A 65-year old man presented with a six-month history of loss of appetite. Clinical examination was unremarkable. Initial endoscopy was reported to be normal. Ultrasound scan of the abdomen showed a dilated common bile duct with no gall bladder calculi. Serum alkaline phosphatase was raised (630.2 U/L). Duodenoscopy with a side-viewing scope (TJF-160R Olympus) revealed a periampullary growth hanging into the duodenal lumen occluding the ampulla (Figure 1). Endoscopic snare polypectomy was performed. Free drainage of bile was observed after the polypectomy (Figure 2).

Histology showed a villous adenoma with moderate dysplasia. Excision margins were clear. Repeat endoscopic retrograde cholangiopancreatogram after...
one month showed a well healed ampulla (Figure 3). Bile duct was normal (Figure 4).

**Discussion**

Periampullary villous neoplasms may occur as isolated lesions or as part of a non-colonic spectrum of hereditary polyposis syndromes. As seen in this case, conventional endoscopy can miss prolapsing peri-ampullary lesions. Duodenoscopy with a side-viewing duodenoscope is essential for diagnosis.

Tumours are amenable for endoscopic excision, endoscopic snare polypectomy is a simple minimal access technique for effective treatment. Surveillance endoscopy is needed for benign lesions with clear margins.

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**Disseminated tuberculosis following BCG vaccination**

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(Index words: Caseation, dactylitis, granulomata)

**Introduction**

Disseminated tuberculosis is rare in infants. The more common presentations of tuberculosis (TB) in infancy include pulmonary and meningeal involvement. Disseminated TB following BCG vaccination is even rarer. The possible reasons for dissemination following BCG are faulty techniques of intra-dermal administration and use of excess doses of the vaccine. Dissemination following BCG also occurs in the setting of immunodeficiency.

**Case history**

A ten-week old baby boy was admitted to Lady Ridgeway Hospital, Colombo, with a history of high fever for 25 days, cough for two weeks and poor feeding. Examination revealed an ill baby with a number of erythematous plaques over the face, BCG site (Figure 1), right areola and the left thigh. There was also a swelling over the dorsum of the right foot without any overlying skin changes. He had received BCG vaccination two days after birth.

The chest xray taken on admission showed nonspecific inflammatory changes and the child was treated with conventional intravenous antibiotics. In spite of treatment he continued to have fever and diffuse changes on repeated chest films. Xray of the right hand showed radiological evidence of dactylitis. Xray of the right foot showed distorted first metatarsal. The ESR was 128 mm and the haemoglobin was 7.8 gm/dl. The Mantoux test was negative. Bone marrow aspiration showed no granulomata and polymerase chain reaction for TB was negative. Cerebro-spinal fluid report showed no cells and was negative for acid fast acilli.

**Discussion**

In this baby there was overwhelming evidence to suggest a diagnosis of disseminated TB. The fact that the baby developed the illness at 6 weeks of age, lack of a positive contact history, the presence of erythematous plaques on the BCG site, and absence of evidence of immunodeficiency all favour the diagnosis of disseminated TB following BCG vaccination. Further proof of this was obtained on histological examination of the

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Received 13 September 2005 and accepted subject to minor amendments 18 December 2005.

Ceylon Medical Journal