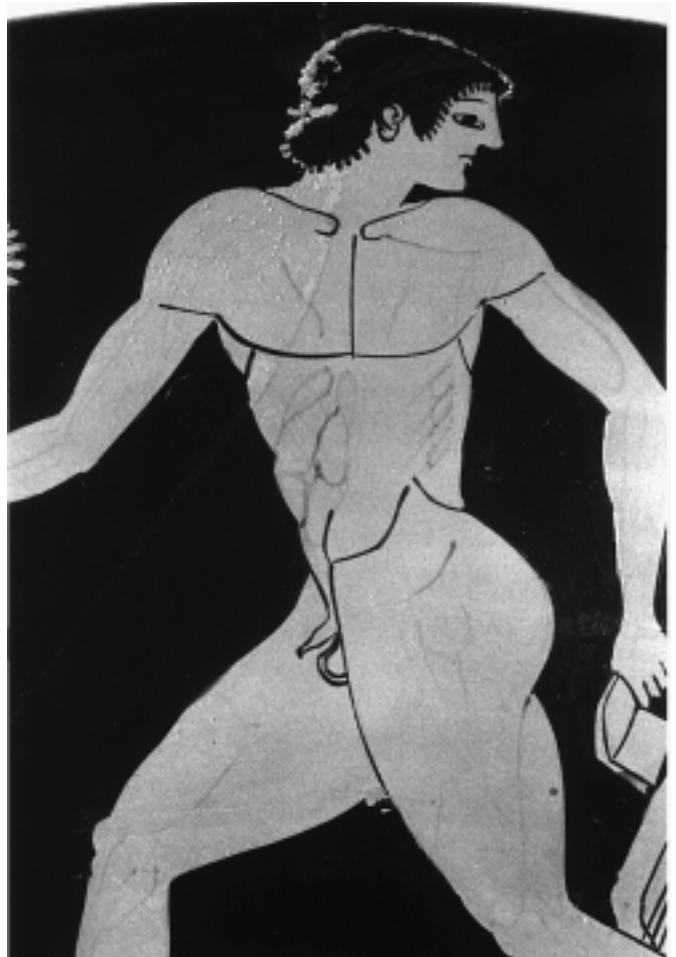
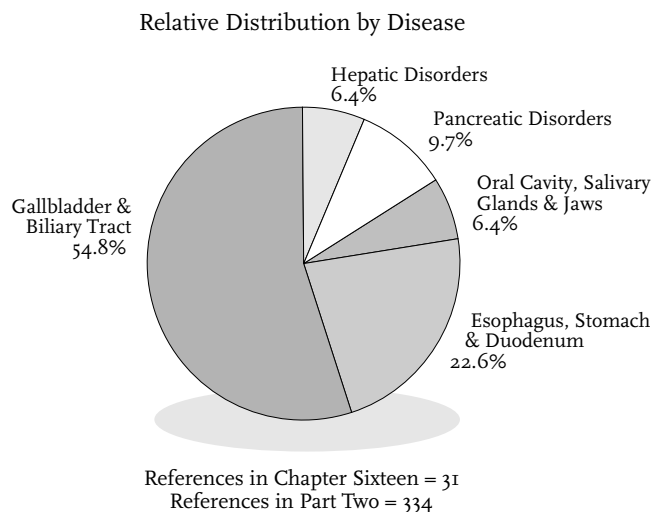


# 16. Remission of Digestive System Diseases



# Remission of Digestive System Diseases



**D**igestive system diseases (ICD•9•CM\* code numbers 520-579) include diseases that affect all structures and organs involved in the digestive process: oral cavity, jaws, salivary glands, esophagus, stomach, small and large intestines, peritoneum, liver, gallbladder, and pancreas. Also included are diseases that affect the peritoneal cavity. Specific diseases and disorders include Menetrier's disease, ulcers, gastric diverticulum, obstructions in digestive organs, appendicitis, hernias, noninfectious enteritis and colitis, anal fistulae, peritonitis, chronic and acute liver diseases and cirrhosis, liver abscesses, hepatitis, cholelithiasis and cholecystitis, pancreatitis, gastrointestinal hemorrhages, and disorders affecting intestinal absorption of nutrients.

Of the 31 references in Chapter 16 (9.3% of the 334 references in Part Two), 21 are annotated. Some of the annotated references contain case reports. There are 10 supplemental references provided as additional research

materials. Full text of 13 case reports is included. A summary of the chapter contents is presented in Table One.

Table One: References and Case Reports in Chapter Sixteen †

Disease/Disorder	References (number)	Cases (number)	Cases (%)
Diseases of Oral Cavity, Salivary Glands, & Jaws	2	2	1.7%
Diseases of Esophagus, Stomach & Duodenum	7	3	2.5%
Menetrier's Disease	5	2	1.7%
Ulcers	2	1	0.8%
Other Digestive System Disorders	22	8	6.7%
Gallbladder & Biliary Tract	17	4	3.3%
Hepatic Disorders	2	0	0.0%
Pancreatic Disorders	3	4	3.3%
Totals	31	13	10.8%

† Total number of case reports in Part Two is 120.

\* The International Classification of Diseases 9th Revision (ICD•9•CM) is a volume that provides an international standard for the classification of diseases. It was prepared by the Commission on Professional and Hospital Activities [Ann Arbor, Michigan: Edwards Brothers, Inc.], April 1986.

