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Gastrointestinal cocaine body packing

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Smuggling of illicit substances by internal bodily concealment, known as body packing, has become a worldwide problem [1,2]. It was first reported in 1973 and since then it has evolved into an important means of international cocaine and heroin smuggling [3].

Herein we present two cases brought under custody to our hospital for treatment, after swallowing packages containing cocaine. Two male persons, a 31-year-old Nigerian and a 38-year-old Peruvian were arrested on suspicion of drug smuggling after arriving at Athens International Airport "Eleftherios Venizelos". Police suspected them of body packing and brought them to the Emergency Department of our hospital. The Nigerian man complained of abdominal pain and constipation while the Peruvian man was frightened of package rupture. The Nigerian had increased bowel sounds on clinical examination but apart from that no other finding was reported in both cases. A plain abdominal radiography demonstrated multiple abnormal radio-opaque foreign bodies in both small and large intestine in the first case but it was normal in the second. Urine toxicology testing was positive for cocaine in the Nigerian. The first case was managed with whole gut irrigation (polyethylene-glycol) and passed 54 packets per rectum which were identical and their dimensions were 4x3x2 cm (Fig. 1). Because of the concern of package rupture the second case underwent upper-gastrointestinal endoscopy which demonstrated 6 packets in the stomach with no evidence of package rupture. Since he was asymptomatic he was managed conservatively with whole gut irrigation and passed uncomplicated 20 handmade packets of cocaine [4,5]. Before being discharged both patients had a computed tomographic examination which did not reveal any remaining intraluminal packet and then they were referred to law enforcement authorities.

Body packers present to hospitals either because they have developed complications or after being arrested by custom officers who seek medical advice on their behalf. These admissions are seen more often in hospitals situated near a port of entry and many of them, in view of the lack of international guidelines, have already developed algorithms and protocols to manage these cases [2]. The medical staff dealing with such cases has to face not only medical but also ethical issues which complicate their management. For example: it is unclear in which extent doctors should cooperate with law enforcement authorities in searching of illicit substances by internal bodily concealment, there is a dilemma whether doctors should report to the authorities-drug smugglers presenting to emergency units seeking for help and how to supervise these cases during hospitalization so as to limit the chance of re-ingesting excreted drug packets.

Figure 1 Forty one of the fifty four machine-wrapped packets containing cocaine recovered from body stools of the first case

In conclusion, body packers put themselves in danger of imprisonment and death so they must be treated both as prisoners and as patients. Therefore there is a need to create international guidelines which will assist the doctors and the hospital's legal counsel and ethics committee in managing these cases.

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Ulcerative colitis associated with extranodal marginal zone B-cell thyroid lymphoma of mucosa-associated lymphoid tissue and Hashimoto thyroiditis: description of a case

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Ulcerative colitis (UC) is a chronic and relapsing large bowel disease which predisposes to the development of large bowel cancer and other malignancies [1,2]. Primary thyroid lymphoma (PTL) is a rare but quite significant malignant tumor of the thyroid gland arising in a proportion of cases on the ground of Hashimoto thyroiditis [3]. The majority of cases are extranodal marginal zone B-cell lymphomas of mucosa-associated lymphoid tissue (MALT), diffuse large B-cell lymphomas or a combination of both [4].

The development of PTL during the course of UC has very rarely been described. Herein, we describe the case of a woman with long-standing UC who developed extranodal marginal zone B-cell MALT lymphoma. The patient, aged 46, suffered from total UC since the age of 26. During all these years, the disease was running with exacerbations of mild-to-moderate severity every one or two years, that were settled promptly. However, at least two exacerbations (the last one in 2008), were so severe that she required hospitalization, full doses of IV corticosteroids, nil by mouth and fluid and electrolyte replacement. From her past history, she mentioned appendicectomy at the age of 18. In 2005, 13 years after the onset of UC, she had undergone surgical drainage of a perineal abscess. Six months later, a total thyroidectomy was performed because of thyroid enlargement accompanied with clinicolaboratory signs of possible thyroid malignancy. Histology revealed the presence of extensive lesions of autoimmune Hashimoto thyroiditis and stromal fibrosis. A further immunohistochemical study using the CD20ass, Clg*(κ,λ,γ,μ,α),* CD21, CD5, CD23, CD45RO, CAM5.2 and PCR:IgH indices, revealed the presence of a polyclonic lympho-hyperplastic lesion [Clg(*κ*)/IgH] with characteristics compatible with extranodal B-(CD20ass+) non Hodgkin lymphoma arising from the cells of the marginal zone of MALT lymphoma. During the next years, she was under substitution treatment with thyrohormone 0.1 mg daily. Up to 2012, there have been no indications of local recurrence or distal metastases. Now, she is on maintenance treatment with *per os* mesalamine. The thyroid function has returned to normal levels.

