Dear Editor,

Eosinophilic gastroenteritis is an inflammatory disease of unknown etiology characterized by infiltration of the gastrointestinal tract with eosinophils, accompanied by varying abdominal symptoms and usually by peripheral blood eosinophilia.\[^1\]

A 41-year-old man presented with abdominal distension and postprandial abdominal fullness for 3 weeks. There was no history of fever, abdominal pain or vomiting. He had no history of worm infestation. There was no history of swelling of feet or jaundice. He had no significant medical or family history and was a non-smoker and alcoholic. Physical examination showed presence of ascites. There was no stigma of chronic liver disease.

Investigations showed peripheral eosinophilia with absolute eosinophilic count was 2100/mm³ with elevated ESR of 54. Routine biochemical investigations were normal. Stool examination was normal. Ultrasound abdomen showed moderate ascites. Ascitic fluid analysis showed low serum ascites albumin gradient (SAAG = 0.7), high protein fluid with elevated eosinophil count of 8350 /mm³. CT scan abdomen showed moderate ascites with thickening of jejunum. Push enteroscopy passed 150 cm in jejunum, which showed edematous mucosal folds of jejunum. Biopsy from jejunal mucosa showed mucosal and submucosal infiltration of eosinophils. Plain radiograph chest

---

**REFERENCES**


---

**Eosinophilic ascites**

Eosinophilic gastroenteritis is an inflammatory disease of unknown etiology characterized by infiltration of the gastrointestinal tract with eosinophils, accompanied by varying abdominal symptoms and usually by peripheral blood eosinophilia.\[^1\]

Situs inversus is a rare, autosomal recessive condition with an incidence of 1/10,000;\[^1\] clinical diagnosis is problematic but modern imaging procedures such as USG usually suffice to diagnose gallbladder disease and as in our case, also reveal the transposition. Laparoscopic cholecystectomy has been rarely reported in situs inversus (total 22 reports found on Pubmed Search) with the first case being reported in 1992\[^2\], Indian references being few\[^3,4\]. All authors have commented on the rarity of the condition\[^4,5\] and have stressed that the procedure requires mental reorientation to the altered spatial relationships of the structures and necessitates reorientation of hand-eye coordination too.

In conclusion laparoscopic cholecystectomy in a patient with situs inversus is difficult due to the unfamiliar spatial orientation of structures. The operation requires mental reorientation and readjustment of the usual hand-eye coordination. However, despite all this, it is still quite feasible and safe, and should be offered to these otherwise normal patients.

**ACKNOWLEDGEMENT**

Dr. Kamalesh Majumdar, Radiologist, for his help in preparing the report and Dr. Soumaparna Kundu, Anaesthetist, for her help during the operative procedure.

S. Das, P. K. Bhattacharjee, S. Bandyopadhyay, T. Choudhuri, P. Goswami, N. Goel

Department of Surgery, R. G. Kar Medical College & Hospital, Kolkata, India

For correspondence: S. Das, Department of Surgery, R. G. Kar Medical College and Hospital, Kshudiram Bose Sarani, Kolkata – 700 004, West Bengal, India. E-mail: partha8292@vsnl.net

---

Indian J Surg | August 2005 | Volume 67 | Issue 4
Letter to Editor

and pulmonary function tests were normal. Bone marrow examinations did not show eosinophilic infiltration. Autoimmune markers like ANA and p-ANCA were negative. Thus, diagnosis of eosinophilic ascites due to serosal eosinophilic gastroenteritis was considered. He was put on oral prednisone, 40 mg/day for 2 weeks followed by slow tapering for 4 weeks. The patient responded to corticosteroids treatment. Patient is asymptomatic on low dose maintenance prednisone 10mg /day for follow up of 13 months.

Eosinophilic ascites is a unique presentation of serosal eosinophilic gastroenteritis. Entire bowel wall is usually involved in serosal eosinophilic gastroenteritis,[1,2] Mechanism of ascites in serosal eosinophilic enteritis is similar to ascites in peritoneal carcinomatosis. [3] In our patients there was no evidence of hypereosinophilic syndrome or connective tissue disorders. Patient responded to corticosteroid treatment, which is the mainstay of therapy. [3, 4] Since our patient is in remission on low dose prednisone, other steroid sparing agents were not considered in him.

Rajiv Mehta, C. P. Mustafa, S. Sadasivan, Anil John, V. V. Raj, V. Narayanan, V. Balakrishnan
Department of Gastroenterology, Amrita Institute of Medical Sciences, Amrita Lane, Elamakkara P. O. Cochin – 682 026, Kerala

For correspondence:
Rajiv Mehta, Department of Gastroenterology, Amrita Institute of Medical Sciences, Amrita Lane, Elamakkara P.O., Cochin – 682 026, Kerala. E-mail: rmgastro@indiatimes.com

REFERENCE


ASIA PACIFIC OBESITY CONCLEAVE
1 – 5 March 2006 * New Delhi * India

ASIA PACIFIC BARIATRIC SURGERY SOCIETY [APBSS]
In conjunction with
Indian Association of Gastrointestinal Endo-surgeons (IAGES)

All India Association for Advancing Research in Obesity (AIAARO)

Organised by
Department of Minimal Access Surgery, Sir Ganga Ram Hospital, New Delhi (India)

Interested surgeons may please send their online request through e-mail or write to
Dr. Pradeep Chowbey, Organizing Chairman
AYUSHMAN, Double Storey Market, R-Block, New Rajinder Nagar, New Delhi-110 060 (India)

Tel.: +91-11-25668768 / 25748085 / 28741188 / 28742929
Fax: +91-11-2651935 / 25748085
e-mail.: info@apoc06.com / chowbey1@vsnl.com