

Fig. 5 Showing "vascular" mass in liver.



Fig. 6: Preoperative cholangiogram showing defect in the common bile duct.

Professor Manzoor Zaidi for chemotherapy at the Jinnah Postgraduate Medical Centre. He remained asymptomatic for almost a year, when gradually jaundice, which had totally cleared, returned and he had further episodes of blood loss, from the upper G.I. tract. He died a year after surgery.

Discussion

Rhabdomyosarcoma is a rapidly growing malignant tumor of striated muscles. The embryonal type is mostly found in childhood¹, and represents about 10–15% of all malignant solid tumors in paediatric age group⁴. It is mostly found either in neonates or at puberty. The commonest site is head and neck, followed by genitourinary tract, trunk and limbs⁴. The lower limbs are more commonly involved. It can occur in the liver and biliary tract as primary tumour², as in our case.

It can present as a mass below the liver, but is commonly diagnosed when obstructive jaundice supervenes. Histologically, it is a variant of mixed mesenchymal sarcoma, and the diagnostic feature is anaplastic stroma with myxomatous tissue, which is characteristically hypovascular³. Since it was discovered that these tumours are radiosensitive, survival after childhood sarcomas has improved. All three modalities of treatment were used in the present case. Extensive resection followed by chemotherapy and radiotherapy improves prognosis. The location of the tumour in the present case prevented total removal.

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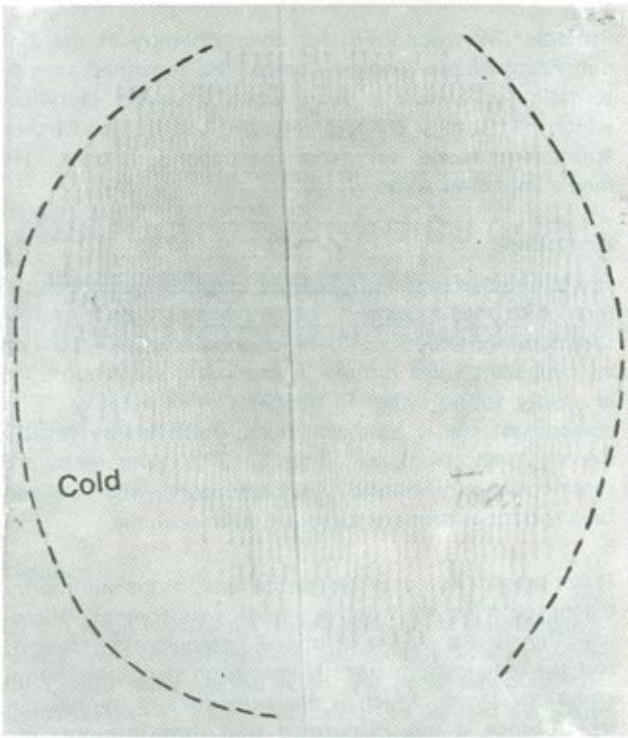


Fig. 1: Liver scan showing cold area Lat view.

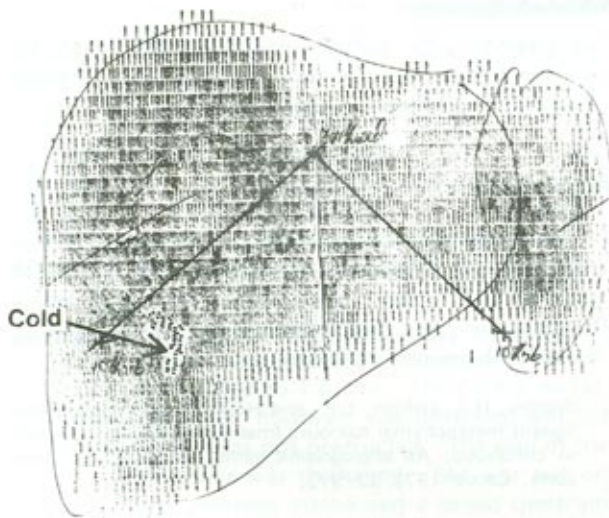


Fig. 2 Liver scan showing cold area A.P. view.



Fig. 3 Ultrasound liver showing cystic lesion R lobe.

