## COMMENT

PH is part of the differential diagnosis of gastric submucosal nodules. The likely aetiology of PH is congenital and usually asymptomatic. However if symptoms occur they are usually in the fourth and fifth decades[5]. PH is a rare differential diagnosis of a submucosal gastric lesion.

The distribution of PH is 25% in the stomach and 30% in the duodenum[9] with the rest distributed at other sites throughout the gastrointestinal tract. There is also the exceedingly rare possibility of malignant change[10, 11].

This case highlights the rare aetiology of a symptomatic gastric submucosal lesion as well as the difficulty in making a preoperative diagnosis even with modern imaging modalities such as CT and EUS.

The authors have no conflict of interest

Richard Mayes, Specialist Surgical Registrar

Inder Mainie, Consultant Gastroenterologist

Richard Davis, Consultant Pathologist

Gary Spence, Consultant Surgeon

Department of Surgery, The Ulster Hospital, Upper Newtownards Road, Belfast, BT16 1RH

Correspondence to Mr Mayes

rick_mayes@doctors.org.uk

## REFERENCES

1. Lackie JM, Mor IAR, Cells and tissues in health and disease. Liver, bilary tract and pancreas. In: MacSween RNM, Whaley K, editors. Muir's Textbook of pathology. 13th ed. London: Edward Arnold; 1992. p. 33 798
2. Mowat A, MacSween RNM, Percy-Robb IW, Foulis AK. Liver, biliary tract and pancreas. In: MacSween RNM, Whaley K, editors. Muir's Textbook of pathology. 13th ed. London: Edward Arnold; 1992. p. 798
3. Bhana BD, Chetty R. Heterotopic pancreas – an unusual cause of cholecystitis. *S Afr J Surg.*1999;**37(4)**:105-7
4. Dolan RV, ReMine WH, Dockerty MB. The fate of heterotopic pancreatic tissue: a study of 212 cases. *Arch Surg*. 1974;**109(6)**:762-5
5. Tonkin RD, Field TE, Wykes PR. Pancreatic heterotopia as a cause of dyspepsia. *Gut* 1962;**3**:135-9
6. Chetty R, Weinreb I. Gastric neuroendocrine carcinoma arising from heterotopic pancreatic tissue. *J Clin Pathol* 2004;**57(3)**:314-7
7. Zinkiewicz K, Juśkiewicz W, Zgodziński W, Szumiło J, Cwik G, Furtak J, *et al.* Ectopic pancreas: endoscopic, ultrasound and radiological features. *Folia Morphol (Warsz)* 2003;**62(3)**:205-9.
8. Kim JY, Lee JM, Kim KW, Park HS, Choi JY, Kim SH, *et al.* Ectopic pancreas: CT findings with emphasis on differentiation from small gastrointestinal stromal tumor and leiomyoma. *Radiology*. 2009;**252(1)**:92-100.
9. Pearson S. Aberrant pancreas. Review of the literature and report of three cases, one of which produced common and pancreatic duct obstruction. *AMA Arch Surg.* 1951;**63(2)**:168-86.
10. Denève E, Ramos J, Aufort S, Marchand JP, Rousset T, Perrochia H, *et al.* [Endocrine tumor arising in heterotopic gastric pancreas.] French. *Gastroenterol Clin Biol***.** 2008 Feb;**32(2)**:195-201.
11. Chetty R, Weinreb I. Gastric neuroendocrine carcinoma arising from heterotopic pancreatic tissue. *J Clin Pathol* 2004;**57(3)**:314-7

## POST-OPERATIVE PYODERMA GANGRENOSUM IN ASSOCIATION WITH ILEAL CARCINOID TUMOUR

**Editor**

Pyoderma gangrenosum (PG) is an uncommon, progressive ulcerative condition of skin. It presents with deep ulceration characterised by an overhanging violaceous border, which can occur on any body surface. It is frequently confused with other more common ulcerating skin conditions such as necrotising fasciitis, vasculitis, pustular drug reactions and skin infections. Since surgery may be used to treat some of these conditions, but is relatively contraindicated in PG, early diagnosis is critical and is usually made in conjunction with a dermatologist.

