The typical presentation is a young female (5) with a large epigastric mass, abdominal pain and loss of weight (6). Obstructive jaundice is present when the tumour involves the head of pancreas and the retroperitoneal common bile duct. These tumours are locally aggressive with a low grade malignancy, and are best treated by aggressive resection and debulking (6, 7). There is a favourable outcome after resection with long term survival of more than 5 years reported (2, 6, 7). One of our cases had an advanced tumour with involvement of the portal vein. Aggressive resection of the mass with portal vein reconstruction was possible. These patients are young and tolerate long complex surgery. The prognosis after resection is good compared to adenocarcinoma of the pancreas. In one series 11 of 12 patients survived a mean of 6.6 years (range 6 months to 15 years) (6).

Papillary cystic neoplasm should be considered in the differential diagnosis of large cystic pancreatic masses, especially in young females.

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References


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Nosocomial infective endocarditis due to a retained guide wire

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Introduction
Intravascular guiding devices are widely used today, especially in intensive care units and by interventional cardiologists and radiologists. Mishandling of such devices could give rise to serious complications. We report an unusual case of infective endocarditis that occurred under such circumstances.

Case report
A 55-year old woman employed in Kuwait suffered severe accidental burn injuries. She was treated in a high dependency unit for two weeks and ten weeks in a general surgical ward. After discharge from the hospital she returned to Sri Lanka. Although the wounds were healing, low-grade fever had troubled her during the last 3 weeks of hospital stay in Kuwait. The day after returning home she was admitted to a surgical ward with fever and feeling unwell, and treated with intravenous broad spectrum antibiotics for 5 days. As her condition worsened and no surgical cause could be found she was referred to our unit.

Apart from fever associated with chills and rigors, she had mild breathlessness, a dry cough and marked loss of appetite. The burn injuries were healed except for a small area over the right thigh, which was not infected. The rest of the clinical examination was normal except for mild pallor and a few crackles over the lower zone of the right lung. Urine analysis showed granular casts. The haemoglobin was 9.2 g/dl and the total white cell count was

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17 200/μl with 88% neutrophils. The ESR was 150 mm in the 1st hour. Two of three blood cultures yielded methicillin-resistant *Staphylococcus aureus*. The radiographs showed a mobile, linear opacity (Figure) within and extending beyond the middle mediastinum (A, B and D). The transthoracic echocardiogram showed large vegetations in the right atrium extending from the orifice of the superior vena cava to the opening of the inferior vena cava (arrowed in C).

The patient was started on antibiotics and transferred to a specialised unit for retrieval of the foreign object within the mediastinum and possibly going through the heart.

It was retrieved percutaneously using the "snare and catheter capture technique". It appeared to be a guide wire that may have been used for insertion of a central venous line via the femoral vein. There were multiple vegetations attached to it in the area that would have been within the right atrium (E).

The patient improved transiently, but rapidly deteriorated with septicemia, multiple lung abscesses and acute renal failure. Eventually she recovered with antibiotic therapy and supportive care including peritoneal dialysis.

**Discussion**

Guide wires are well known to slip or break. Retrieval by a percutaneous method or by formal venotomy is very important as leaving it may lead to serious complications. One such complication is infective endocarditis. The guide wire can act as a foreign object on which organisms grow, and progress to infective vegetations, septicemia, septic embolisation and abscess formation. The diagnosis may be delayed as it may not be suspected or overlooked in a patient who is ill. The organisms causing nosocomial endocarditis are often virulent coagulase negative staphylococci or methicillin resistant, *Staphylococcus aureus*, making therapy more difficult and increasing the risk of complications such as valve destruction (1, 2).

This case illustrates the need to be more vigilant during invasive procedures using guidewires. It is important to ensure that guide wires are removed and inspected for any possible fractures. Routine xray will further improve safety.

**References**