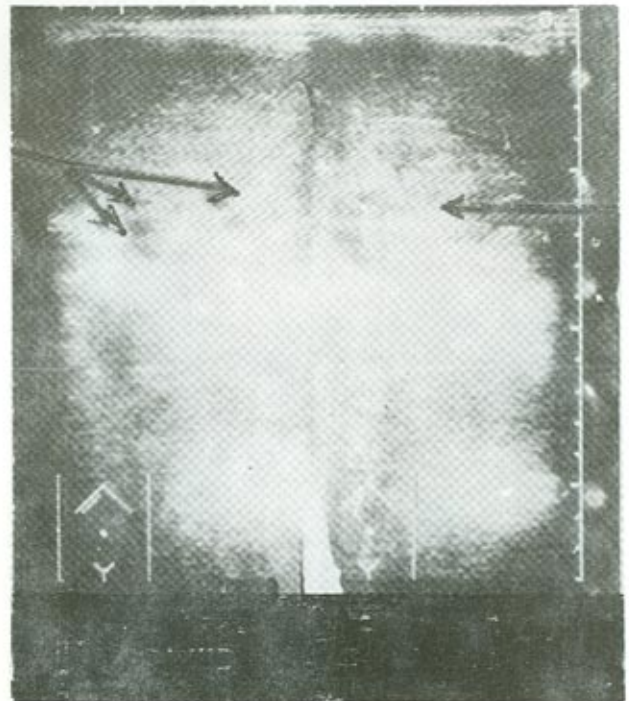


Fig. 4 Showing complex mass in G.B. fossa.

Sarcoma Botryoides of the Common Bile Duct

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Abstract

A case of Sarcoma botryoides of the bile ducts in a six year child is described.

Key words: Sarcoma botryoides — Common bile duct.

M.S., six years old male child was first seen in September 1986 with a history of fever and rigors, severe abdominal pain, and jaundice. He was found to be slightly malnourished with a tender liver just palpable beneath the costal margin. His general practitioner diagnosed hepatitis. When his condition did not improve, he was referred to a hospital in Larkana. On investigation, serum bilirubin level was 7.0 mg/dl (conjugated bilirubin 5.0 mg/dl) SGPT 150 units, alkaline phosphatase 95 units, thymol turbidity at 20. His stools by this time had become clay coloured. The liver scan showed a cold area posterolaterally (Figures 1 & 2). A diagnosis of liver abscess was made and treatment altered accordingly, with the addition of Flagyl to the regime. The fever persisted and jaundice deepened. He was brought to Karachi in November, 1986. An ultrasound was done in Larkana prior to coming to Karachi (Fig. 3). This revealed the liver to be enlarged with a localisation of small cystic lesions in the right lobe which were interpreted as being due to haemangiomas. The biliary canaliculi showed compression. The gall bladder was not visualised.

Ultrasound was repeated in November in Karachi (Figure 4,5). This revealed a complex mass above the gall

bladder fossa in right lobe of liver. It was highly vascular and of variable consistency with a size of 4 to 7 cms in different planes. A large vessel appeared to be feeding this mass.

At this stage his Hb was 8.4 g/dl, prothrombin time 54 seconds with the control of 15 seconds. Serum bilirubin was 9.8 mg/dl (direct bilirubin 6.6 mg/dl). SGPT 26 and alkaline phosphatase 184 units. After stabilizing, a laparotomy was done. The gall bladder was found to be normal but empty. The common bile duct was dilated and felt full and firm. Operative cholangiogram through a needle inserted into the duct revealed a dilated duct with a space occupying lesion filling (Figure 6). The wall was rather thickened. The dye entered freely into the duodenum. The duct was opened and found to contain grape like mass protruding from above and free from the duct wall. This was removed piece-meal. Both hepatic ducts were found to be dilated. Bile gradually started coming out of these ducts. No significant bleeding was encountered. Distally the duct was found to be clear.

A choledochoduodenostomy was performed. The gall bladder was not removed. Gross examination of the removed specimen suggested Sarcoma botryoides. Histopathology subsequently confirmed the diagnosis. Postoperatively on the third day, the patient had haemetemesis and melena. The haemoglobin dropped to 6.1 g/dl. He was adequately transfused and the Hb rose to 14.7 g/dl by the 6th postoperative day. The bilirubin level at this time was 4.0 mg/dl (direct 2.4 mg/dl). Normal feeding was gradually established by the twelfth day. After discharge from hospital, he was referred to

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