# Diseases of the Oral Cavity, Salivary Glands, and Jaws

## Spontaneous Regression of an Intraosseous Vascular Lesion after Aspiration

### *Report of a Case*

GOLDBERG S; STERN M; KAUFMAN P

*Journal of Oral and Maxillofacial Surgery* 30(10): Oct 1972; 734-736

#### *Extracted Summary*

An unusual case of an intraosseous vascular lesion that underwent spontaneous regression after aspiration is described. Involution of the lesion with preservation of the dentition was accomplished without the need for surgical intervention.

#### SELECTED CASE REPORT

An 8-year-old Negro boy was referred by his dentist for evaluation and treatment of a swelling of the right body of the mandible. Although the swelling was asymptomatic, the boy's parent related that the right side of his face had been swollen for approximately three months. Further questioning led to the conclusion that, except for the usual childhood diseases, the child's medical history was non-contributory.

Examination: Extra-oral examination disclosed a slight facial asymmetry characterized by a fullness over the right body of the mandible in the premolar region. The skin of the right side of the face had a diffuse, irregular "vascular nevoid lesion" that extended from the lower border of the mandible to the temporal region. The parent said that this had been present since birth but in the past few years it had become more prominent. There was no discernible bruit when the area over the bony lesion was auscultated. There was no facial paresthesia.

The intra-oral examination disclosed a dome-shaped expansion 3 centimeters long in the right premolar region that distorted the depth of the mucobuccal fold. The expansion was bony hard and noncompressible; there was no evidence of crepitus. The overlying mucosa was intact and of normal color and tone. The other intra-oral examination results were normal.

Radiographic examination disclosed a 3 centimeter diffuse radiolucent area with indistinct, irregular borders that extended from the mandibular right canine to the right second molar region. The radiographs also disclosed a thinning of the inferior border of the mandible, blunting of the roots of the permanent first molar, and a displaced unerupted second premolar within the lesion.

Treatment and Course: On January 18, 1970, the patient was admitted to the hospital. All routine preoperative laboratory results, including serum calcium, phos-

phorus, and alkaline phosphatase, were within normal limits. On January 19, the patient was taken to the operating room and a general anesthetic was administered via a nasoendotracheal route.

The lesion was aspirated with an 18-gauge needle. Aspiration produced 48 milliliters of blood that did not represent an endpoint and in which the flow of blood had spontaneously pushed up the barrel of the syringe. Hemostasis was obtained with direct pressure. To confirm that the original aspiration had not punctured the inferior alveolar artery, the procedure was again attempted more posteriorly and laterally. The findings of the first aspiration were confirmed. An unsuccessful attempt was made to biopsy the lesion with a Silverman needle. Again hemostasis was obtained with direct pressure. Bleeding was well controlled and the postoperative course was uncomplicated. A presumptive differential diagnosis included central hemangioma, arteriovenous fistula, and aneurysmal bone cyst.

Two days later, an angiogram of the right brachial carotid artery was performed. A report of the angiogram said "that passing out from the facial artery are three large branches leading into the mandible. These branches enter the radiolucent lesion and a large accumulation of contrast material within the lesion can be demonstrated. A prominent draining vein is also visible."

As a result of the surgical findings as well as the carotid angiogram, a vascular lesion in the category of a central hemangioma or an arteriovenous fistula was thought to be most likely. The modalities of treatment available were direct surgical intervention, cryosurgery, the use of sclerosing agents, radiation, or no active therapy. The latter course was selected. The patient was discharged from the hospital to be observed periodically.

The patient was seen three months later and, at that

time, the radiographs disclosed some increased radiopacity of the lesion. At the end of a year, clinical examination disclosed that the mandibular right second premolar, which had been displaced within the lesion, had erupted into its normal occlusal relationship with the surrounding

teeth. In addition, radiographs showed what appeared to be complete involution of the lesion. The patient was last seen approximately 18 months after the aspiration; he remained clinically and radiographically asymptomatic.

## Spontaneous Regression of a Dentigerous Cyst in a Middle-aged Adult

IRVING SP

*Oral Surgery, Oral Medicine, and Oral Pathology* 57(6): June 1984; 604-605

### *Extracted Summary*

Follicular cysts associated with impacted teeth in adults usually increase in size or remain static. A case is presented in which a typical dentigerous cyst decreased in size without any subjective or objective evidence of spontaneous drainage.

### SELECTED CASE REPORT

In March 1981, a 63-year-old white woman was referred for evaluation and removal of a distoangularly impacted lower right third molar and its associated pericoronal cyst. The patient was edentulous except for the impacted tooth, which was discovered on a routine panoramic radiograph.

Examination of the patient's file revealed a panoramic radiograph dated May 29, 1979, which showed a distoangularly impacted third molar with a pericoronal radiolucency, the border of which stood 4 to 5 millimeters away from the crown of the tooth. A second panoramic radiograph dated November 5, 1980, showed significant diminution in size of the radiolucency, which now was bordered by a cortical rim of bone. To make certain that the dates of the radiographs were not inadvertently transposed, a third panoramic radiograph was taken on March 23, 1981, and this was essentially identical to the radiograph of November 5th.

The patient, who was judged to be a very reliable historian, was carefully questioned about symptoms, including pain, swelling, denture irritation under the distal flange of her lower denture, and history of intraoral drainage. The history and examination yielded nothing of significance. The crown of the tooth was palpable through

clinically normal gingiva posterior to the distal extension of the lower denture. No evidence of a fistula or scarring was noted.

