lesions in the liver. It is commonly associated with cutaneous lesions and rarely with hemangiomas in the gut wall [1].

The commonest complication of hepatic haemangioma is congestive cardiac failure which needs intensive medical therapy [2]. Pressure on the stomach and duodenum by large pedunculated lesions may present with abdominal pain, nausea and vomiting. Compression of inferior vena cava may result in “Budd-chiari syndrome”.

The “Diffuse neonatal haemangiomatosis” is a rare disorder that usually present in infancy and has a high mortality rate. They have haemangiomas which are calcified in the liver, bowel wall, spleen, and adrenal gland [3]. The infantile haemangiomas are asymptomatic and treated conservatively with watchful expectancy. The goals of pharmacotherapy are to reduce morbidity and to prevent complications. Oral and intralesional corticosteroids are effective at slowing growth and decreasing the size of proliferating haemangiomas. Interferon - 2-a inhibits endothelial cell migration and specific growth factor. It can be used in lesions that are unresponsive to steroids. Laser surgery is beneficial in treating both proliferating and residual vessels of haemangiomas. When liver haemangiomas are complicated with cardiac failure, it can be treated with ligation of hepatic artery and prednisolone, digoxin, diuretics [4].

References

Aneurysm of the left common iliac artery

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Introduction
Aneurysm is an abnormal dilatation of an artery. Abdominal aorta is the commonest site. Aneurysms presenting with symptoms (pain, distal embolization, rupture) need repair. Asymptomatic patients need careful evaluation (risk of rupture vs risk of repair) to decide on elective repair. Aneurysms are repaired surgically or by endovascular techniques [1,2].

Case history
A 75 year-old patient presented with lower and central abdominal pain of two weeks duration. He complained of persistent pain which had progressed in intensity. He had no alteration in bowel habits and had no urinary symptoms. He had a poor response to analgesics. An ultrasound scan revealed an aneurysm of the common iliac artery which had probably leaked but contained. An urgent CT scan confirmed the findings.
The patient was prepared for emergency repair of the aneurysm. At the surgery a leaked and contained aneurysm of the right common iliac artery was found. The neck of the aneurysm was extending up to aortic bifurcation. The abdominal aorta and both common femoral arteries were dissected. Vascular clamps were applied to occlude the infrarenal aorta, right common iliac artery distal to aneurysm and left common iliac artery. The aneurysm was opened and thrombus removed. Reconstruction was performed by aorto-bifemoral synthetic graft. Patient had an uneventful recovery.

Discussion

Aneurysms of the iliac arteries are rare. They may present with abdominal and back pain, distal ischaemia or as an emergency due to rupture. Pain has to be carefully evaluated as it may be due to another pathology. Symptomatic aneurysms need repair.

Asymptomatic aortic aneurysms need elective repair if the diameter is larger than 5.5cm or rate of expansion is greater than 0.5cm in six months (due to high risk of rupture). However, in elective operations fitness of the patient and the life expectancy also need consideration [1, 2].

The patient under discussion had pain and a suspected aneurysmal leak on imaging. He had hypertension which was well controlled medically. He was otherwise well.

He was subjected to open repair, a major procedure involving aortic clamping which has a significant morbidity and mortality rate. These risks are minimal in endovascular repair in which a stent graft is deployed into the aneurysmal segment through the femoral artery. Endovascular repair does not involve general anaesthesia, laparotomy and aortic clamping.

References


A rare case of multiple hereditary exostoses with spinal cord compression

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A nine year-old previously well child presented with weakness of both lower limbs of 9 months duration. He developed numbness and weakness of the right lower limb 9 months back. Then the child was admitted to General Hospital, Matara and was investigated. The child went home prematurely before the completion of investigations and defaulted follow-up due to multiple social problems. Six weeks later he developed weakness of the left lower limb as well. Weakness of limbs progressed slowly over the next few months and he became bed-bound with paraplegia. He had urinary and faecal incontinence. As a result of his illness he was unable to attend the school and stopped schooling completely. There was a family history of multiple hereditary exostoses (HME) in the father, younger sister, and a paternal aunt. The family was affected by Tsunami in 2004 and shifted residence. The father was jailed for