It is the author's intention not to add immunosuppressives, and certainly not, biologic agents, in case of a future severe flare-up of UC in this patient. An exacerbation could be treated with appropriate doses of corticosteroids. The addition, or not, of immunosuppressives would be a matter of detailed discussion with the patient.

The combination of UC with PTL is extremely rare. García Arroyo *et al* [5] described a series of 6 patients with PTL of the type of large-cell lymphoma. One of these patients was concurrently suffering from UC [4], representing probably the only published case of a combination of UC and PTL so far. Obviously, there is no etiological link between UC and PTL and the development of PTL in this patient might be considered as development by chance. It has been suggested, however, that both antigenic stimulation on the setting of Hashimoto thyroiditis and aberrant somatic hypermutation are important factors contributing to the pathogenesis of PTL [5]. On the other hand, thyroid disease of the type of autoimmune thyroiditis and hypo- or hyperthyroidism have frequently been associated with UC [6,7], suggesting that autoimmunity is a significant factor in the whole process of both situations.

In conclusion, extranodal marginal zone B-cell MALT lymphoma could develop in the course of long-standing UC.

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Innocent unilateral facial swelling after endoscopic sphincterotomy

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A 73-year-old woman with choledocholithiasis was referred to our department for ERCP. She was overweight and had a history of hypertension but despite that she was very fit. She did not report any allergic diathesis to iodine-containing contrast media drugs, food, history of asthma, urticaria, or allergy to insect bites. ERCP was performed, under conscious sedation with intravenous (iv) injection of midazolam, with the patient in prone position and demonstrated a dilated common bile duct (diameter 12 mm) with two stones. She had an uncomplicated endoscopic sphincterotomy (ES) with successful basket clearance of stones. The patient was transferred to the ward for post-procedure follow up. The nurse observed the development of a unilateral left facial swelling (Fig. 1) from the upper mandible to the upper lid. The patient did not report any abdominal pain, while the abdomen was soft with no tenderness and no subcutaneous emphysema was noticed over the face and neck. Chest and abdominal CT scans were negative for retroperitoneal air. Hematological and biochemical profile including C-reactive protein and erythrocyte sedimentation rate were normal. After consulting with the ENT surgeon, observation was decided. The patient had an uneventful post-procedure course with resolution of facial swelling after 6 h. She was discharged the following day and remains well.

Appearance of facial swelling after ES due to subcutaneous emphysema is an unusual first sign of retroperitoneal perforation [1]. Radiological imaging reveals extensive retroperitoneal and mediastinal air [2]. There is no clear explanation of our patient's unilateral facial swelling. We suppose that the facial swelling is related with patient's position during ERCP; local pressure of the face's left-side led to exudation of fluids in the interstitial space and unilateral facial swelling. The rapid resolution of swelling strengthens our hypothesis**.** An alternative explanation of our patient's unilateral facial swelling might be due to an acute allergic reaction after receiving midazolam [3], a short-acting benzodiazepine frequently used for conscious sedation for a variety of endoscopic procedures. Facial edema after iv injection of midazolam was also observed during cesarean section [4]. However, in our case no other relative symptoms attributed to potential midazolam allergic reaction such as pruritus were observed.

In conclusion, the occurrence of facial swelling after ERCP is not always related to subcutaneous emphysema due to ES perforation.

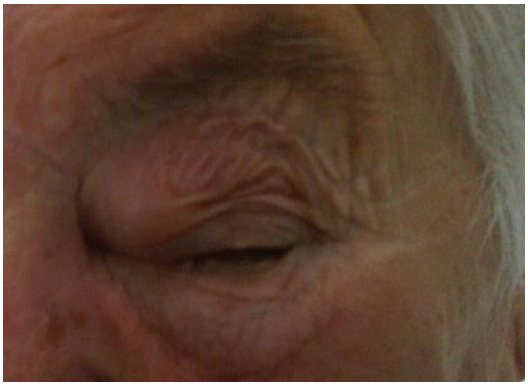

Figure 1 Photograph showing unilateral left-sided facial swelling

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Intraluminal migration of drain tube: a short report

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A 55-year-old female was diagnosed to have malignant mucinous cystic neoplasm (MCN) of the distal pancreas.