Upon surgical exploration, the crown of the tooth was found to be partially exposed through the bone, with the overlying follicular sac intact and normal in appearance. The tooth and its pericoronal dentigerous cyst were easily removed. The patient recovered uneventfully and has shown complete bony fill and no evidence of pathosis as of April 1983.

Histopathologically, the pericoronal soft tissue consisted of a cavity lined with nonkeratinizing stratified squamous epithelium with a mild chronic inflammatory infiltrate in the lamina propria. The diagnosis was dentigerous cyst.

It is most unusual for a pericoronal radiolucent lesion to decrease in size spontaneously. This could occur if such a lesion became exposed to the oral cavity and decompressed. There was no subjective or objective evidence that the cyst had been infected or that spontaneous drainage had ever occurred. However, to account for this unusual regression in size over time, one must assume that the lesion did decompress spontaneously.

# Diseases of the Esophagus, Stomach and Duodenum

## MENETRIER'S DISEASE

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### Menetrier's Disease

#### *Case Report with Apparent Spontaneous Remission*

BERMAN JR; SPIEGEL EL

*Gastrointestinal Endoscopy* 15(4): May 1969; 230-234

#### *Extracted Summary*

The case of a 41-year-old man with Menetrier's disease is presented who was first seen in 1964. With conservative treatment (without surgery) the hypoproteinemia remitted spontaneously and, to this date, there is still complete remission of symptoms.

The triad of epigastric pain, x-ray evidence of large gastric folds, and hypoproteinemia should alert the clinician to this entity.

### Menetrier's Disease

#### *Report of a Case with Transient and Reversible Findings*

LESSER PB; FALCHUK KR; SINGER M; ISSELBACHER KJ

*Gastroenterology* 68(6): June 1975; 1598-1601

#### *Extracted Summary*

This report is of a case of Menetrier's disease which resolved spontaneously over a 3-week period. We suggest that the case is unique because of its short course, apparent reversibility, and possible allergic etiology.

#### SELECTED CASE REPORT

A 49-year-old housewife, M. L., shortly after eating a crabmeat sandwich, suddenly developed nausea and vomiting which lasted 5 days. Ten days after the onset of the vomiting she began to notice bilateral ankle edema, which over the next few days extended to her groin, and was accompanied by a 15-pound weight gain. At this time, she first noted cramping abdominal pain which was relieved by frequent feedings. She developed pruritus of one leg without a skin rash. She denied fever, chills, and arthralgias. There was no history of asthma, renal, liver, prior intestinal disease, or allergies.

On physical examination, on the 19th day of illness, she was well except for pitting edema of both legs. There were no stigmata of liver disease.

Initial laboratory data revealed a total serum protein, 3.9 gm; albumin, 2.3; calcium, 7.7 mg; and phosphorus, 4 mg/100 ml. There was no evidence of proteinuria. The hematocrit was 43% and the white cell count was 15,700 with 65% polymorphonuclear leukocytes, 33% lympho-

cytes, and 2% eosinophils. The blood urea nitrogen, creatinine, SGOT, alkaline phosphatase, bilirubin, uric acid, electrolytes, and blood sugar were within normal limits.

An upper gastrointestinal series taken early in the course of her illness demonstrated enormous, irregular, distorted gastric folds extending from the fundus to the antrum, along the lesser and greater curvature. The small bowel appeared normal. At gastroscopy there were large, thickened, irregular nonulcerated folds. Cytological brushings were negative for malignant cells. Biopsies through the endoscope demonstrated cystic dilation of the more basally oriented glands. There was no infiltration of the biopsy with eosinophils. After the intravenous injection of [<sup>51</sup>Cr] albumin, stools were collected for 110 hours, and 11.6% of the administered label was recovered in the stools (normal, less than 1%).

She was placed on a low salt, high protein diet. Within 3 weeks of the start of her illness she felt better, the leg

edema had markedly decreased, and she was free of abdominal pain. Serum protein increased to 6.1 gm and the albumin to 3.7 g/100 ml. Two months from the onset, a repeat upper gastrointestinal series showed a marked decrease in the size of the gastric folds. A repeat [<sup>51</sup>Cr]

albumin study, 4 months after the onset of her illness, showed a decrease in excretion to 1.4%. It is noteworthy that the patient developed some pruritus, edema, and a rash at the chromium injection site. She is currently symptom-free and has normal serum protein levels.

## Spontaneous Remission of Protein-Losing Gastropathy Associated with Menetrier's Disease

### *A Plea for Conservative Management*

BERRY EM; BEN-DOV Y; FREUND U

*Archives of Internal Medicine* 140(1): Jan 1980; 99-100

#### *Extracted Summary*

Spontaneous remission of the protein-losing gastropathy of Menetrier's disease occurred after four months of disease activity. Because the natural history and cause of Menetrier's disease is unclear, we suggest a more conservative approach to the management of this condition, despite recent publications to the contrary.