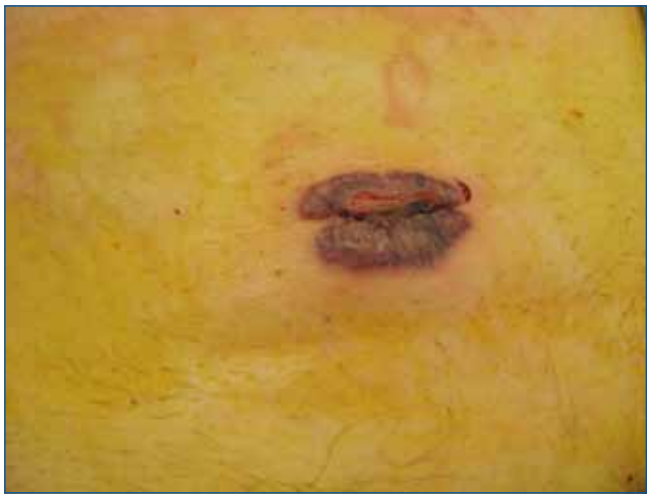


*Fig 1*. Early violaceous change around a laparoscopic port site

This 76-year-old male had a laparoscopic assisted right hemi-colectomy for an apparent ascending colonic tumour, however histology actually revealed a well differentiated neuroendocrine tumour of the terminal ileum. Serum pancreatic polypeptide, N and C-terminal glucagon, chromogranin A and urinary 5-HIAA collection were all elevated.

On day 7 this man's left iliac fossa port site was noted to be indurated and erythematous. Cefuroxime was empirically commenced for a presumed wound infection. He became pyrexic with a leukocytosis of 30,000 $mm^3$ and skin at the port site quickly became sloughly and ischaemic (Figure 1). Following debridement he required transfer to intensive care as a case of suspected necrotising fasciitis.

The patient's necrotising skin condition progressed relentlessly. He required 4 further debridement's with intermittent returns to the intensive care unit for supportive therapy (Figure 2). Microbiology of the skin specimens was insignificant and pathology described neutrophillic abscesses with no evidence of vasculitis, granulomatous inflammation or metastatic tumour. Following a dermatological opinion a diagnosis of PG was made.

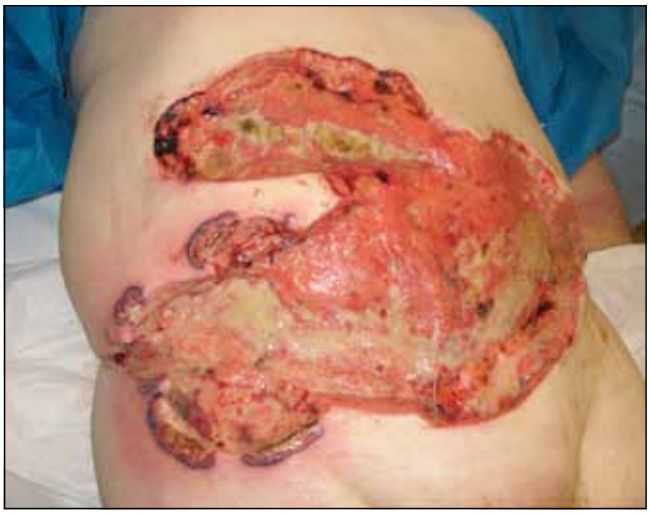


*Fig 2*. Extensive abdominal wall debridement with classical violaceous borders seen at the wound periphery

Intravenous antibiotics were stopped and high dose prednisolone was commenced in addition to the already prescribed somatostatin (Octreotide®). The patient was maintained on azathioprine (Imuran®) once the prednisolone had been tapered. His large abdominal defect was dressed with Activon tulle® honey dressings. He progressed well and was discharged. Follow up revealed satisfactory recovery of the wound.

