

ings can be mistaken for a haemorrhagic tumour or a large oesophageal varix (Vyas et al, 2004).

Spontaneous oesophageal haematoma is usually managed conservatively and the prognosis is usually good. Initial management should include the following: nothing by mouth during the acute phase, intravenous fluids, and acid suppression to minimize the risk of ulcer formation.

Conclusions

Oesophageal haematoma should be considered as one of the possible diagnoses in patients who present with retrosternal pain, haematemesis or dysphagia. Awareness of this condition is important as conservative management usually suffices. **BJHM**

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IMAGES IN MEDICINE

Chyloperitoneum following abdominal aortic aneurysm repair

A 52-year-old man presented with a 3-week history of increasing abdominal distension and lethargy, having undergone repair of a ruptured abdominal aortic aneurysm 12 weeks previously. On examination, there was a healing midline laparotomy scar and the abdomen was grossly distended. Computed tomography revealed the previous aneurysm repair to be intact and demonstrated marked intra-abdominal ascites (*Figure 1*).

Ultrasound-guided insertion of a pigtail catheter (*Figure 2*) yielded 1.8 litres of a milky white ascitic fluid.

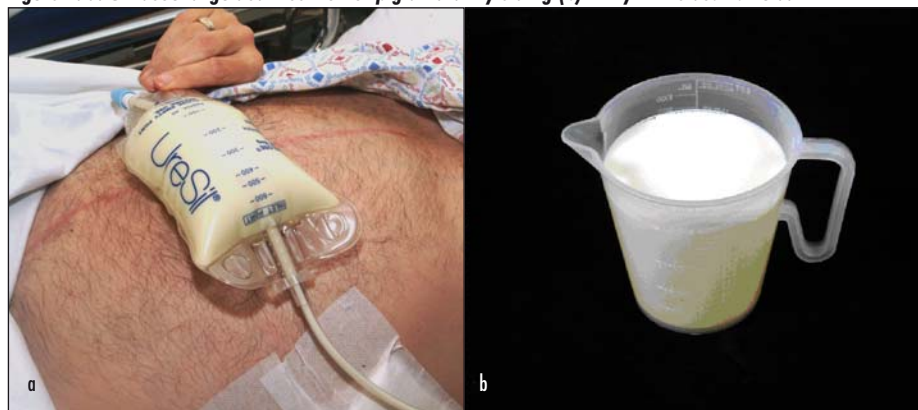
The drain was clamped and a sample of the ascitic fluid sent to the laboratory confirmed a markedly elevated triglyceride level consistent with chyle. Chylous ascites is a rare clinical condition resulting from the extravasation of chyle into the peritoneal cavity. It occurs secondary to disruption of abdominal lymphatics by surgery, blunt trauma or malignant neoplastic processes, with abdominal aortic aneurysm repair (Williams et al, 1991; Haug et

al, 1998) and retroperitoneal lymph node dissection the surgical procedures most commonly implicated. Conservative approaches to its management are aimed at reducing flow of chyle into lymphatics and include medium-chain triglyceride diets and total parenteral nutrition.

Figure 1. Computed tomography scan of the abdomen demonstrating marked intraabdominal ascites.



Figure 2. a. Ultrasound-guided insertion of pigtail drain yielding (b) milky-white ascitic fluid.



Surgical management with peritoneovenous shunts (Sarazin and Sauter, 1986; Boyd et al, 1989) and open ligation of the lymphatic fistula should be reserved for those who have failed conservative treatment (Pabst et al, 1993). **BJHM**

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