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Gastric cancer in southern Croatia during 2002-2003

Despite an overall declining incidence, gastric adenocarcinoma remains the second most common cause of death from malignant disease worldwide. About 85 percent of stomach cancers are adenocarcinomas, with 15 percent due to lymphomas and gastrointestinal stromal tumors. High rates are observed in Japan, China, Finland, and Eastern Europe, and low incidence is observed in Western Europe and USA. The annual incidence of gastric cancer in Croatia in the last thirty years is in decline, though it is still rather high at approximately 30 cases per 100,000 in the male population and 23 cases per 100,000 in females. We retrospectively analyzed the data on 86 cases of histologically diagnosed and surgically resected gastric adenocarcinoma seen in our hospital during 2002-2003. Adenocarcinoma was classified according to histologic subtype, depth of invasion, site, presence of *Helicobacter pylori*, and age and gender ratio.

The mean (SD) age of the patients was 60 (20) years, and male / female ratio was 2.5:1 (62/24) which is in congruence with other studies. Approximately 37 percent of gastric carcinomas in Western Europe and the United States originate in the upper third of the stomach, whereas 20 percent originate in the middle third, and 30 percent in the lower third; 12 percent of gastric carcinomas involve the entire stomach. In our patients the most frequent location was antrum (48 percent), followed by corpus (31.4 percent). The proximal stomach was involved in 19.8 percent (cardia 15.1 percent, fundus 4.7 percent). Several studies have shown sharp decrease in the incidence of the intestinal type of gastric adenocarcinoma but in our population the incidence is still 84.9 percent. In Western countries the incidence of early cancer exceeds 16 percent; in Japan it ranges from 40 percent to 60 percent. In our study the figure was about 16 percent. Epidemiologic studies have demonstrated an association between *Helicobacter pylori* infection and risk of gastric cancer.

We intend to initiate a program of screening endoscopy for persons 50 years of age or older in order to identify early gastric carcinoma. We also believe that control of *H. pylori* infection has the potential for prevention of gastric cancer.

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References


**Prevalence of cholelithiasis in children – a hospital-based observation**

Cholelithiasis is relatively uncommon in children. In the US, the reported prevalence is 0.15% to 0.22%, whereas in adults it is 4%-11%.1

Of 13,675 children who had ultrasound examination of the abdomen in our hospital during the period January 1999 to December 2003, 43 (0.31%) were detected to have gallstones. The indications for ultrasonography in these children were fever with hepatosplenomegaly in 16 (37%), recurrent abdominal pain in 5 (12%), ureteric colic in 1 (2%), and miscellaneous in 21 (49%). None of them had cholecystolithiasis, hemolytic anemia or jaundice.

The male:female ratio was 2.3:1. The median age for boys was 5 years (range 3 months to 14 years) and for girls it was 9 years (range 7 months to 15 years); 28% were less than one year old, 23% between one and 5 years, 37% between 5 and 10 years, and 12% between 10 and 15 years. Of the 13,632 children who did not have gallstones on ultrasonography, the male:female ratio was 1.1:1; 27.5% were less than one year old, 25.2% between 1 and 5 years, 27.8% between 5 and 10 years, and 19.5% between 10 and 15 years. All the stones were less than 5 mm in size and they were solitary in 56%. Forty-one (95.3%) children were asymptomatic and two were symptomatic and underwent cholecystectomy. The symptomatic children were 9 and 7 years old; the former presented with recurrent abdominal pain and the latter with fever and vomiting.

Friesen et al2 in a review of 693 children with gallstones reported that infants less than 6 months of age represented 10% of cases, 69% were in the age group 11-21 years, and 21% between 6 months and 10 years. A hospital-based review of cholelithiasis in children less than 12 years of age over a period of 10 years, including a Medline search during the same period, reported that 87% of children with gallstones were asymptomatic.3

We have for the first time outlined the frequency of incidental gallstones detected on routine ultrasonography in children in India. In the absence of hemolytic anemia, the etiology needs to be evaluated. The consequences on long-term follow up in non-operated cases needs to be ascertained.

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**References**


**Treatment of appendiceal mass**

The article1 by Dr Kumar and Dr Jain is incomplete in its message. Appendiceal mass is a late presentation of appendicitis. Its treatment could be surgical or expectant conservative treatment. Conservative treatment is less dangerous especially if the surgeon is less experienced and does not have access to adequate equipment. Conservative treatment classically follows the Ochsner-Sherren regimen, about which the authors make no mention. Surgical treatment may be early or planned.

I would recommend planned surgery over a conservative approach in the following or similar situations:

- If the patient is from a rural area, unable to get appropriate treatment near home
- Students preparing for professional examinations, who are unlikely to obtain leave in the near future
- Individuals who travel a lot
- Young women, in whom the right fallopian tube may be affected by the inflammation
- Where there is suspicion of malignancy.

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**Reference**