Figure 2 Slice of explanted liver showing multiple tumour nodules

periphery. In a patient with an abnormal liver ultrasound or CT, without a history of malignant disease or chronic liver disease, a guided liver biopsy may be appropriate. The biopsy appearance in the present patient was typical, with spindle-shaped tumour cells infiltrating the sinusoids and blood vessels. Intracytoplasmic vacuoles may be found, some containing red blood cells.³ Over time the tumours become sclerotic and calcified, and may coalesce to form a large fibrotic mass. Endothelial markers include factor VIII antigen, CD34 and CD31.

There are few treatment options. Chemotherapy and radiotherapy yield no improvement in survival,¹ and surgical excision is usually impossible because of the multifocal nature of the disease; indeed, attempted resection may provoke aggressive regrowth. Orthotopic liver transplantation offers a possibility of long-term cure,⁵ although some patients do well without any treatment. How these 'indolent' cases can be identified is unknown. Experience of transplantation for this tumour at the Liver Transplant Unit in Birmingham is as follows. The first patient, transplanted in 1984, lived for 7 years; she died of lymphoproliferative disease. The second patient, transplanted in 1996, has recently been shown to have lung metastases; there is uncertainty whether metastases affect overall survival, and so far no treatment has been given. Three patients transplanted in 2003 are alive at the time of writing. Out of nearly 40 000 liver transplants undertaken in Europe up to 2001, only 11% were for cancers⁶ and 66 of these were for epithelioid haemangioendothelioma. 5-year survival is estimated at 55–71%.⁷

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Lymphatic fistula to the vagina

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Lymphoceles and lymphatic fistulae are rare complications of abdominal surgery. External drainage of chyle via the rectum or vagina is unusual and difficult to manage.

CASE HISTORY

After panproctocolectomy for ulcerative colitis a woman of 44 developed a profuse watery vaginal discharge. There were no associated urinary tract or bowel symptoms and swabs from the discharge yielded no evidence of infection. CT revealed a substantial amount of intra-abdominal fluid, which was then drained by abdominoparacentesis, the drain being left *in situ*. On removal of the drain the discharge persisted. Again no microorganisms could be cultured from it. The watery nature of the discharge and a slight right-sided hydronephrosis noted on a repeat CT scan led to a full urological investigation for a presumptive ureteric or vesicovaginal fistula but none was found. At this point the clinicians speculated that the intra-abdominal fluid collection might be a lymphocyst draining into the vagina. A lymphangiogram was reported as normal but the adequacy of the study was questioned. A second lymphangiogram, deemed satisfactory, was reported as showing no evidence of a lymphatic leak. An exploratory laparotomy revealed no cause for the discharge and a hysterectomy and bilateral salpingo-oophorectomy were undertaken. The discharge

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Figure 1 Intraoperative sinogram

persisted and the patient was then referred to St Mark's Hospital, a colorectal tertiary centre. Here, when examined under anaesthesia, she was found to have two holes in the posterior vaginal wall. One of these was cannulated and an intraoperative sinogram was performed under fluoroscopic control. Contrast filled a cavity of about 5×5 cm. Occlusion of the inlet with a pledget provided enough pressure to show filling of an obstructed lymphatic vessel on the right side of the sacrum (Figure 1). The cannulated sinus was extended to facilitate drainage of chyle. The patient declined further interventions.

COMMENT

Chyloperitoneum is a rare complication of abdominal surgery that should be considered in cases of persistent abdominal distension. Sampling should yield sterile, lipaemic fluid. We have found no previous report of a lymphatic fistula draining externally via the rectum or vagina. To determine the site of the leak the mainstay of imaging is lymphangiography,¹ though its lack of total sensitivity is illustrated by the present case. Lymphangiography can be done as an intraoperative procedure during attempted surgical repair, and localization may be further improved by injection of patent blue violet.² CT in conjunction with lymphangiography can help to establish or exclude the presence of associated retroperitoneal masses or lymph node enlargement. It may also be of assistance in improving localization of abnormal retroperitoneal and pelvic lymphatic vessels. Lymphatic leaks have also been localized with the use of oral iodine-marked fatty acids (¹²³I-pentadecanoic acid).³

The management options for lymphatic collections and fistulae include a diet high in medium-chain triglycerides, a period of total parenteral nutrition, insertion of a peritoneovenous shunt, catheter drainage, sclerotherapy with tetracycline and surgical closure.⁴⁻⁷ If the present patient changes her mind about treatment the best option might be surgery to clear tissue away from the vaginal vault.

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Spastic paresis in Paget's disease

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Paget's disease should be considered in the differential diagnosis of spinal cord compression when MRI is suggestive of malignant disease.

CASE HISTORY

A woman of 60 had for eighteen months noticed altered sensation in her legs, beginning in the feet and progressing up both legs to involve the trunk to the level of her breasts. Her legs were also weak and stiff. She had become increasingly unsteady and had fallen several times; for the past year she had used a stick to walk, and for the last month a frame. Recent new features were urinary urgency and occasional incontinence. There was no history of acute

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