

## Discussion

Acute pancreatitis was diagnosed mainly by demonstrating increased levels of serum amylase and lipase in the past, but now ultrasonography is a helpful tool in diagnosis(2). In acute stage of pancreatitis, levels of serum amylase are increased to as high as three fold above normal but these come down to normal levels within 48-72 h; however, high values may persist if there is pseudocyst formation(1). In our case pseudocyst formation could have caused persistent rise in serum amylase level.

In our patient we could not identify a cause for acute pancreatitis from the list of common causes(1). Our patient presented with acute dysentery and her widal test was positive indicating a possible involvement of salmonella species in the disease process. Recently, a high incidence of pancreatitis with acute gastroenteritis secondary to salmonella infection has been reported in adults(3). No organisms could be isolated in our patient from stool and blood probably because of prior antibacterial treatment.

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## Intrauterine Intussusception as a Cause of Intestinal Atresia

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Intrauterine intussusception is a very rare cause of intestinal atresia. The pathogenesis of this disorder is still unknown. We report an ileal atresia due to intrauterine intussusception in which the intussusceptum was seen inside the post-atretic blind intestinal segment.

### Case Report

A 2-year-old, full-term male baby weighing 2.6 kg was admitted on 9.4.90 with a history of bilious vomiting and abdominal distension since the age of 15 hours. No meconium had been passed after birth. The mother had polyhydramnios during pregnancy. Examination of the baby revealed abdominal distension and moderate dehydration. An erect roentgenogram of the abdomen showed multiple air-fluid levels with no gas shadows in the true pelvis, suggesting a small bowel obstruction.

The baby was hydrated with intra-

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venous fluids and was operated 6 hours later. At laparotomy, a type IIIa ileal atresia was found at about 25 cm proximal to the ileocecal valve. A tubular structure of approximately 3 cm long was felt inside the postatretic blind segment of the intestine. About 12 cm of the dilated proximal and 4 cm of the distal segment of intestine was resected and a single layer end-to-end anastomosis was carried out. Postoperative course was uneventful. The baby was discharged on 25.4.90.

Pathological examination of the specimen revealed the tubular structure inside the lumen of the resected post-atretic intestinal segment as the intussusceptum (Fig.).

### Discussion

Tandler's theory of lack of revacuolization of the solid cord stage of intestinal development(1) does not explain all cases of intestinal atresia. It has been reported that some intestinal atresia may result from in-

terference with the blood supply to a portion of fetal gut(2,3). Interference of blood supply may occur by various mechanical factors like volvulus, intussusception, snaring at the umbilical ring, kinks and bands(4-6). It is noteworthy that in 45% of midgut atresia, there is malfixation of the mesentery, a factor which is known to predispose to both volvulus and intussusception(3). Intussusception is rare before the age of 3 months. The incidence is 0.3% in the neonatal period(7). Intrauterine intussusception is still rarer. Its pathogenesis is still not fully understood. It is the least frequently reported cause of intestinal atresia(7,9). It has been found in only 0.6-13.1% of the reported cases of intestinal atresia(9). Type II or IIIa ileal atresia has been observed in these patients(6,8,10). In our case, it was a type IIIa ileal atresia. The lumen of the blind distal intestinal segment clearly showed the intussusceptum, thus supporting the possibility of intrauterine intussusception as a cause of intestinal atresia.

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Fig. The intussusceptum (arrow mark) delivered out of the post-atretic intestinal segment.

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## Colonoscopically Reduced Intussusception and Testicular Involvement in Henoch-Schonlein Purpura

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Henoch-Schonlein Purpura (HSP), predominantly a medical disease of young

children, can often present challenging surgical problems. Although the incidence of surgical complications is as low as 2-6%(1), they have a significant morbidity. In this report we present a rare combination of surgical complications encountered in a single patient and the successful use of colonoscopic air insufflation to reduce the intussusception.

### Case Report

A 10-year-old boy was otherwise well till a month ago. He presented with rashes over the lower limbs and abdominal pain of 1 month duration. The abdominal pain was colicky in nature but not associated with vomiting. He also complained of pain in the knee and ankle joints on both sides. His stools were blood stained and mucoid on 3 occasions 20 days before admission. Three days prior to admission he developed puffiness of the face, swelling of the lower limbs and a decreased urine output. At about the same time he complained of pain in the left testis and mild swelling was noticed. There was no history of bruisability or any other major illness. There was no history to suggest a bleeding disorder in the family.

He was afebrile, weighed 20 kg, had a pulse rate of 100/min and blood pressure of 150/110 mm of Hg. He had Grade II malnutrition, pallor and bilateral mild pedal edema. Purpuric rashes were present over the buttocks and back of the thighs on both sides, which did not blanch on pres-

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