Intraoperatively, the lesion was 10×10×15 cm in size arising from the distal pancreas involving the splenic hilum and transverse mesocolon with no evidence of dissemination. So she underwent *en bloc* resection of the tumor with distal pancreatectomy, splenectomy and segmental resection of the involved transverse colon. The bowel continuity was restored with end-to-end anastomosis of the transverse colon. The specimen on histopathological examination proved to be a malignant MCN of the distal pancreas with adequate margin clearance. Postoperatively the patient developed pancreatic stump leak which was managed conservatively and she was discharged on postoperative day 14 with left flank drain in position. She came for the first review after two weeks with complaints of accidental slippage of the drain tube with persistent fluid leakage and soiling through the drain site. So a 20 French Foley catheter was introduced through the drain site under radiological guidance and it was attached to a collection bag. The balloon of the Foley catheter was inflated with 10 mL of distilled water and the catheter was sutured to the abdominal wall. She was discharged and asked to keep a daily drain output chart with proper drain care and weekly reviews. However, she was then lost to follow up. After one month she reported back with complaints of abdominal pain, constipation and vomiting of two days duration. The abdomen was distended with mild diffuse tenderness. The drain tube and bag were missing. The patient gave a history of accidental slippage and subsequent removal of drain at home ten days back. The drain site showed skin erosions with a healing wound. An emergency ultrasound and subsequent computed tomograph (Fig. 1A, B) showed evidence of bowel obstruction with the presence of the Foley catheter intraluminally in the descending colon. The proximal end of the catheter was lying outside the bowel in the peritoneal cavity and the distal end was reaching up to the sigmoid colon. The patient was shifted to the operation theatre and an emergency laparotomy was done. Intraoperatively the proximal end of the Foley catheter was found lying outside the bowel with the site of the previous anastomosis of the transverse colon (Fig. 2) serving as the point of entry into the colon. The catheter was taken out and the bowel defect closed with sutures. She had an uneventful postoperative recovery.

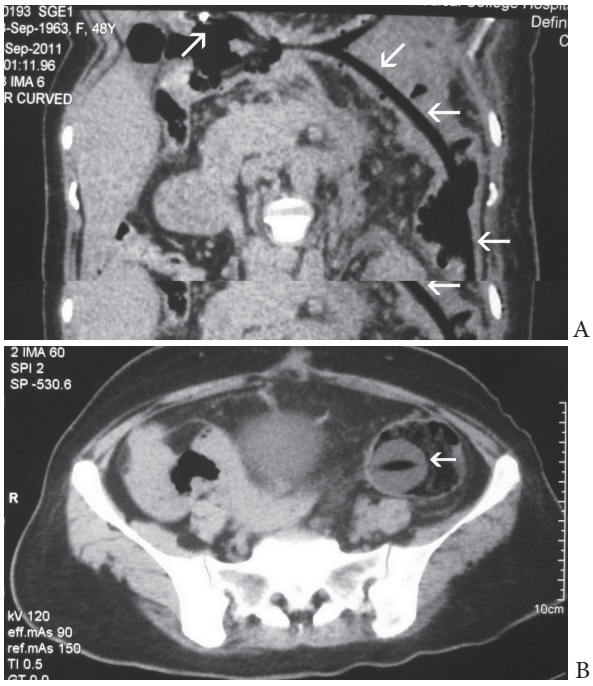

Figure 1 (A) Computed tomography (coronal section, curved reformation) demonstrating the Foley catheter (arrows) intraluminally in its entire length, starting from mid transverse colon and reaching up to sigmoid colon. (B) Computed tomography (axial section) demonstrating the Foley catheter (arrows) intraluminally in descending colon

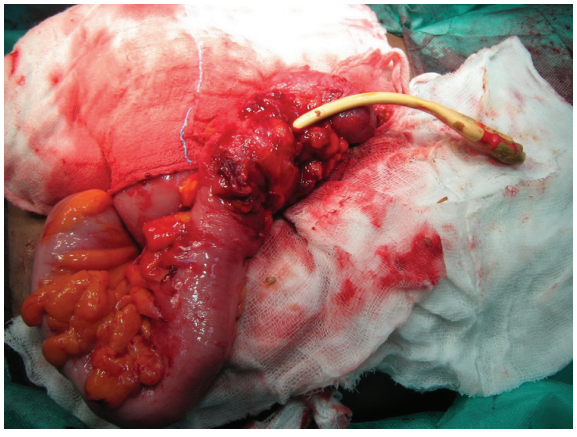

Figure 2 Intraoperative picture showing Foley catheter entering the lumen of transverse colon through the site of previous anastamosis

The exact mechanism of intraluminal migration of the drain tube is uncertain even though there are reports of such events occurring after esophagogastrectomy [1,2] and feeding jejunostomy [3-5]. In this case, probably the patient had subclinical dehiscence at the site of anastomosis of transverse colon secondary to pancreatic leak, through which the tube might have migrated intraluminally. As described by Prahlow *et al*, the peristalsis-induced intraluminal antegrade movement of the distal end of the tube with concomitant retrograde movement of the colon over the tube ultimately resulted in reaching up to the sigmoid colon [4].

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Hepatic pulmonary fusion: a rare association of right-sided congenital diaphragmatic hernia

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Hepatic pulmonary fusion is a rare association of right-sided congenital diaphragmatic hernia. The repair and reduction in this case depends on the extent of fusion to the lungs and the associated mediastinal structures [1]. This case has thumb and index finger syndactyly and multiple clefts in vertebrae besides hepatic pulmonary fusion which makes it unique, the first of its kind.

