



Towards Healthier Tomorrow

Dr. Babasaheb Ambedkar Medical Research Society

MEDI-SEARCH

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From the editors' desk

Greetings to the readers of Medisearch.

Firstly, let me declare right at the outset that this medisearch is entirely dedicated to the department of surgery and is one of our efforts to fulfil the appetite of doctors with a penchant towards surgical case scenarios.

Secondly, as we all know that it has always been a dream of a number of clinicians and surgeons to have their name in the list of pioneers who have made a mark by virtue of their innovative instincts and whose work has changed or improved office practice to a great extent; we are proud to share with our readers that, at Dr Hedgewar Hospital, we have amongst us one such innovative personality -Dr Prasad Vaidya, senior surgeon who has endeavoured to reach such heights. His innovative thinking has let him convert simple concepts into good utility products that will fetch comfort for the needy. I will not steel the thunder of his article in the editorial itself, as you can read it highlights on the product and its use in the various categories of patients. (Article 3)

Finally, the best part that a doctor should learn during his upbringing days is the value of medical care. Money should always be secondary and the pain relieving and social support should form priority in every medical student's mind. Working on such principals and trying to inculcate such practices in the new breed of doctors is the SEVANKUR project headed by Dr Tupkary, CEO of Dr Hedgewar Hospital, through which 275 medical students from various parts of Maharashtra had the previlage to visit different tribal areas of Jashpur district, Chattisgarh. We take pride in sharing this with our readers.

-Editors.



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GIANT CUTANEOUS HORN AT NECK A CASE REPORT

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INTRODUCTION

Cutaneous horn (cornu cutaneum) is a relatively uncommon lesion consisting of a projectile, conical, dense, hyperkeratotic nodule, which resembles the horn of an animal. Cutaneous horn has been noticed on top of many clinical conditions like actinic keratosis, wart moluscum contagiosum, seborrheic keratoses, keratoacanthoma, basal cell carcinoma and squamous cell carcinoma. We report a case of giant cutaneous horn overlying a seborrheic keratosis treated with surgical excision and primary closure. Because of their malignant potential, the lesions must always be considered for histopathological evaluation.

CASE REPORT

84year-old male presented with a horny projection on the Neck of 3 Yr duration. There was no history of pain or discharge over the growth. On examination, there was a hyperkeratotic growth of 6 × 3 cm size (Fig.1 ,2) There was no tenderness or bleeding from the growth. There was no regional lymphadenopathy. Excision of the cutaneous horn with an elliptical incision and primary closure of defect was done under local anesthesia . Histopathological examination revealed hyperplastic skin with hyperkeratosis and parakeratosis. The epidermis showed irregular acanthosis, elongated rete ridges and papillomatosis and horn cyst. The one year follow-up was uneventful without signs of recurrence.

DISCUSSION

Cutaneous horns are elongated, keratinous projections from the skin, ranging in size from a few millimeters to many centimeters that resembles a miniature horn. The base of the horn may be flat, nodular or crateriform. The horn is composed of compacted keratin. The distribution of cutaneous horns usually is in sun-exposed areas, particularly the face, pinna, nose, forearms and dorsal hands. Usually, a cutaneous horn is several millimeters long. Malignancy is present in 16–20% of cases, with squamous cell carcinoma being the most common type.⁽¹⁾ Tenderness at the base of the lesion and lesions of larger size favor malignancy. Most cutaneous horns arise from actinic keratoses but they may also result from seborrheic keratoses, warts, keratoacanthomas, squamous cell carcinomas and basal cell carcinomas. Histologically, there is a greatly thickened stratum corneum with scattered areas of parakeratosis. The horn at the base will display features characteristic of the pathologic process responsible for the development of the horn.^(2,3) Excision biopsy of the lesion and histopathological examination to rule out malignancy is recommended. Malignancies should be excised with appropriate margins and evaluated for metastasis. A careful physical examination of the lymph nodes draining the area of lesion often is adequate. Local destruction with cryosurgery is first-line treatment for verruca vulgaris, actinic keratosis and molluscum contagiosum.

Treatment options include wide surgical excision with careful histological examination to exclude a focus of malignancy and carbon dioxide or Neodymium YAG laser is used for patients who refuse surgery⁽⁴⁾

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Innovation: The Uropant.

Prasad Vaidya MS

Necessity is the mother of all inventions. But to invent something is not everyone's cup of tea. We are proud to share with our readers that Dr Prasad Vaidya, senior surgeon working at Dr Hedgewar Hospital has, by virtue of his innovative instincts, brought about the concept of UROPANT and made this concept a reality.

