of the procedure and sustainability of outcome still needs to be tested.

References


Dyke – Davidoff- Masson Syndrome

Vipin Ola*, Gaurav Mathur**, Bhupendra Sihag*, JK Meel***, Parmendra Sirohi****, RP Agrawal†

Sir,

Hemiparesis is a common clinical finding in neurological patients admitted in general wards or intensive care units of a tertiary care hospital like ours. It is also not unusual for seizures to be present in a good number of such patients at some point in their natural course of disease. CNS imaging in the form of NCCT or MRI usually reveals an area of infarction or less commonly haemorrhage or a space occupying lesion in a majority of cases. However, a finding like atrophy or hypoplasia of one cerebral hemisphere is not commonly encountered in our day to day practice. Originally described by Dyke, Davidoff and Mason, the syndrome named after them, if not uncommon, is not very commonly found. In the benefit of medical science, we are reporting about one such patient that came to our attention.

An 18 year old Hindu male patient was admitted in the medicine ward with the complaint of recurrent tonic-clonic seizure in right half of his body with secondary generalisation for the last 10 years. On further enquiry it was found that he had a seizure episode at the age of one year also for which no specific treatment was prescribed. But when the seizures became recurrent, starting at the age of 10, despite taking full therapeutic doses of first line antiepileptic drugs for one to two years, he sought further medical help. He was not symptom free on these medications and at the age of 18, he was brought to our hospital for further management. At the time of examination, he had right hemiparesis, brisk deep tendon reflexes (+++ ) and extensor plantar response (right). There was no evidence of any cranial nerve involvement. Right sided power was grade 4/5 in upper and lower limbs. Left side had normal power. Head circumference was normal, as were vision and hearing. No asymmetry of face was found. No neurocutaneous marker was found. There was no history of birth asphyxia or trauma. On neuro imaging, NCCT scan and MRI of brain revealed atrophy of left cerebral hemisphere, dilation of left lateral ventricle and widening of ipsilateral sulci, consistent with the diagnosis of Dyke Davidoff Mason Syndrome (Figure 1).

DDMS is characterised by seizures, contralateral hemiplegia / hemiparesis with or without mental retardation with atrophy or hypoplasia of one cerebral hemisphere secondary to brain insult in foetal or early childhood period. Our report is a contribution to the few cases reported from India. The three scientists, in 1933, described the plain skull radiographic and pneumatoencephalographic changes in a patient whose clinical characteristics included hemiparesis, seizures, facial asymmetry and mental retardation (although mental retardation is not always present)². Clinical findings may

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Received: 08.02.2011; Revised: 22.04.2013; Accepted: 25.06.2013
vary according to the extent of brain injury.

In 1939 Alpers and Dear found two types of cerebral hemiatrophy:

- Congenital type
- Secondary to cerebrovascular lesion, inflammation or head trauma.

When it develops early in life, the compensatory changes like homolateral hypertrophy of skull and sinuses occur due to relative vacuum created by the hypoplastic cerebrum.

Different Indian studies have shown an aetiological relationship between cerebral hemiatrophy and seizures.

Differential diagnosis includes

- Sturge-Weber Syndrome
- Some brain tumours
- Silver Syndrome
- Conditions associated with mega-encephaly as in the Linear-Nevus Syndrome.

Hemispherectomy may be done in selected cases.

Prognosis is better if hemiparesis occurs after the age of 2 years and in the absence of recurrent seizures.

References


Gastric Carcinoid Presenting with Hematemesis: An Uncommon Disease with a Rare Presentation

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Sir,

Gastric carcinoids account for <1% of gastric neoplasms and 2-4% of primary enteric carcinoids. They have remained a topic of interest because of their rarity of occurrence, protean clinical manifestations, and wide variety of radiological and endoscopic presentation which make their recognition extremely difficult. Only few cases of gastric carcinoid presenting with severe bleed have been reported. Here we describe a case of metastatic gastric carcinoid presenting with hematemesis.

A 30 yr old male was admitted with history of blood in vomitus. There was no history of pain abdomen, fever, jaundice or decreased appetite. His blood pressure was 90/60 mmHg and pulse rate- 110/min. Investigations: Hemoglobin- 9 gm/dl and normal platelet count, INR and liver biochemical tests. After resuscitation, esophagogastro-duodenoscopy (EGD) was performed, which could not localise the site of bleed due to lot of blood in stomach. Patient was managed with