or bat droppings that contain small spores (microconidia) the infectious form of the fungus. Like Mycobacterium H. capsulatum is an intracellular parasite of macrophages. The clinical presentation also strikingly resembles that of tuberculosis, including, a self limiting and often latent primary pulmonary involvement which may result in coin lesions on chest radiography; chronic progressive secondary lung disease which is localized to the lung apices and causes cough fever and night sweats, and finally a widely disseminated involvement.

The pathogenesis of Histoplasmosis is incompletely understood. It is known that macrophages are main target of infection. H. capsulatum may be internalized into macrophages after opsonization or by a discrete mechanism that appears specific to this fungus. The fungus expresses heat shock protein (HSP60) on the cell surface that binds to beta 2 integrins on the surface of macrophages. Histoplasma yeasts so phagocytosed multiply within the phagolysosome and lyses the cell. The released triggers helper T cells. These secrete interferon gamma which in turn acts on histiocytes to produce epithelioid granulomas; these undergo coagulative necrosis. Differentiation from tuberculosis, sarcoidosis and coccidiodomycosis requires identification of 3-5 cm thin walled yeast forms.

The diagnosis is established by culture, identification of the fungus in tissue can also be useful. In addition serologic tests for antigen and antibodies are also available. Antigen detection in body fluids is most useful in the early stages, because antibodies are formed two to six weeks after infection.

**Conclusion**

Histoplasmosis is a cause of lymphadenopathy and should be kept in mind when investigating lymphadenopathy with fever. A tissue biopsy and culture is highly recommended.

**References**


**Case Report**

**An unusual cause of haemoperitoneum in a child.**

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**Abstract**

We present a case of haemoperitoneum in a child, who presented with signs of acute abdomen with subacute intestinal obstruction. Abdominal paracentesis aspirated fresh blood. Ultrasound and CT scan abdomen showed loculated haemoperitoneum. A definitive diagnosis could not be made and an exploratory laparotomy was undertaken which revealed a large cystic lymphangioma of greater omentum with acute massive spontaneous haemorrhage. It was excised in toto along with the involved omentum leading to excellent recovery. Abdominal cystic lymphangioma first presenting as a spontaneous, life threatening haemorrhage has to our knowledge, not been reported before. It may have to be included in the differential diagnosis of acute haemoperitoneum.

**Introduction**

Cystic lymphangioma is a rare benign congenital condition arising from abnormal cystic dilatation of lymph channels. The commonest site is the neck but rare cases have been reported in unusual sites including the abdomen. Abdominal lymphangioma is basically a malformation of the mesenteric and/or retroperitoneal lymphatics. Clinical presentation is variable and may be misleading. We present a unique case where the child presented with massive intracystic haemorrhage, mimicking a tense haemoperitoneum, which required urgent transfusions and laparotomy.

**Case Report**

A 9 year old boy presented at his local hospital with sudden tense abdomen, with vomiting, colicky abdominal pain and constipation. An ultrasound examination showed fluid in the abdomen and intra-peritoneal haemorrhage was suspected. He was managed conservatively with transfusions, intravenous fluids and antibiotics. As the child...
continued to have pain and abdominal distention, he was referred to us after 4 days. Abdominal paracentesis was done to confirm haemoperitoneum, based on clinical suspicion. Abdominal distention was progressive but the pain was vague and dull in nature. There was no history of fever, recurrent abdominal pain, weight loss, any febrile illness or abdominal trauma in the recent past. On arrival he was conscious but pale looking with pulse rate of 110/min, blood pressure of 103/70 mmHg and respiratory rate of 22/min. He was afebrile. The abdomen was grossly distended, but soft and non tender. Bowel sounds were not audible. Rectum was empty on digital rectal examination.

A working diagnosis of spontaneous splenic rupture, a ruptured hepatic haemangioma or haemorrhagic pancreatitis was made.

Serial estimation of abdominal girth and haematocrit were carried out. The blood counts showed haemoglobin of 6.4 gm/dl. Platelet count, reticulocyte count, coagulation profile, serum and ascitic fluid amylase and all other biochemical tests were within normal limits. Plain X ray abdomen was opaque with some distended intestinal loops without air fluid levels. Ultrasound and CT scan abdomen revealed fluid in the peritoneal cavity and distended fluid filled gut loops with normal liver and pancreas. There was a suspicion of a small splenic laceration.