This is a case of a full-term neonate who presented with signs of respiratory distress at 13 h of life. On examination, trachea was central in position with decreased air entry on right side of chest and right thumb and index finger syndactyly. Chest x-ray showed homogenous opacity involving right hemithorax mainly in mid and lower zone, with well-defined superior margin with no mediastinal shift and clefts in vertebrae (Fig. 1 A). Contrast-enhanced computed tomography of thorax revealed migration of liver into the thoracic cavity in the posterior aspect with normal appearing anterior diaphragm with right lung hypoplasia or collapse and multiple cleft vertebrae (Fig. 1 B). Peroperatively, the entire liver was found to be displaced into the right thoracic cavity with pneumatization of right lobe of liver and the diaphragm was stuck to remnant pulmonary tissue and adjacent mediastinal tissue. It was difficult to achieve a clear-cut line of cleavage. The diaphragmatic defect was partially approximated and sutured. Postoperatively, the patient died at day 11 of life due to respiratory insufficiency.

The association of hepatic pulmonary fusion to congenital diaphragmatic hernia is still incompletely understood. There may be primary fusion between liver and lungs followed by lack of development of embryonic structures later on, however the most logical explanation is failure to fuse rather than failure to form. The failure to fuse the diaphragmatic membranes may allow the fusion of adjacent future pulmonary and hepatic tissue [2]. The association of limb defects like syndactyly and polydactyly with congenital diaphragmatic hernia suggests disturbed migration of neural crest cells and mutation of *FGF10* [3]. These gene mutations might explain the occurrence of congenital diaphragmatic hernia with vertebral and digital anomalies in our case.

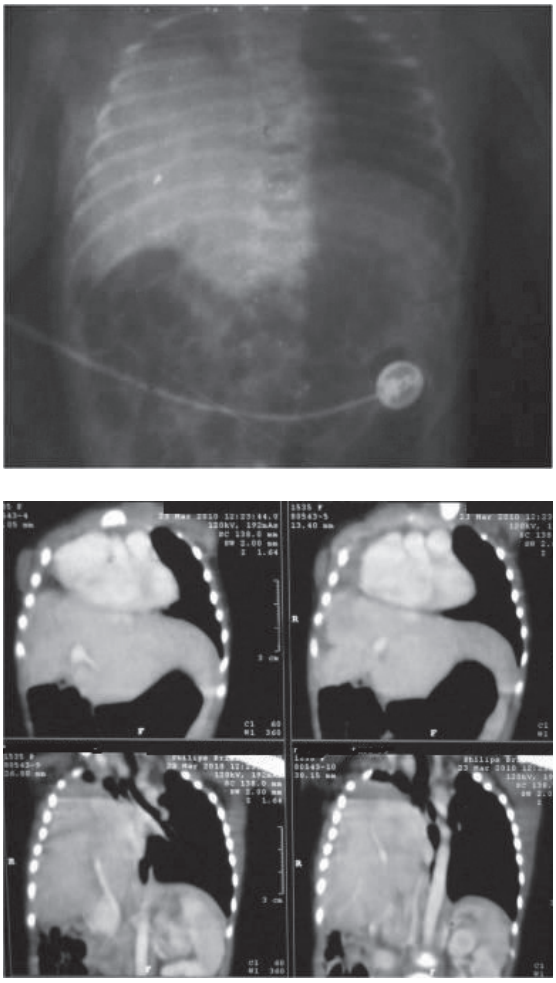

Figure 1 (A) X-ray film of chest and abdomen showing homogenous opacity involving right hemithorax without mediastinal shift and presence of clefts in vertebrae. (B) Contrast-enhanced computed tomography of chest and abdomen showing migration of liver into the thoracic cavity in the posterior aspect with right lung hypoplasia/collapse

It is important to consider hepatic pulmonary fusion in the differential diagnosis when congenital diaphragmatic hernia is suspected because the presence of this entity makes the reduction of hernia and preservation of the lungs difficult [4]. Magnetic resonance imaging (MRI) is very important in this regard as it may show some unique findings suggestive of hepatic pulmonary fusion [4]. Most of the case reports favor that non-shifting of mediastinal structures away from the affected side in a right-sided congenital diaphragmatic

hernia is an indicator of hepatic pulmonary fusion [4-6]. This is also true in our case as there was no evidence of shifting of mediastinum in x-ray film.

In summary, in a suspected case of right-sided congenital diaphragmatic hernia, hepatic pulmonary fusion should be suspected whenever imaging findings show intrathoracic liver and lack of mediastinal shift. Proper radiological imaging especially MRI should be considered for a better surgical outcome.

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