vary according to the extent of brain injury.

In 1939 Alpers and Dear found two types of cerebral hemiatrophy 3:

- 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. 4

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

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. 1 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. 2 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, esophagogastroduodenoscopy (EGD) was performed, which could not localise the site of bleed due to lot of blood in stomach. Patient was managed with

References

were normal. Anti-Chromagranin A was positive both in serum and biopsy. CECT abdomen showed gastric submucosal lesion with multiple space occupying lesions (SOL) in the liver, FNAC from which was suggestive of metastatic deposits (Figure 3). Serum calcium, parathormone and gastrin levels were done to rule out MEN I syndrome, which were normal. Patient was advised further treatment but was lost to follow up.

Carcinoid tumors are rare, slow-growing neuroendocrine tumors arising from enterochromaffin cells. About 55% are found within gastrointestinal tract (small intestine-45%, rectum-20%, appendix-17%, colon-11%, stomach-7%), and 30% in bronchopulmonary system. According to WHO, gastric carcinoids are classified as: Type I (70-80%, mostly benign), associated with chronic atrophic gastritis; Type II (<10%, usually benign), associated with gastrinoma in patients with MEN1; and Type III (25-25%, sporadic) which behave aggressively. Our patient had type III carcinoid.

Preoperative diagnosis of gastric carcinoid usually remains elusive because of its varied clinical manifestations. Commonest reported symptom is pain, usually localized in upper
abdomen. Vomiting and weight loss are next common, while gastrointestinal bleeding, usually not severe, is less frequent (about 14%). Our patient presented with the rarest clinical feature i.e massive hemetemesis. Therefore, pre-endoscopic possibility of gastric submucosal lesion/carcinoid was not entertained.

Workup for gastric carcinoid necessitates EGD with biopsy. Most common location is fundus/body. The classical finding of irregularly shaped erythematosus dimple in center of a submucosal mass, as seen in this case, is rare. CECT abdomen is recommended for local spread and distant metastases. Gastric carcinoids of size >2 cm are usually malignant and frequently metastasize, as in this case. Serum chromogranin A levels are elevated in about 50% cases and are considered to be gold standard biochemical test for confirming diagnosis of carcinoid and following the course.

Primary treatment of gastric carcinoid is endoscopic/surgical removal, but long-acting octreotide has shown promise, as a palliative agent. Metastatic disease has a low 5-year survival rate, and aggressive surgical resection of primary and metastatic disease has been proposed.

With this report, we suggest that gastric carcinoid should be considered in cases of focal massive upper gastrointestinal bleed, in absence of more common causative lesions, especially when a submucosal mass is seen on endoscopy. Recognition of gastric carcinoid is important, as certain types have high malignant potential. Secondly, if emergency EGD is uninformative due to blood obscuring the view, a re-look EGD should be performed before proceeding to other diagnostic tests.

References

Obituary

Dr. Mahendra Singh Mathur was born on August the 7th, 1930, in Sirmur, Himachal Pradesh and did his graduation and post graduation from SMS Medical College, Jaipur. He was the first Postgraduate in Medicine of Ajmer, Rajasthan. He joined the faculty as Senior demonstrator on May the 1st, 1955, at SMS Medical College, Jaipur and Lecturer in Medicine in the same college. He then shifted to JLN Medical College, Ajmer as Professor on March the 29th, 1973. he remained Professor for more than 15 years. He has headed the Department of Medicine and also remained superintendent of JLN Hospital, Ajmer, for more than 12 years. He had been the examiner in different national universities and public service commissions for graduate, postgraduate, and super speciality like DM in Gastroenterology. he had more than 35 publications in various national and international medical journals. He was life member of various medical and social organisations and in last he was actively working with Radhaswami Satsang Sabha. he was a perfect clinician and an excellent academician. he was very humble, sober, hard working and ever helping personality. He was much respected by fellow colleagues, juniors, students, and local public. Till his last day he was giving consultation to the patients. He served API Ajmer branch in various capacities. he was deeply involved in various academic, social and cultural activities. He developed Acute Pulmonary oedema and Cardiac Arrest and subsequently attained Heavenly Abode on October 10th, 2013, at Ajmer, leaving behind Mrs. Madhu (Wife), Dr. Rajeev (son), consultant neurologist and Dr. Sanjeev (son), Holland, USA. We all salute this dedicated and kind hearted personality. May his soul rest in peace and we all the members of API pray to Almighty to give strength to Dr. M.S. Mathur’s family to overcome this irreparable loss.

Dr. Sanjiv Maheshwari
Hon. Secretary, API, Rajasthan Chapter