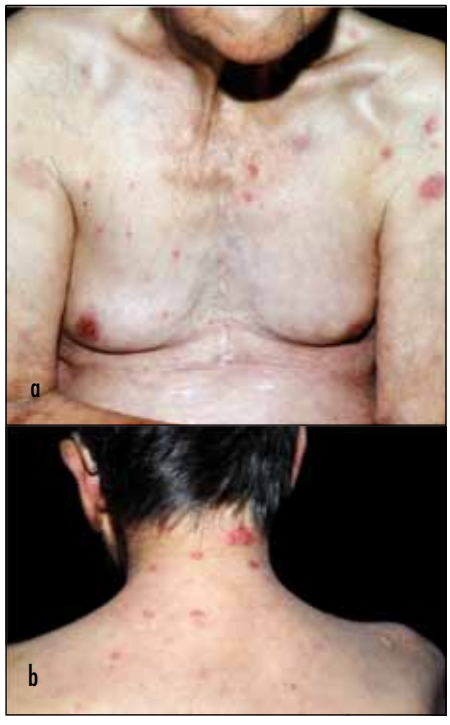
been used (Horio et al, 1980; Bourke et al, 1997). Recurrences are common, seen in 30% of all cases and 50% of malignancy-associated disease. BJHM

Figure 3. Clinical features of Sweet's syndrome in patient 2.



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LEARNING POINTS

- Sweet's syndrome comprises fever, neutrophilia and a characteristic rash.
- The rash of Sweet's syndrome is typically painful rather than itchy.
- Sweet's syndrome may be classical, associated with a haematological malignancy or secondary to a drug trigger.
- Treatment of Sweet's syndrome is mainly with systemic steroids.
- Sweet's syndrome recurs in about 30% of patients.

Case Report 2

A 71-year-old man presented with a 10-month history of an intermittent painful eruption. Examination revealed multiple erythematous plaques over the upper trunk, posterior neck and proximal arms (*Figure 3*). Skin biopsy revealed chronic perivascular neutrophilic inflammation with no evidence of microorganisms on special staining. Baseline bloods revealed a mild macrocytic anaemia. A diagnosis of malignancy-associated Sweet's syndrome secondary to haematological malignancy was suspected. Bone marrow confirmed myelodysplastic syndrome (refractory cytopenia with multilineage dysplasia).

Because he had multiple comorbidities the patient was not a candidate for stem cell transplantation and has subsequently been managed supportively. As his myelodysplastic syndrome could not be cured his Sweet's syndrome remains intermittently active and is controlled with topical and systemic steroids as required, having only partially responded to ciclosporin, rapamycin and infliximab.

Painful nodule at the laparoscopic port site

A 29-year-old man had undergone a laparoscopic low anterior resection for rectal cancer. The histology was reported as pT4a N2 Mx poorly differentiated adenocarcinoma. Two months after his operation he presented with a painful right-sided port site lump and no cough impulse. A computed tomography scan excluded port site hernia (*Figure 1*). He underwent exploration of the port site which demonstrated a dumb-bell-shaped 3 x 3 cm mass, and the area was excised with a wide margin down to the peritoneum. The resultant defect was repaired with a composite mesh. Histology confirmed it to be a port site metastasis. The patient received adjuvant chemotherapy.

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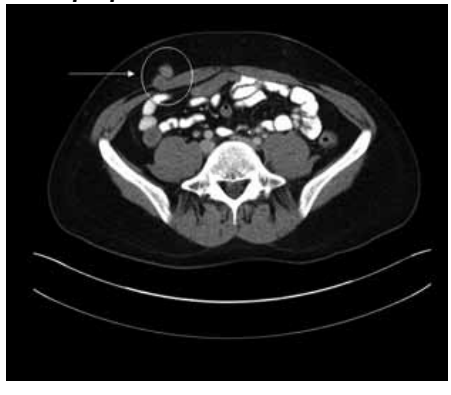
Figure 1. Transverse section of computed tomogram of the abdomen demonstrating a dumb-bell shaped port site metastasis.



Laparoscopy is increasingly performed for cancer of the rectum. Port site implantation was common during the initial use of laparoscopic colectomies. However, with technical improvements and use of wound protectors, the rate of port site tumour implantation has dropped remarkably, and is now rarely seen. This image raises the awareness of port site metastasis. Any patient presenting with a painful lump and no cough impulse following a laparoscopic colonic resection should be viewed and treated as having a possible port site metastasis until proven otherwise. BJHM