#### SELECTED CASE REPORT

A 58-year-old man was admitted to Hadassah University Hospital because of edema of the legs. He had been completely well until one month prior to admission. Then he started to suffer from watery diarrhea without blood or mucus. There was no fever. The diarrhea subsided with symptomatic treatment, but subsequently the patient noticed swelling of the legs and gained 8 kilograms. There was no relevant personal or family history. Findings on physical examination were normal except for edema of the legs. Laboratory tests showed normal urinalysis results, hemoglobin level, electrolytes, BUN level, and liver function test results. The albumin content was 2.0 gm/dl. Xylose absorption and results of Schilling tests were normal. Barium meal examination disclosed hypertrophic gastric mucosa with a suspicion of an infiltrating neoplasm.

In view of the hypoalbuminemia and edema and the patient's relatively good clinical condition with no evidence of renal disease or malabsorption, the possibility of a protein-losing gastropathy was entertained. The gastric juice contained large amounts of protein. Despite the

suspicious results of the barium meal study, gastroscopy with multiple biopsies did not show malignant changes but only mucosal hypertrophy and inflammation. The clinical picture and these findings were consistent with the diagnosis of Menetrier's disease. Laparotomy was performed, and a full-thickness stomach biopsy specimen was typical of the pathological changes of Menetrier's disease. The patient was treated conservatively with a high protein diet. The serum albumin level rose to 4.0 gm/dl, and the peripheral edema disappeared. Repeated investigations were performed after four months of remission. There was a sharp decrease in the gastric protein concentration and the polyvinyl pyrrolidone excretion was decreased. The remission has been maintained during 18 months of follow-up. During this period, the patient was receiving a regular diet. A recent upper gastrointestinal study showed that the clinical remission was accompanied by a return to within normal limits of the roentgenographic findings.

#### SUPPLEMENTAL REFERENCES MENETRIER'S DISEASE

Menetrier's Disease: Spontaneous Metamorphosis of Giant Hypertrophy of the Gastric Mucosa to Atrophic Gastritis

FRANK BW; KERN F JR

*Gastroenterology* 53(6): Dec 1967; 953-960

Spontaneous Remission in Hypertrophic Gastropathy (Menetrier's Disease)

WALKER FB IV

*Southern Medical Journal* 74(10): Oct 1981; 1273-1276

## Spontaneous Healing of Duodenal Ulcers

FREDERIKSEN HJB; MATZEN P; MADSEN P; KRAGELUND E; KRAG E; CHRISTIANSEN PM; BONNEVIE O  
*Scandinavian Journal of Gastroenterology* 19(3): May 1984; 417-421

### Extracted Summary

Ninety-one patients with duodenal, pyloric, or prepyloric ulcers were studied endoscopically. Spontaneous ulcer healing was seen in 29 patients within 2 weeks (rapid healing) and in 23 patients within 6 weeks (slow healing). More ulcers healed spontaneously in women than in men ( $P < 0.05$ ). Spontaneous healing in men was related to a low gastric peak acid output ( $P < 0.05$ ). During follow-up study for 2 years of patients with spontaneously healed ulcers 13 patients had no recurrence, whereas 19 patients had 1 or 2 recurrences, which also healed spontaneously; 11 patients had to be given active treatment, and 9 patients did not complete the study. Cigarette smoking was more frequently recorded in the group receiving active treatment than in the group with spontaneous healing. In men, ulcers needing active treatment during the follow-up period were related to a high peak acid output ( $P < 0.05$ ).

## Case Report: Spontaneous Healing of a Gastro-Colic Fistula Due to a Benign Gastric Ulcer

MCCULLOUGH KM; GREGSON R  
*Clinical Radiology* 38(4): July 1987; 431-433

### Extracted Summary

Gastro-colic fistula is an uncommon complication of a benign gastric ulcer. The commonest causes of a gastro-colic fistula are carcinoma of the stomach, carcinoma of the colon and previous gastric surgery for peptic ulcer disease and surgery is the treatment of choice. We report a case of gastro-colic fistula due to a benign gastric ulcer, which healed spontaneously without treatment. Only one previous case of spontaneous healing of a gastro-colic fistula has been described and this patient subsequently had surgery to exclude an underlying malignant disease.

### SELECTED CASE REPORT

A 62-year-old man presented in 1983 with a 6-week history of epigastric pain and intermittent diarrhea. He had had a lumbar sympathectomy in 1960 for hypertension and right orchidectomy in 1972 for testicular seminoma with postoperative radiotherapy to the para-aortic and iliac lymph nodes with renal shielding (30 Gy in 24 days). He was taking digoxin, cyclopentiazide with potassium chloride and guanethidine regularly for hypertensive heart disease, but had recently been started on naproxen for a painful right knee.

He was referred by his general practitioner for a barium enema, which showed a fistula between the transverse colon and the greater curve of the stomach. A barium meal confirmed the presence of the gastro-colic

fistula and showed that this was caused by a large gastric ulcer.

Endoscopy was performed about a month after his barium studies. This showed a healed gastric ulcer on the greater curve of the stomach with mucosal folds radiating towards the site of the scar. Biopsies taken from this region showed a chronic inflammatory cell infiltrate in the lamina propria, but no evidence of malignant cells.

On follow-up a repeat barium meal also showed a healed gastric ulcer on the greater curve of the stomach and a barium enema now showed a normal transverse colon with no evidence of a gastro-colic fistula. The patient remains alive and well 3 years later.