People who face problems of urinary incontinence secondary to various causes, people who are unable to control their urge to urinate making it difficult for them to socialize will be benefitted to a great extent by using the UROPANT.

The uropant works on the principles of gravity and uni-directional flow of water. It is designed to be similar to an under pant that is made out of an umbrella cloth. Wearing the uropant when one passes urine in standing position, the urine flows downward into the collecting extension of the uropant (with an inbuilt valve) through to a tubing and gets accumulated in a collecting bag tied over the calf using welcrow. This bag has a capacity of 2 litres, so one can urinate 6-8 times while wearing the uropant. The bag can be emptied when full. Uropant is washable and has a good seal that conceals the smell of urine thereby avoiding social embarrassment. The Pant can be used by both males and females of all ages. Picture 1.

It is a simple and non invasive option available in addition to being non irritant and reusable. Using diapers and condom catheters entails the problem of smell and the need of changing frequently. The only disadvantage of this uropant is that it cannot be used in lying down position. One has to stand or at least sit on the edge of the cot/chair to pass urine. The uropant is useful for all ages especially the disabled ones who cannot walk up to the urinals, children who keep on wetting their clothes and bus travellers who face circumstances that force a prolonged waiting untill arrived at a certain destination. The uropant is also useful for women in India who avoid visting outside urinals while travelling; so also for people involved in security services who cannot leave their work place for long hours.

This was a team effort done by Dr Prasad Vaidya, his wife Mrs. Bhavana Prasad Vaidya and Mr Prashant Ausekar who is a tailor by occupation. They endeavoured to come to a conclusive design and manufactured the uropant on small scale. This is, in a way, an effort to support The Swachha Bharat Abhiyan.

Picture 1: Showing the Uropant and the next picture – trousers can be worn comfortably over the uropant.



PATENT VITELLO-INTESTINAL DUCT WITH UMBILICAL ABSCESS

Narendra Kulkarni, MS; Rajashree Purohit MS, Pranit Mankare, DNB Resident

INTRODUCTION

In the human embryo, the vitelline duct, also known as the omphalomesenteric duct, is a long narrow tube that joins the yolk sac to the midgut lumen of the developing fetus. Generally, the duct fully obliterates (narrows and disappears) during 9th week of gestation, but a failure of the duct to close is termed a vitelline fistula. This results in discharge of meconium or stools from the umbilicus [1]. Persistent duct is seen in 2% of humans and gives rise to a group of anomalies of which Meckel's diverticulum is the commonest, but

CASE REPORT

We report a case of three and half year old female with umbilical abscess secondary to a patent vitello intestinal duct

CLINICAL FEATURES

A three and half year old female child presented with large swelling 10 cm in diameter in umbilical region. There was history of fever, redness, pain in umbilical region. There was history of occasional discharge from the umbilicus since birth. The symptoms aggravated over a period of three weeks, for which the patient approached us. It had gradually increased in size. She was put on intravenous antibiotics after admission and was posted for emergency exploration.

On examination, there was swelling in umbilical region of size 10 cm in diameter with redness, tenderness and increased temperature with active sero-purulent discharge. Rest of the examination was within normal limits

INVESTIGATIONS

Hb: 9.5 gm %

WBC: 22,500/cmm

N:62% L:24% M:8% E:01%

RBS: 90 mg %

Blood Urea: 19.10mg %

S. Creatinine: 0.28 mg %

S. Na: 132.10 mEq/L

S. K: 4.73 mEq/L

MANAGEMENT

Exploration was done under GA. To our surprise, on exploration, there was an abscess with a complete patent vitello-intestinal duct from antimesenteric border of the ileum upto the umbilicus. There were adhesions to the transverse colon and the omentum near the umbilicus. The adhesions were separated, and the duct was dissected.

The patent vitello-intestinal duct was around 10 cm in length. The base of the duct was broad and 1.5 cm in diameter. Fig 1. Omphalectomy with wedge resection of the ileal end was done and sutured transversely in two layers. Postoperative recovery of the patient was uneventful and she was discharged on the 8th day.

