A 60-year old male with right scrotal hernia was assaulted with a brick on the right groin leading to swelling of right scrotum. He had been treated for scrotal contusion at the local hospital and died on the third day.

Postmortem examination: Externally two abrasions on right groin, red and swollen scrotum with circumference of 35 cm and postmortem loss of epidermis on bottom of the scrotum were seen. Internally congested viscera, fibrinous adhesions of bowel, enlarged soft spleen, pulmonary oedema, yellow swollen renal cortices and perforation (1cm) in anti-mesenteric border of the distal ileum one foot proximal to the appendix with a black margin were noted (Figure 1). Cause of death was decided as septicaemia due to peritonitis following rupture of the ileum, compatible with blunt trauma.

Discussion
Following are the causes of bowel rupture in trauma victims [1]: (a) open abdominal injuries such as stabs, firearm injuries and bomb blasts, (b) closed abdominal injuries producing shock waves, shearing force, crushing of bowel between weapon and spine, tear by fractured bone, raised intraluminal pressure within a closed loop, (c) injuries to mesenteric arteries leading to thrombosis, then bowel infarction leading to delayed perforation, and (d) jumps from height causing a sudden jolt in an inguinal hernia [2].

In this case, trauma had caused crushing of small bowel between the blunt weapon and the underlying pubic bone. Abrasions are due to a corner of the brick. The original injury was legally classified as fatal in the ordinary course of the nature.

References
Fine needle aspiration cytology (FNAC) revealed a moderately differentiated squamous carcinoma. An upper gastrointestinal tract endoscopy, dermatological and ENT surgical evaluation excluded a primary source of spread. Her chest x-ray was normal. Total mastectomy and level III axillary clearance was performed. Histology confirmed the FNAC. In addition, it excluded vascular or lymphatic invasion, and none of the harvested lymph nodes contained tumour deposits. Post-operative ultrasound scan of abdomen, contralateral mammogram and a Technetium 99 bone scan excluded metastatic disease.

Primary squamous carcinoma of breast (PSC) is rare [1–5] with a reported incidence of 0.1% [1]. A primary tumour, which could metastasise to the breast, needs exclusion, before diagnosing PSC [1, 2].

The recommended initial treatment for PSC is surgical excision [1]. Menes and colleagues reported a lower rate of lymph node metastasis, which was 22%, versus a 40–60% rate for infiltrating duct carcinoma [3]. The role of lymph node involvement, in determining the outcome in PSC, remains unresolved [3, 4]. Our patient did not have any evidence of metastatic disease during the follow up 12 months.

Although chemotherapy is recommended, its role remains unresolved for lack of data. The hormone receptor levels are very low in PSC [1, 3, 4] thus excluding the need for adjuvant hormonal therapy. However this patient was given radiotherapy, warranted because the deep margin of resection of the tumour.

The clinical behaviour of PSC of breast remains uncertain [5]. One case report indicates an indolent clinical course with good prognosis [1], while another indicates an aggressive course [3]. PSC should be treated on an individual basis, taking available evidence into consideration and with regular follow up.

References