# Other Digestive System Diseases

## GALLBLADDER AND BILIARY TRACT

### Spontaneous Disappearance of Gallstones

MILLER MC

*Gastroenterology* 31: Nov 1956; 588-591

#### *Extracted Summary*

A case is presented of a young woman who had several attacks of biliary colic during pregnancy. Three weeks postpartum oral cholecystography showed a normally functioning gallbladder containing many small radiolucent calculi, presumably of cholesterol. Five weeks after the gallbladder x-ray, laparotomy was performed and no gallstones were found. It is suggested that surgery for cholelithiasis in the immediate postpartum period be deferred for several months, and cholecystography routinely repeated before laparotomy, to make sure that the gallstones are still there.

#### SELECTED CASE REPORT

**M**rs. J. W., age 23, was referred to me by her obstetrician for cholecystography. She had delivered her first child, a normal full-term delivery, on December 19, 1953. During her pregnancy she had had many attacks of severe upper abdominal pain, radiating to the right lower posterior chest, associated with nausea and vomiting. She had had a further attack during her labor, and two attacks after delivery.

On January 8, 1954, cholecystography 14 hours after the oral ingestion of 6 Telepaque tablets showed good filling and excellent concentration of the dye by the gallbladder, which contained many small radiolucent shadows. The films were exposed by my technician in my presence, and were personally checked. Because of the possibility of provoking an attack of biliary colic, no fatty meal was given, and the patient was sent home.

The result of cholecystography was communicated to her obstetrician, who referred the patient to Dr. John C. Armour for surgery. Dr. Armour concurred in the diagnosis and advised cholecystectomy.

It is interesting to note that the patient's father, who is a physician practicing in Massachusetts, well versed in x-ray, came to Montreal, inspected the x-ray films, concurred in the diagnosis and advised his daughter to wait a few more months before submitting to a cholecystectomy, in order that she might regain her strength following her parturition. The patient, however, refused to delay, prefer-

ring surgery to further attacks of biliary colic. She had had no further attacks of colic in the interval between the cholecystogram and cholecystectomy.

On February 18, 1954, Dr. John Armour explored the abdomen, with the patient's father standing behind him. At operation no stones could be palpated in the gallbladder or common bile duct. The gallbladder was removed, and was opened after removal, and found to contain normal clear bile, but no calculous material. The mucosa of the gallbladder, however, had lost some of its velvety nature and was rather whitish and a little roughened in color and appearance.

The pathologic report read as follows: "There are congestions of the mucosa and serosal blood vessels with perivascular infiltrations of lymphocytes and plasma cells in the serosal coat. There is also mucosal infiltration by lymphocytes. The mucosal and muscular lymphatics are dilated. The diagnosis is mild exudative cholecystitis."

The news that the patient had no gallstones was communicated to me. I checked immediately, and verified that there could be no mistake or mix-up in the films. Flat plate of the abdomen postoperatively shows identical rib markings, so that this is another check showing that we are dealing with the same patient. The films have since been shown to 10 radiologists and 6 gastroenterologists, who all agree that they show cholelithiasis.



# Spontaneous Disappearance of Gallstones

LINSMAN JF; CORDAY E

*Journal of the American Medical Association* 171(8): Oct 24 1959; 120-122

## Extracted Summary

A case report presents in which sizable multiple gallstones disappeared during a four-year interval without any history of biliary colic, jaundice, or other episode that would suggest the formation of a fistula between the gallbladder and some other part of the intestinal tract.

# Recent Experiences with Spontaneously Disappearing Gallstones

DWORKEN HJ

*Gastroenterology* 38: Jan 1960; 76-86

## Extracted Summary

Five patients are described in whom gallstones previously demonstrated by x-ray were found to have disappeared at the time of surgery. In 4 patients interval cholecystograms had foretold this disappearance. Repetition of cholecystograms prior to surgery in patients with "known" gallstones is strongly recommended, especially if the stones are small, or associated with a recent pregnancy or relapsing pancreatitis.

# Spontaneous and Total Disappearance of Stones from the Gallbladder

HANSSON K; LUNDH G; RAMBERG L

*Acta Chirurgica Scandinavica* 127: 1964; 176-180

## Extracted Summary

A case is described in which some 30 stones in the gallbladder and one measuring 10 by 12 millimeters in the common bile duct were demonstrated cholecystographically. At operation one year later were no stones in either the gallbladder or deep biliary tract. The literature is reviewed and different explanations for the spontaneous disappearance of stones from the gallbladder are discussed.

Re-examination of the cholecystograms in a series of 104 patients who had undergone repeated cholecystographic examinations in no instance demonstrated spontaneous and total passage or dissolution of gallstones.

# The Spontaneous Disappearance of Gallstones

ARCOMANO JP; SCHWINGER HN; DEANGELIS J

*American Journal of Roentgenology* 99(3): March 1967; 637-64

## Extracted Summary

The rarity of the reports of the spontaneous disappearance of calculi from the gallbladder is considered. It is suggested once again that gallbladder calculi can and do pass painlessly through the biliary duct system. The spontaneous disappearance of calculi in the post-pregnancy state is again noted. It is recommended that if a significant painless interval elapses between the demonstration of calculi and surgery, particularly if the calculi are small, repeat cholecystography be performed prior to surgery.