As the child was haemodynamically stable, it was decided to treat him conservatively with intravenous fluids, blood and nasogastric aspiration, under active observation in the intensive care unit. The child remained haemodynamically stable, till the 5th day of admission, when he started having swinging, high grade pyrexia. With the possibility of an infected peritoneal haematoma exploratory laparotomy was carried out. No free blood was obtained on opening the peritoneum, but huge, multiloculated, infected cystic lymphangioma of the greater omentum was found, which occupied the whole of peritoneal cavity (Figure 1). It was extending from greater curvature of stomach to pelvis and from flank to flank. It was excised in toto along with the omentum. The intestines were collapsed but were normal. Liver, spleen, pancreas and kidneys were all normal.

Patient made an uneventful recovery and was discharged on 6th post operative day. On follow up he was asymptomatic. Histopathology report confirmed the diagnosis of omental lymphangioma.

Discussion

Omental lymphangioma, though a rare lymphatic malformation, is encountered more frequently, possibly due to the availability of better diagnostic modalities. Omentum is the second most common site of abdominal cystic lymphangioma, after mesentery of terminal ileum. The embryology is puzzling with the most popular theory being pinching off or sequestration from main lymphatic sacs resulting in non communicating cysts, usually multilocular. Only two-thirds of the cases present at birth.3

It is more common among boys and most often occurs in children under 5 years of age.3 They have variable presentation, the most common symptom being an abdominal tumour or "acute abdomen" in children.4 Abdominal ultrasonography is the procedure of choice for establishing the diagnosis. Acute cases with intracystic haemorrhage are more difficult to diagnose. Computed tomography and celioscopy may be useful. Treatment is total excision without sacrificing the vital structures.2

Intracystic hemorrhage following abdominal trauma, leading to acute abdomen is known but exceedingly rare, and a misleading complication. Only three cases have been reported in literature.5-7 Two of these presented after trauma, causing haemorrhage into the abdominal lymphangioma, and the third one was a newborn, with antenatal haemorrhage into the cyst. In our case there was no history of preceding trauma and haemorrhage occurred spontaneously. This is a unique presentation of cystic hygroma. In such cases CT scan and especially MRI have better diagnostic yield than ultrasonography.6 As these lesions do not undergo spontaneous regression, only treatment option is surgery which involves total excision of the lesion, without harming the vital structures.

Conclusion

Abdominal lymphangioma is a rare congenital disorder, which may present late in life. Some are diagnosed incidentally by ultrasounds, others present as an emergency. Haemorrhage in such a cystic lesion can occur after trivial trauma. Our case had spontaneous haemorrhage in the cyst
presenting as haemoperitoneum. Careful evaluation avoids emergency surgery.

References

Case Report

Anaesthetic management of patient with Ellis Van Crevel syndrome
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Abstract
A known case of Ellis-Van Crevel Syndrome was scheduled for emergency repair of obstructed paraumblical hernia. We describe the anaesthetic management of the case with special reference to the classic physical and physiological manifestations of this syndrome present in our patient.

Introduction
Ellis-Van Crevel Syndrome or chondroectodermal dysplasia is a form of short-limbed dwarfism. The name chondroectodermal is used because it affects the skeleton (chondro) and the skin (ectoderm).1 The syndrome was first described by Ellis and Van Crevel2 in 1940 and this disease was found mainly among the Amish group of population chiefly in Pennsylvania, Ohio and Indiana. The disorder is characterized by anomalies of the hands and ectodermal dysplasia involving the nails and teeth. Reported incidence is one in 1,500,000 live births.1 Incidence in Pakistan and India is very rare. Literature search from publication of first case in 1940 to date revealed only five case reports from this region.

Case report
A 36 year old female, known case of Ellis-Van Crevel Syndrome, presented in the hospital emergency room with vomiting, abdominal swelling and pain. A diagnosis of obstructed paraumblical hernia was made and the patient was scheduled for emergency repair of the obstructed hernia.

On preoperative evaluation, patient had short stature, short limbs in relation to the trunk, polydactyly of the hands (Figure 1), protuberant abdomen, narrow chest and moderate lumbar lordosis. She was morbidly obese with a body mass index (BMI) of 47.87. There was no abnormality of cervical spine and airway examination was unremarkable. Blood pressure was 160/100 mmHg and heart rate 95-100/min. The white blood cell count was 23,000/cmm and baseline arterial blood gases showed a PaO₂ of 65 mm Hg and SaO₂ of 92% on room air.

An echocardiogram done one year back showed a moderately dilated right atrium, mild right ventricular hypertrophy, large atrial septal defect (secundum type) with left to right shunt and severe pulmonary stenosis. The left ventricular systolic function was normal. The patient was evaluated by cardiologists and placed in high cardiac risk category for any kind of surgical intervention under general anaesthesia.

Supplemental oxygen was started via face mask preoperatively. Aspiration prophylaxis (Syrup Sodium citrate 0.3 M 30 ml, Inj. Ranitidine 50 mg and Inj.