the distal oesophagus' and this finding may be significant as it has been suggested that these polyps may occur as a response to injury[5].

To assume that the HPOA in this case was necessarily due to the fibroid polyp may not be correct. It remains possible that the vagotomy, itself unavoidable during oesophagogastrectomy, led to the resolution of the patient's HPOA[6].

Rather we feel that this IFP occurred at a critical site in relation to as yet unknown pleural or subpleural receptors. In this way it may share a mechanism with other unusual causes of HPOA such as pleural fibromas.

Since his operation Mr PM has eaten a normal diet, gained weight and is back to living life to the full.

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Lienocolonic fistula following splenic abscess

M R Cowie MRCP **B I Hoffbrand** FRCP
D S Grant MRCP FRCR *Department of Medicine, Whittington Hospital, London N19 5NF*

Keywords: splenic abscess; ultrasonography; computerized tomography

Case presented to Clinical Section, 13 December 1991

Splenic abscess is a rare clinical problem. Rupture of such an abscess into the colon has been reported on only two previous occasions to our knowledge[1,2]. A further case is now described.

Case report

A 55-year-old man with chronic renal impairment and non-insulin dependent diabetes mellitus presented with a 7-day history of malaise, vomiting, rigors and vague left-sided abdominal pain. The patient had been born with ectopia vesicae and had had bilateral ureterosigmoidostomy performed at age 5 years.

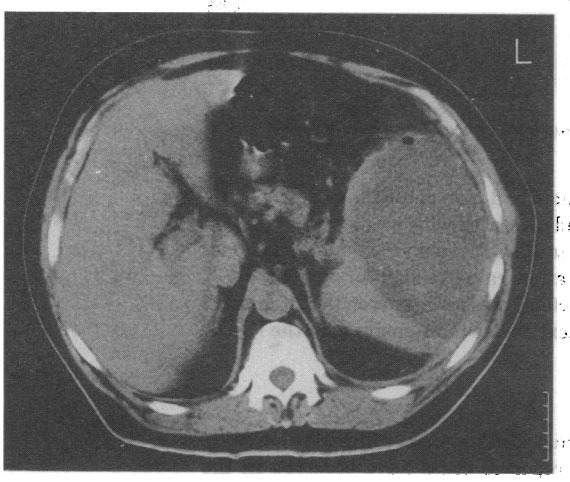

Figure 1. Computerized tomogram of the abdomen showing large abscess cavity within spleen

He was afebrile on admission, with minimal left-sided abdominal tenderness on deep palpation. Investigations revealed a *Klebsiella aeruginosa* bacteraemia, and a decline in renal function with plasma urea 38.4 mmol/l and creatinine 338 μmol/l. The infection was presumed to arise from the urinary tract and treatment with intravenous cefuroxime commenced (to which the organism proved sensitive). The pain resolved and intermittent fever settled, but just before discharge the pain and fever recurred. No organism was initially cultured from the blood. Two abdominal ultrasound examinations revealed no obvious source of sepsis, but a computerized tomogram of the abdomen revealed a 10 cm hypodense lesion within the spleen, with no enhancement after contrast (Figure 1). A percutaneous drain was inserted into the lesion and pus aspirated. This subsequently grew *Klebsiella aeruginosa* sensitive to amoxycillin and clavulanic acid (with which the patient was treated).

Large amounts of pus continued to drain from the abscess cavity for a further 40 days. A sinogram was performed

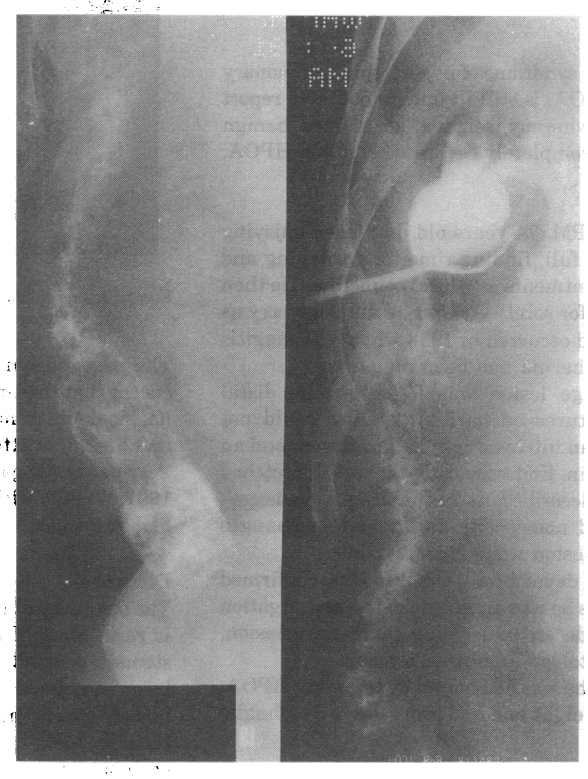

Figure 2. Sinogram showing fistula connecting splenic abscess cavity to descending colon

Correspondence to: Dr B I Hoffbrand, Whittington Hospital, Highgate Hill, London N19 5NF

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