which revealed cholelithiasis, extensive pancreatic calcification, and dilation of the common bile duct to 13 mm with a calculus in its distal aspect. ERCP was then performed with common bile duct injection confirming the presence of a calculus. Cannulation for therapeutic endoscopy was unsuccessful, however, and the patient was referred to our institution.

Review of the radiographs revealed the common bile duct to be normal in caliber through the pancreatic head but dilated just proximal to the pancreas. It was believed that the stone had impacted just proximal to the pancreatic head. Repeat therapeutic ERCP was then undertaken. Common bile duct injection revealed a solitary stone judged to be approximately 14 mm in size (Fig. 1). Retrieval was deemed possible and a papillotome sphincterotomy of 15 mm was performed without difficulty. A 15-mm balloon was successfully inserted but failed to return the stone. Subsequent attempt at basket extraction successfully placed the stone into the basket but the basket and stone could not be withdrawn through the head of the pancreas. The stone could not be removed from the basket and an impaction proximal to the pancreatic head ensued. At surgery the following day, the stone and basket were removed. A cholangoscope was introduced through the cystic duct but could not be passed into the pancreatic head. The pancreas was found to be firm and inflexible. That portion of the common bile duct coursing through the pancreas was felt to be non-distensible.

Basket impaction is described in the literature as occurring at the ampulla.1,2 In our patient, however, the basket and stone could not be passed beyond the point at which the common bile duct entered the pancreas. We believe the impaction occurred secondary to extensive pancreatic calcification. In retrospect, the change from dilation to normal caliber at the juncture of the common bile duct with the pancreas probably reflected the pancreatic calcification and the indistensibility of that portion of the common bile duct that passed through the pancreatic head. We believe this to be the first case describing such an impaction and recommend that such changes in common bile duct caliber be considered in stone extraction in patients with a history of chronic alcoholic pancreatitis.

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Caustic colitis due to formalin enema

To the Editor:

Colitis has been reported by rectal instillation of a variety of agents: soap enemas,1-2 water-soluble contrast media,3 hydrogen peroxide,4-5 vinegar, potassium dichromate, potassium permanganate, copper sulfate, brown sugar,6 glutaraldehyde,4 non-steroidal anti-inflammatory agents,7 and ethyl alcohol.8

We report a 54-year-old man, who accidentally received a 100-ml enema of 10% formalin. Within minutes the patient experienced severe sharp pain located in the left lower abdomen followed by rectal bleeding.

Five days later, colonoscopic examination revealed an edematous and erythematous mucosa with multiple petechiae and superficial erosions in the rectum and sigmoid up to 25 cm from the anal verge. Histology showed a nonspecific chronic colitis, superficial erosions, lymphocytes and plasma cells infiltrate, and erythrocyte extravasation.

Following treatment with corticosteroid enemas rapid improvement was achieved. Two months later he was asymptomatic and endoscopy showed a distensible rectum with almost complete resolution of colitis. Biopsies revealed a very mild non-specific colitis in a regenerative phase. Currently, 2 years later, the patient is asymptomatic.

The severity of the acute colonic damage after caustic enema depends on the chemical constituent, the concentration of the solution as well as the duration of mucosal contact.1,8

Between the third and fifth week, a cicatrization phase begins; afterward the lesion may progress to stricture formation,9 a complication that did not occur in our patient. Corticosteroids or ACTH have been employed,1,8 but we
have not found other cases managed with corticosteroid enemas. To our knowledge, this is the first reported case of acute colitis due to rectal administration of formalin.

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Colonoscopic diagnosis of an appendiceal villous adenoma

To the Editor:

Adenomas of the appendix are rare and are not usually diagnosed pre-operatively. We report a patient in whom a villous adenoma, which was fully contained within the appendix, was diagnosed at colonoscopy.

An 80-year-old man who was well underwent a screening flexible sigmoidoscopy. A minute polyp was removed from the sigmoid colon. He was advised to undergo colonoscopy. At colonoscopy the mucosa of the entire colon appeared to be normal. The appendiceal orifice was initially normal (Fig. 1). Several minutes were spent in the cecum demonstrating to observers how to enter the ileum. During that time suction in the cecum resulted in the appearance of a small polyp in the appendiceal orifice (Fig. 2). Biopsy of this lesion resulted in a large polypoid lesion being pulled from the appendix (Fig. 3). Biopsy revealed villous adenomatous tissue. Appendicectomy was advised and was performed under spinal anesthesia. A mass was palpated in the appendix which could be prolapsed into the cecum. The appendix was amputated at its junction with the cecum. When opened there was a polypoid mass on a stalk 1 cm from the proximal margin of the appendix. Pathology confirmed the presence of a tubulovillous adenoma.

Appendiceal adenomas have rarely been diagnosed pre-operatively.1–3 Morrison et al.3 reported the diagnosis of an appendiceal villous adenoma at colonoscopy, but there was obvious cecal involvement by the adenoma allowing diagnosis.3 Our case is unique in that the tumor resided wholly within the appendix and was only apparent after prolonged visualization and suction in the cecum.

Figure 1. Normal-appearing cecum and appendiceal orifice.
Figure 2. Small polyp visible in appendiceal orifice.
Figure 3. Large polyp extruded from appendix.

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