Histopathology report confirmed Patent Vitello-intestinal duct with an umbilical abscess. fig 2

OPERATIVE FINDINGS



Fig 1. : Vitello-intestinal duct

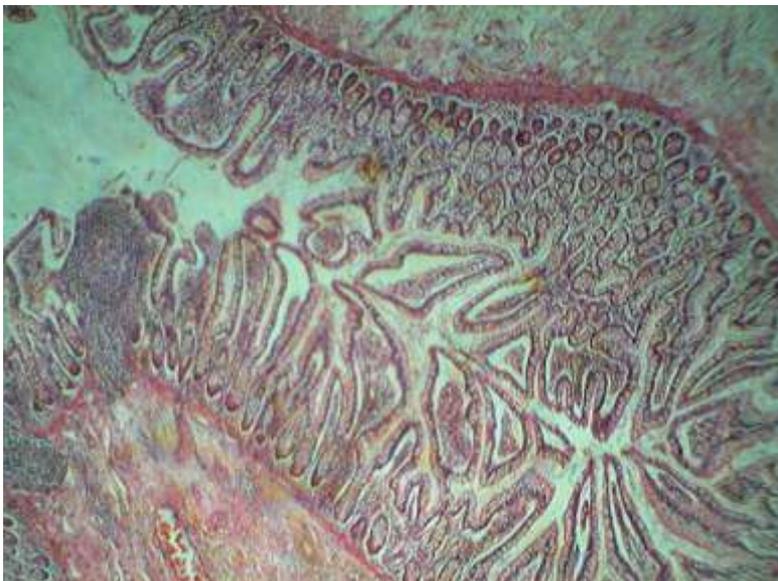


Fig. 2: Histopathology of the specimen

DISCUSSION

The incidence of a completely patent vitello-intestinal duct is reported to be 0.0063–0.067% [2]. Of all the anomalies of the VID, complete patency of the duct is the rarest. The condition is mostly seen either in neonates or in infants [3].

The vitelline duct normally closes between the 5th and the 7th weeks of embryonic development but can lead to several pathologies in case of closure defects, giving rise to intra-abdominal (Meckel's diverticulum, vitelline cyst) or umbilical lesions (umbilical fistula, umbilical sinus and umbilical polyp) [4]. Vitello intestinal duct as an abscess is a rare presentation as shown in the study conducted by Ali et al [5].

Patent vitello-intestinal duct can present as umbilical abscess, and it should be kept as a differential diagnosis, specifically in children presenting with umbilical discharge since birth [6]

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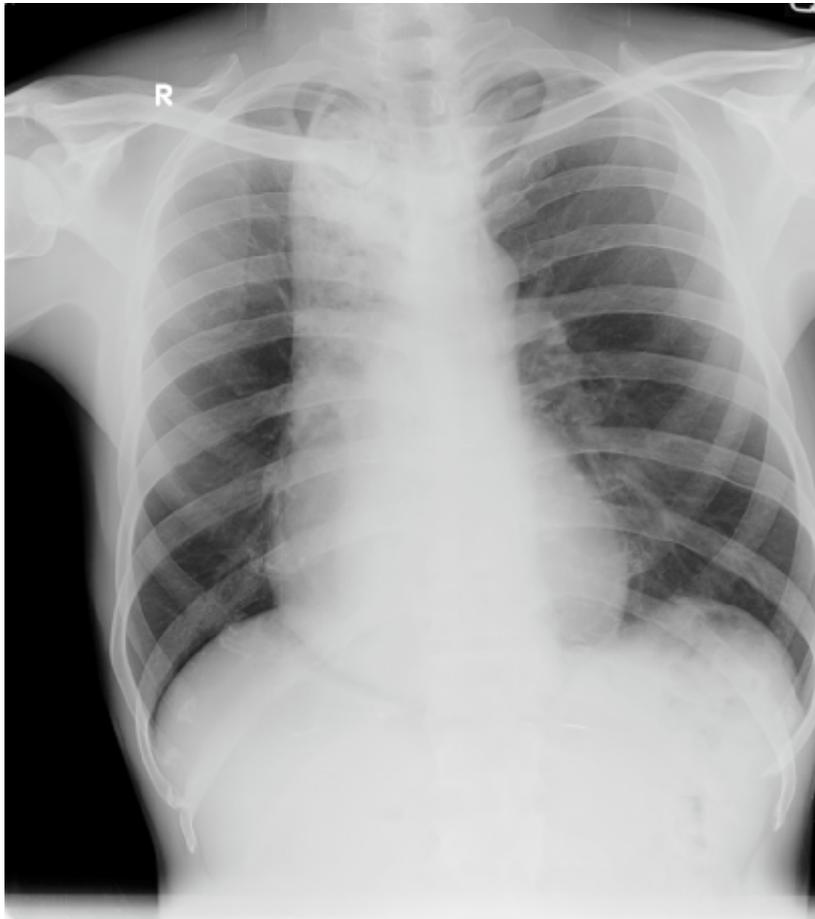
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Now its Quiz time !

16 year old Adolescent coming with history of Dysphagia and heart burns.
Below is his plain x-ray chest PA view.

Q1. Give only One positive finding in this x-ray.

Q2. What could be the probable cause of dysphagia in this patient?



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