## DISCUSSION

The literature yields only one other case connecting PG with carcinoid tumour[1], while most reports correlate the occurrence of PG to trauma, typically surgery[2]. The delay in the recognition of this serious dermatological condition was associated with increased morbidity for our patient. PG is a serious and potentially fatal skin condition when correct treatment is not quickly commenced. Management is relatively simple once recognised with the use of corticosteroids and immunosuppressant. Surgery is not thought to be beneficial and in many circumstances can worsen the condition[3].

We recommend that in any significant skin condition, particularly post-operatively or in one not responding to treatment effectively, one must seek the early advice of a dermatologist and not be guided primarily by histology.

The authors have no conflict of interest.

William Campbell *ST4 in Surgery*

Elizabeth Baird *F1 in Surgery*

Katherine Murtagh *F1 in Surgery*

David Eedy *Consultant Dermatologist*

Rob Hannon *Consultant Surgeon*

Southern Trust, Daisy Hill Hospital, 5 Newry Road, Newry, BT35 8DR

Department of Dermatology,

Southern Trust, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Correspondence to Mr Campbell

Email: billcampbell1@hotmail.com

## REFERENCES

1. Lee SS, Biro L, Price E Pyoderma gangrenosum with carcinoid tumour. *Cutis* 1976; **18:** 791-794.
2. Armstrong PM, Ilyas I, Panday R, Berendt AR, Conlon CP, Simpson AHRW Pyoderma gangrenosum: a diagnosis not to be missed. *J Bone Joint Surg* 1999; **81:** 893-4.
3. Tay YK, Friednash M, Aeling JL Acute Pyoderma gangrenosum does not require surgical therapy. *Arch Fam Med* 1998; **7:** 377-80

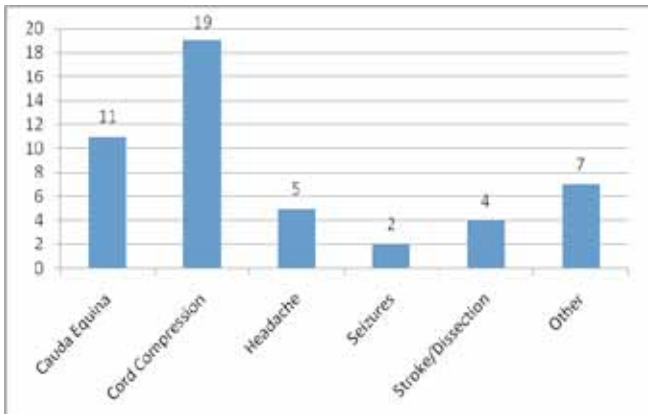
## USE OF OUT OF HOURS MRI IN THE ROYAL VICTORIA HOSPITAL – A 6 MONTH RETROSPECTIVE REVIEW

**Editor**

Through the ongoing development of the Critical Care Centre, it is anticipated that the region's principal trauma receiving unit at the Royal Victoria Hospital will attain Level 1 Trauma Centre status. However an essential criterion for this is the provision of 24 hour access to MRI, as stipulated by the American College of Critical Care Medicine[1]. Out of hours MRI is currently provided as a time-limited, daily service on a consultant to consultant referral basis. Within the UK, it has been reported that only 32 out of 88 (36.3%) trauma units with MRI provide an out of hours service[2].

We undertook a 6 month retrospective review of all patients requiring out of hours MRI between November 2007 and May 2008. Records were assessed for referral information, imaging result and clinical outcome. 74 patients in total had out of hours MRI. Of these, 48 were regarded as emergency (scan performed <24 hours from referral).

Of the 48 emergency requests, the majority came from neurosurgery (n=27) and neurology (n=14), with orthopaedics (n=5), general medicine (n=1) and A&E (n=1) making up the remainder. Figure 1 illustrates the categories of clinical referral, with the majority for either suspected cauda equina syndrome or cord compression.




Out of hours MRI had the greatest impact in suspected cauda equina syndrome, as all scan positive patients (n=5) had surgery on the day of scanning, and made good neurological recovery, with only 1 having ongoing pain at 6 month follow-