#### SELECTED CASE REPORT

**C**ase I: P. P. A 26-year-old female stated that 2 1/2 years ago, immediately following the birth of her second child, she experienced an acute attack of upper quadrant pain with nausea and vomiting. A roentgenographic examination performed in the hospital on September 23, 1963, showed a nonfunctioning gallbladder. A repeat study using a double dose of the contrast material on September 24, 1963, revealed a poorly functioning gallbladder with many tiny calculi. The patient elected to defer surgery and for the past 2 years has been

completely asymptomatic. In January 1966, the patient saw another surgeon for evaluation for possible operation despite the asymptomatic interval. The surgeon recommended repeat gallbladder series and on January 17, 1966, a gallbladder study was performed using 6 grams of Telepaque, which proved to be normal. On January 21, 1966, a repeat examination using a lesser amount of contrast material was performed. Delayed, decubitus and many erect roentgenograms failed to reveal any evidence of calculus.

## Spontaneous Disappearance of Gallstones

LESLIE D

*Medical Journal of Australia* 2(27): Dec 30 1972; 1498-1499

#### Extracted Summary

A review is made of the possibility of the spontaneous disappearance of gallstones. Some explanations for this phenomenon are examined. In most cases it is probable that a gross residual pathological state persists and that cholecystectomy will still be required despite the disappearance of the stones.

## Spontaneous Disappearance of Gallstones

LIEBERMANN TR

*Gastrointestinal Radiology* 4(3): Aug 15 1979; 265-267

#### Extracted Summary

A case of spontaneous disappearance of gallstones in a 55-year-old woman is presented. Examination of biliary lipids after the stones had disappeared revealed supersaturated bile with cholesterol. This suggests that the stones migrated from the gallbladder to the small intestine via the biliary ductal system. (Permission to reproduce case report denied by author.)

## Spontaneous Dissolution of Gallstones

### A Case Report

AHLBERG J; EINARSSON K; WESTBERG G

*Acta Chirurgica Scandinavica (Suppl 500)*: 1980; 3-5

#### Extracted Summary

Spontaneous dissolution of gallstones is seldom observed. According to present knowledge the maximum spontaneous disappearance rate of radiolucent stones should be less than one percent per year. The present paper reports on the gradual disappearance of multiple gallstones, probably by dissolution, in an elderly woman. Possible contributing factors are discussed.

#### SELECTED CASE REPORT

**A** 76-year-old woman was admitted to Serafimerlasaretet because of cholelithiasis. During the last 11 years she had frequent episodes of upper abdominal discomfort, postprandial distension and belching. A cholecystography performed in 1966 revealed several gallstones in the gallbladder. She was recommended to

eat a low-fat containing diet and avoid egg, fruits and vegetables. In 1975 she had a mild attack of biliary colic which was treated with antispasmodics. A cholecystography performed in 1976 showed several gallstones, now much smaller. Another cholecystography 6 months later showed a well-functioning gallbladder free from gall-

stones. She had never been overweight (body weight, 53-54 kilograms, height 162 centimeters). During the last year she had lost 2-3 kilograms of body weight. She had never taken drugs known to influence the bile lipid

composition. Laboratory investigations including routine blood counts, alkaline phosphatases, transaminases, serum cholesterol and triglycerides were normal.

## Spontaneous Disappearance of Limy Bile

### *Report of a Case with Review of the Literature*

NOMURA F; SUZUKI Y; SUZUKI K; YAMAMOTO K; OHSHIMA H; NAKAYAMA T; YOKOSUKA O;  
OHNISHI K; SAISHO H; OHHARA K; OKUDA K

*American Journal of Gastroenterology* 79(11): Nov 1984; 884-888

#### *Extracted Summary*

Spontaneous disappearance of limy bile is extremely rare, and only four cases have so far been reported. This is the account of the fifth case, a 42-year-old woman, who spontaneously lost a stone incarcerated in the neck of the gallbladder and all of the limy bile, after symptoms suggestive of a transient obstructive jaundice. Various investigations including ultrasound, computed tomography, and percutaneous transhepatic cholangiography suggested spontaneous passage of the stone through the cystic duct and the papilla of Vater, followed by limy bile. Apparently the patient's gallbladder had a contracting capacity. The literature on this subject is briefly reviewed.

#### SELECTED CASE REPORT

A 42-year-old woman came to Yachiyo Chuo Hospital on June 29, 1982, because of epigastric discomfort. Upper gastrointestinal series revealed a deformed duodenal bulk with evidence of an active ulcer. Radiopaque material was also noted in the right upper quadrant under fluoroscopy. Abdominal scout film made on July 8 showed a visible gallbladder of calcium density and a small radiopaque stone shadow, most likely a calculus impacted in the neck of the gallbladder. Since she had never received cholecystographic agents, a diagnosis of limy bile was made. Surgery was advised, but refused. She was followed as an outpatient until the end of August when she noticed dark urine, and complained of mild abdominal pain, nausea, and vomiting. She was admitted to the same hospital on September 4, 1982, with a diagnosis of obstructive jaundice perhaps due to passage of the stone into the biliary system. Physical examination on admission was not remarkable except for slight icterus and right upper quadrant tenderness.

Laboratory study showed Hb, 9.1 gm/dl; white blood cell count, 7100/mm<sup>3</sup> with a normal differential count; normal electrolytes; aspartate transaminase, 298 IU/L; alanine aminotransferase 554 IU/L; alkaline phosphatase, 553 IU/L (normal 100-280 IU); serum bilirubin, 4.7 mg/

dl with a direct reacting fraction of 3.5 mg/dl; and normal serum amylase, HBsAg was negative.

Plain films on admission disclosed no trace of the radiopaque material in the gallbladder, indicating complete evacuation of limy bile from the gallbladder.

