LETTER TO THE EDITOR

(J Banagladesh Coll Phys Surg 2014; 32: 179-181)

To

Editor- in- Chief

Journal of Bangladesh College of Physicians and Surgeons.

Sir,

At First, we would like to thank to the editor for publishing the case report on 'Cholecystocutaneous fistula fallowing drainage of parietal abscess' in your journal on January' 2014 issue. we have gone through this article and found the content is very interesting and informative. However, we like share some of my observations and comments.

A patient with Cholecystocutaneous fistula may give history of discharge of stones or granular sludge through the cutaneous opening[1]. But in the reported case the patient did not mention history of such type of discharge, although USG showed sludge in the gallbladder lumen.

While investigating the patient, sonogram revealed linear tract communicating with a cavity. But it was not mentioned whether the cavity was parietal or intra abdominal. If contrast CT scan[2] would have been done it could show the exact location of the cavity together with its possible communication with a intra abdominal viscus.

Exploratory laparotomy should have been the procedure of choice as the sinus tract communicated with a intra abdominal viscus. But it was planned for exploration and excision biopsy of the sinus tract only.

Finally, we thank the authors for presenting this case repost on rare Cholecystocutaneous fistula and enriching our knowledge.

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   Associate Professor, Department of Surgery, Dhaka Medical College, Dhaka.
2. **Dr. H.A. Nazmul Hakim**
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To

Editor – in – Chief

Journal of Bangladesh College of Physicians and Surgeons.

Subject: Responding to readers comment regarding the case report on "Cholecystocutaneous fistula following drainage of parietal abscess" published in vol . 32, No. 1; Page 37-40; January 2014.

Sir,

First of all we express our deep gratitude to you and all concerned for publishing our case report in the Journal of Bangladesh College of Physicians and Surgeons.

We are also thankful to our two honorable readers for going through the case report and making comments. We are very happy to see that it has generated lot of enthusiasm and queries among the readers. We shall try to address to the issues raised by the learned readers.

I have tried to give the answers of their questions.

1. Our patient had developed an intervening abscess cavity in the parietes from where seropurulent materials were discharged recurrently. Cholecystectomy revealed that the gall bladder was containing pus and some necrotic debris. In our opinion a simple, straight tract probably may discharge stones or biliary sludge if any, in a case of cholecystocutaneous fistula.
2. Sinogram (not sonogram) revealed a linear tract communicating with a cavity but could not accurately locate it. We agree with you that a contrast CT scan would have been the preferred next step for further evaluation but as the patient had financial constraint we decided to operate on the basis of USG and contrast X ray finding.
3. None of our preoperative investigations could delineate certainly, the presence of a fistula communicating with an intra-abdominal viscus. A negative laparotomy could not be justified in that case. Our initial step was to explore the tract keeping in mind that laparotomy may be needed. Operative findings guided us in that way which led to complete excision of sinus tract along with cholecystectomy.

Regards.

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To
Editor in chief
Bangladesh College of Physicians and Surgeons

Sir,

I had gone through the original article of the valuable journal, volume 32, No1 Journal 2014 title with "Clinicopathological profile of Wilms' tumor in children" by M.Majumder et all with keen interest and have few observations.

The article was well written and the contents and illustrations were nice.

Wilms' tumor is the most common abdominal tumor of childhood[1] Early stage and favorable histology has excellent outcome after treatment. Most Wilms' tumors are unilateral, only about 6% are bilateral presentation and it is termed as stage V, It is the exceptional stage.[2]

Regarding diagnosis now the recommendation is not to do biopsy unless unresectable and bilateral.[3]In current COG renal tumor protocol children who present with bilateral renal masses receive two cycles of chemotherapy without biopsy. Biopsy is reserved for those who do not show volume reduction.[2]

Bilateral Wilms' tumors are not usually hereditary.[4] Many bilateral tumors are present at the time Wilms tumor is first diagnosed (i.e., synchronous), but a second Wilms' tumor may also develop later in the remaining kidney of 1% to 3% of children treated successfully for Wilms' tumor. The incidence of such metachronous bilateral Wilms' tumors is much higher in children whose original Wilms' tumor was diagnosed before age 12 months and/or whose resected kidney contains nephrogenic rests. Periodic abdominal ultrasound is recommended for early detection of metachronous bilateral Wilms' tumor as follows:[5,6]

- Children with nephrogenic rests in the resected kidney (if younger than 48 months at initial diagnosis)—every 3 months for 6 years.
- Children with nephrogenic rests in the resected kidney (if older than 48 months at initial diagnosis)—every 3 months for 4 years.
- Other patients—every 3 months for 2 years, then yearly for an additional 1 to 3 years.

Another important point to note that neuroblastoma may be confused with neproblastoma. Neuroblastoma is the extra-renal mass. Neproblastoma is renal origin. Previously it can be distinguished by IVU. Now a days MRI is sufficient.[7]

In or country most of the patients present in stage III and abdominal radiotherapy is needed. For local control and to prevent metastasis radiotherapy should be started early within 9-10 days after surgery. This is an exception as because in other malignant cases it is prohibited due to risk of wound dehiscence .Now common consensious that radiotherapy should be started on 9th post operative day. In stage V when there is both lungs metastasis radiotherapy can be given as lung bath. If pulmonary nodule disappears after giving chemotherapy, radiotherapy can be omitted[2]

Absence of anaplasia is a good prognostic factor, Anaplasia correlates best with responsiveness to therapy rather than to aggressiveness. It is most consistently associated with poor prognosis when it is diffusely distributed and when identified at advanced stages. These tumors are more resistant to the chemotherapy traditionally used in children with favorable-histology Wilms' tumor.[8]

The tumor is chemosensitive. In early stage most of the cases are treated with Vincristine, Doxorubicin, Actinomycin D . In unfavorable group and stage IV Carboplatin, Etoposide, Ifosfamide combination can be used. It is very toxic combination and response is only 30%.[2]

This article only covers the clinicopathological profile of Wilms' tumor. For a better overview of the disease - diagnostic procedure, treatment modalities and available treatment facilities in our country and outcome of treatment may be included in this article, so that the physicians can acquire knowledge about it at a glance.

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Author's Reply

To

Editor in chief

Bangladesh College Of Physicians and Surgeons

Sir

We thank Professor Dr .Md. Moarraf Hossen & Dr. Aliya Shahnaz for their interest & valuable observations on the original article.[1].I totally agree that this article only covers the clinicopathological profile of Wilms' tumor. For a better overview of the disease - diagnostic procedure, treatment modalities and available treatment facilities in our country and outcome of treatment should be included in this article. My study period was short &it was only designed for the clinicopathologicalprofile . As a part of limitation of the study I have stated that this study raised the necessity of further large scale work on the issue.

Regarding anaplasia as you mentioned that Anaplasia correlates best with responsiveness to therapy rather than to aggressiveness. It is most consistently associated with poor prognosis when it is diffusely distributed and when identified at advanced stages. These tumors are more resistant to the chemotherapy traditionally used in children with favorable-histology Wilms' tumor.[2] It also said that focalanaplasia is a comparable to favourable histology.[2]

But later the 5th NWTS results showed that the prognosis for patients with stage I AH is worse than that for patients with stage I favourablehistology.[3] Noveltreatment strategies are needed to improve outcomes for patients with AnaplsticHistology, especially those with stage III to V disease.[3]

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