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Gastrointestinal bleed after leeching in a patient on aspirin therapy
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Leeches (Hirudo medicinalis) have been used in health care for their property of bloodletting. Bleed occurring from the site of leech attachment has been well documented. We report a 50-year-old man who was on aspirin therapy for coronary artery disease, and presented with GI bleed after leech treatment for his knee pain. [Indian J Gastroenterol 2005;24:170]

Leeches have been used in health care since ancient times.1 The leech salivary gland produces substances like hirudin (with antithrombotic property) and platelet aggregation inhibitor, which are responsible for bleed occurring after leech treatment.1 Bleed from site of leech attachment is a well-known complication of leech treatment.1

A 50-year-old male with coronary artery disease, who had undergone coronary artery bypass graft and was on aspirin 150 mg OD and atenolol 50 mg OD for several months, presented with vomiting of 100-150 mL of blood. He was a non-smoker, non-alcoholic and there was no history of intake of any other drugs. On examination the patient was conscious and oriented but pale. There were a few marks over his right knee, but no other mucocutaneous lesion.

Investigations: hemoglobin 8 g/dL, PCV 32% and platelet 200,000/mm³. Coagulation profile and serum biochemistry did not reveal any abnormality. Endoscopy showed erosive gastritis and presence of altered blood in the stomach. The patient was managed with proton pump inhibitors and was transfused one unit of blood. He recovered uneventfully.

On reviewing the history it was found that the patient had got leeches applied over his right knee for pain, twice over a period of four days, and developed GI bleed few hours after the second application.

Michalsen et al2 reported that leeches showed promise in the treatment of knee pain.3 In villages of India, leeches are used for treatment of many conditions including knee pain. Our patient developed GI bleed after applying leeches over his knee for pain. Endoscopy showed erosive gastritis. This patient was on aspirin, which is well known to cause erosive gastritis and thus GI bleed. But in view of the occurrence of GI bleed few hours after leech therapy, we believe that leech therapy could have played a precipitating role in the GI bleed.

Blackshear and Ebener3 showed that medicinal leeching did not produce any alteration in the systemic coagulation profile. However, there is no information on synergistic effect of aspirin and leech hirudin. With leeches playing an important role in conditions like repair of graft skin flaps, breast reconstruction, post phlebotic syndrome,1 and knee pain,2 studies are required to substantiate the risk of systemic bleed due to leech hirudin when combined with an antiplatelet agent.

References

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Complete gastric duplication cyst
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We report a 13-year-old boy who was detected to have an abdominal mass on ultrasonography. A possibility of tuberculous lymph nodes was considered in view of history of pain, low fever, and anorexia. Histology of the excised mass showed complete gastric duplication cyst. [Indian J Gastroenterol 2005;24:170-171]
Intestinal duplications are rare congenital anomalies that can occur anywhere along its length. Ileum is the most common site involved, and gastric duplications are rare.1

A 13-year-old boy presented with abdominal pain, low-grade fever and loss of appetite since six months. There was no history of vomiting, diarrhea or GI bleed. His vitals were stable and hematological investigations did not reveal any significant abnormality. Abdominal examination was normal. Mantoux test was equivocal. Ultrasonography showed a small mass in the omentum, close to the greater curvature of the stomach, but separate from it. The mass had a central echogenic focus. No definite cyst was identified. CT scan did not reveal any other anomaly. The lesion was surgically excised in toto.

The specimen was a gray white, smooth surfaced, globular, soft-tissue mass, measuring 4 cm x 3.5 cm x 3 cm, with focal areas of congestion. Cut section showed a collapsed irregular cystic structure, lined by a gray white wall, 2-3 mm thick. Surrounding this, the lesion was composed of firm to myxoid tissue (Fig a).

Microscopic examination showed a cystic structure lined by gastric mucosa (Fig b), submucosa and muscularis propria. This was surrounded by loose myxoid and fibrous tissue. The mucosa was predominantly composed of gastric corpus-type specialized mucosa, with focal antro-pyloric type of mucosal lining. Occasional lymphoid aggregates were seen in the mucosa. A final diagnosis of complete gastric duplication cyst was made.

Gastric duplications comprise only about 9% of intestinal duplications,1 and occur along the greater curvature in most instances. They have been classified as tubular and cystic,2 the latter usually not communicating with the stomach. Most gastric duplications are attached to the wall of the stomach.1 We found only one earlier report of gastric duplication cyst without any attachment to the stomach.3

Foregut duplications usually present in infancy due to intussception or distension leading to vomiting, abdominal mass, or melena due to ulceration.1 Our patient presented at age 13 years, with abdominal pain, fever and loss of appetite. Barium studies help only when the cyst communicates with the bowel. Ultrasonography can define the cystic nature, and an echogenic inner rim suggests the diagnosis.4

Intestinal duplications are lined by mucous membrane identical to that of adjacent viscus. Rarely it may be heterotopic or primitive in type.5 Heterotopic gastric mucosa has been reported in 29% of all intestinal duplications.1 In our case, the cyst was lined by mature type of gastric epithelium.

Intestinal duplications are associated with a range of congenital anomalies, including scoliosis, hemivertebrae and spina bifida.4 Vertebral anomalies are more common with supradiaphragmatic foregut duplications. A rare complication of duplication cyst in adults is malignant change. The malignancy is usually adenocarcinoma, though rarely squamous cell carcinoma has also been reported.5 Serial sections in our case did not reveal any malignant change.

Management of intestinal duplication is primarily surgical.1 Conservative management may be complicated by perforation due to peptic ulcer and, rarely, malignancy. Mucosal stripping and marsupialization has been tried, but it may leave a potentially unstable mucosa prone to complications.1

References

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