Percutaneous transhepatic cholangiography performed on the 7th hospital day showed a slight dilatation of the common bile duct, but no calculus or fistula was demonstrated in the biliary system. Disappearance of limy bile was also confirmed by other diagnostic modalities such as ultrasonography and computed tomography. The first ultrasonographic examination of the gallbladder demonstrated an echogenic material occupying the lumen of the gallbladder, and, on the second examination on admission, it was no longer demonstrable. The early abdominal computed tomography showed two kinds of increased density representing a gallstone in the neck of the gallbladder and limy bile. These increased densities were no longer seen on the computed tomography scan performed 3 weeks after admission. She was discharged from the hospital on the 34th hospital day. She had been in good condition up to the present (June 1984) with no evidence of recurrent stone disease or limy bile.

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A Propos de L'Évolution de la Lithiase Biliaire.

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47: Mar 1958; 555-560

The Problem of Disappearing Gallstones: Another Case of Spontaneous Disappearance on Cholecystography

OCHSNER SF; GIESEN AF

*American Journal of Roentgenology* 83(5): 1960; 831-834

Radiographic Demonstration of Spontaneous

Disappearance of Limy Bile

SCHWARTZ A; FEUCHTWANGER M

*Gastroenterology* 40(6): June 1961; 809-812

Spontaneous Migration of Gallstones

RICHARDS P; CHIR B

*New England Journal of Medicine* 266(6): 1962; 299-300

Dissolution Spontanée de Calculs Vésiculaires

LEVRAT M; PASQUIER J; TISSOT A

*La Presse Medicale* 71(30): June 19 1963; 1511-1513

Spontaneous Disappearance of a Solitary Obstructive Gallstone in the Neck of the Gallbladder (Spontanes

Verschwinden eines solitären Verschlusssteines im Gallenblasenhals)

DINKEL L

*Fortschritte auf dem Gebiete der Roentgenstrahlen* 113(3):

Sep 1970; 387-389

Spontaneous Disappearance of Large Stones from the Common Bile Duct

EVANS RC; KAUDE JV; STEINBERG W

*Gastrointestinal Radiology* 5(1): Feb 1 1980; 47-48

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HEPATIC DISORDERS

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## Spontaneously Healing Pyogenic Liver Abscess

MOINUDDIN M; ROCKETT JF

*Southern Medical Journal* 73(11): Nov 1980; 1531-1533

### *Extracted Summary*

We have presented an unusual case of pyogenic liver abscess due to gamma streptococci group D, which remained undiagnosed for about seven months, and which ruptured spontaneously into subcutaneous tissue, resulting in self-cure. Despite the large hepatic abscess seen on liver scan and ultrasound, results of liver function tests remained normal. A mass seen on liver scan or ultrasound in patients with a malignancy does not necessarily indicate metastasis, and a more aggressive approach is required to treat a potentially curable disease.

## Spontaneous Remission of Congenital Liver Cysts

VAN NIEUWENHUIZE H

*Tijdschrift voor Kindergeneeskunde* 56(3): Jun 1988; 130-132

### *Extracted Summary*

A six-weeks-old infant presented with vomiting, malnutrition, pneumonia and signs of biliary obstruction. The liver was enlarged; ultrasonography showed three large cysts in the right lobe. The cysts were thought to be congenital. Before we could differentiate them from other causes they disappeared spontaneously. To our knowledge, spontaneous regression of congenital cysts of the liver has not been reported previously.

## Spontaneous Resolution of Pancreatic Masses (Pseudocysts?)

*Development and Disappearance after Acute Alcoholic Pancreatitis*

CZAJA AJ; FISHER M; MARIN GA

*Archives of Internal Medicine* 135: April 1975; 558-562

### *Extracted Summary*

To determine the incidence and the natural history of retroperitoneal masses complicating acute pancreatitis, 104 cases of acute alcoholic pancreatitis were evaluated prospectively for mass formation. Abdominal masses detected by physical examination and serial x-ray films of the upper portion of the gastrointestinal tract were localized to the retroperitoneum by additional contrast studies, including abdominal angiography. Nonoperative management was urged only for patients with an asymptomatic mass. An abdominal mass developed in 19 patients (18%). In eight of these, it disappeared rapidly, but in 11 (11%), it persisted, and was considered to be a pancreatic pseudocyst. Eight of the 11 patients were treated nonoperatively, and the mass resolved without complication three weeks to three months after diagnosis. In three patients, a pseudocyst was confirmed at laparotomy. Exploration was justified by an unstable clinical course in only one instance. A routine surgical approach to an asymptomatic retroperitoneal mass developing after acute alcoholic pancreatitis may not be necessary in patients who are improving clinically because the mass may resolve without complication.

### SELECTED CASE REPORTS

**P**atient 2B: A 37-year-old alcoholic, with several previous hospitalizations for pancreatitis, was admitted to the hospital with chest and epigastric pains. He had bronchial breathing in the right side of the chest and epigastric tenderness. His serum amylase level was 410 Somogyi units. A chest x-ray film showed an abscess in the middle lobe of the right lung and upward displacement of the gastric bubble. Serial x-ray films of the upper portion of the gastrointestinal tract, obtained one week after admission, demonstrated upward and medial displacement of the stomach and downward displacement of the transverse colon and the splenic flexure. The colonic displacement was confirmed by barium enema examination. A left-upper-quadrant abdominal mass became palpable during the second week of hospitalization, although the patient had become asymptomatic. Two months later, the abnormal abdominal findings had disappeared. Serial x-ray films of the upper portion of the gastrointestinal tract disclosed a normal stomach contour and normal gastric

and colon position; findings of barium enema examination were normal. He left the hospital fully recovered.

**P**atient 3B: A 20-year-old alcoholic was admitted with vomiting and abdominal pain. His abdomen was diffusely tender and remained tender despite continued nasogastric suction. Admission serum amylase level was 600 Somogyi units. One week after admission, a mass was palpable in the midepigastrium. Serial x-ray films of the upper portion of the gastrointestinal tract showed compression of the duodenal bulb and displacement of the duodenal loop to the left. Intravenous cholangiography demonstrated compression of the fundus of the gallbladder by a soft tissue density, with displacement of the duodenal gas shadow. Selective gastroduodenal arteriography showed stretching of vessels in the pancreatic arcade. A slow improvement followed. Serial x-ray films of the upper portion of the gastrointestinal tract, one month after admission, disclosed marked diminution in the size of the mass. By the end of the sixth week of hospitalization, the abdominal mass was no longer palpable.

# Spontaneous Internal Drainage of Pancreatic Pseudocysts

CLEMENTS JL JR; BRADLEY EL III; EATON SB JR  
*American Journal of Roentgenology* 126: 1976; 985-991

## Extracted Summary

Six cases are reported in which spontaneous internal drainage between a pancreatic pseudocyst and the alimentary tract became established. In each instance the communication was demonstrated radiologically. The clinical circumstances and radiographic features of these cases are described, and the existing literature pertaining to this phenomenon is reviewed.

## SELECTED CASE REPORT

A 28-year-old black alcoholic, B. W., had had several previous chemically documented attacks of acute pancreatitis. He was admitted because of severe epigastric pain with radiation to the back, a sense of abdominal fullness, nausea, vomiting, and anorexia. Physical examination revealed epigastric tenderness and decreased bowel sounds. Laboratory studies showed glycosuria, hyperglycemia, and marked hyperamylasemia. Initially the symptoms remitted and serum amylase values fell, but after a few relatively symptom-free days, the epigastric pain recurred, serum amylase values rose, and a large

epigastric mass became palpable. An ultrasonic abdominal examination performed at this time demonstrated a large left upper quadrant cystic mass.

Two days later the patient developed mild hematemesis, and an upper gastrointestinal barium examination revealed communication between the stomach and an irregular cystic space. During the next 2 days the epigastric mass disappeared, and 3 days after the barium study a repeat ultrasonic examination confirmed complete resolution of the mass.

# Rapid Development and Spontaneous Regression of Pancreatic Pseudocysts Documented by Ultrasound

SARTI DA  
*Radiology* 125(3): Dec 1977; 789-793

## Extracted Summary

Three cases of pancreatic pseudocyst were followed serially by ultrasound examination. The entity was found to be more dynamic than had been generally thought. The rapid development and spontaneous regression of pancreatic pseudocysts was documented. The timing of surgical intervention in these cases must be reevaluated.

## SELECTED CASE REPORT

Case 2: A 52-year-old woman was admitted with a chief complaint of abdominal pain, weakness, and weight loss of 15.5 kilograms (34 pounds) over the previous 5 months. Persisting for 3 to 4 days was a sharp, intermittent, and crampy epigastric pain. The patient had had several previous admissions for chronic pancreatitis. Her history included heavy alcohol intake in the past, but she denied any recent use.

A physical examination of the abdomen revealed a slight fullness and guarding of the right upper quadrant with no organomegaly. Her amylase level on admission was 92, with a total bilirubin of 4.7 milligrams and a direct bilirubin of 1.5 milligrams. Diffuse pancreatic calcification was noted by an excretory urogram. Ultrasound demonstrated a 6 centimeter sonolucency situated beneath the left lobe of the liver between the inferior vena cava and

the aorta. This mass displaced the inferior vena cava to the right and the aorta to the left. An upper gastrointestinal series showed a questionable compression of the C-loop, although hypotonic duodenography done 1 week after admission did not demonstrate any mass in the head of the pancreas. Neither an inferior venacavagram nor a celiac angiogram done at about this time revealed any neovascularity. However, an avascular area noted in the epigastric region which displaced the inferior vena cava and the aorta corresponded to the ultrasound finding. The patient was started on peripheral alimentation, and a repeat ultrasound study 5 days later demonstrated an increase in the size of the mass, with the borders appearing more tense than earlier. The patient's hematocrit, 29% on admission, had dropped to 20.5%. No source of bleeding was found, and it was felt that the patient might

have bled into the pseudocyst. A central hyperalimentation line was inserted. Although the patient's amylase level was normal on admission, it had risen to 685. A third ultrasound examination obtained 3 weeks after admission demonstrated that the mass had decreased in size to approximately 4 centimeters in diameter.

One week later, ultrasound exams showed that the size of the cyst had further decreased to a diameter of 2.5

centimeters. After 2 more weeks it disappeared. The patient continued to improve, with a weight gain of 4 kilograms (9 pounds) and a stable hematocrit at 32%. At discharge, her amylase level was slightly elevated at 420. She has been followed as an outpatient, with later amylase levels at 295 and 313. She has continued to do well, with no complaints of abdominal pain.