Gastric Stromal Tumour presenting as Upper Gastrointestinal Bleed

Dear Editor,

We read with interest, the case report titled "Gastric Stromal Tumour presenting as Upper Gastrointestinal Bleed" published in April 2008 issue of MJAFI. Gastro-intestinal stromal tumours (GIST), till 1998, consisted of a heterogeneous group of mesenchymal tumours primarily involving the wall of the bowel. Subsequent to the seminal work of Hirota et al [1], the term GIST seized to be an all encompassing non-committal term and the diagnosis of a GIST now mandates the demonstration of the KIT gene or its expression as CD117 (*c-kit*) for which 95% of GISTs are positive. Subsequently two large studies, one addressing all GISTs [2] and another, only gastric GISTs [3] have clearly stated that all GISTs harbour an uncertain biological behaviour and should be stratified as very low risk, low risk, intermediate risk and high risk on the basis of tumour size and mitotic index per 50 high power fields. Implicit in this classification is that rarely a very low risk GIST may demonstrate aggressive behaviour. GISTs are no longer classified as benign or malignant.

The case report has omitted essential information such as tumour mitotic count, tumour size at histopathology (this is always more accurate than the estimation prior to resection) and presence of

necrosis, if any. Expression of KIT has not been mentioned. Consequently the case report has not fulfilled current criteria for the diagnosis and risk stratification of gastrointestinal stromal tumours.

References

1. Hirota S, Isozaki K, Moriyama Y, et al. Gain-of-function mutations of *c-kit* in human gastrointestinal stromal tumours. *Science* 1998; 279: 577-80.
2. Fletcher CD, Berman JJ, Corless C, et al. Diagnosis of gastrointestinal stromal tumours: a consensus approach. *Hum Pathol* 2002; 33:459-65.
3. Miettinen M, Sobin LH, Lasota J. Gastrointestinal stromal tumours of the stomach : a clinicopathologic, immunohistochemical and molecular genetic study of 1765 cases with long term follow up. *Am J Surg Pathol* 2005;29: 52-68.

Contributed by

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Reply

Dear Editor

At the outset the authors wish to thank the reader for the keen interest shown in the article. I fully agree with the author that the diagnosis of a GIST now mandates the demonstration of the KIT gene or its expression as CD 117 (*c-kit*) for which 95% of GISTs are positive. CD 117 (*c-kit*) was done by IFC method at AFMC Pune in our patient and was found positive fulfilling the criteria for diagnosis. At histopathology the specimen measured 4.5 x 3.5 x 3 cm and had mucosa on one aspect. As the size was already mentioned

in preoperative finding and legend of Figure 1, it was omitted in text to avoid duplication. Cut surface showed areas of cystic degeneration and hemorrhages as shown in Figure 1. No necrosis was noted.

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Pediatric Nephrology Experience in Afghanistan

Dear Sir,

Afghanistan is a war torn country with third highest under five mortality rate in the world [1], due to political unrest and lack of primary health facilities. India is supporting Afghanistan in various ways one of which is by establishing Indian Medical Mission since 2001. Currently there are five teams working at five different parts of Afghanistan.

One of the most frustrating part of working here is losing a child for want of basic modalities of treatment which we tend to take for granted in India. One such example of managing a child with acute renal failure due to a reversible cause is presented.

A child was brought to Indira Gandhi Institute of Child Health, Kabul with complaint of anuria for four days and coma of one day duration. Clinically the child was having acidotic breathing and was not dehydrated. Investigations revealed high blood urea (197mg/dl) and creatinine (9.7mg/dl), Hb (11gm%), total leukocyte count (9000/mm³). Ultra sonography showed bilateral hydronephrosis and hydroureter with multiple calculi and complete obstruction. ECG showed tall T waves. No other investigation was available.

Initially empiric treatment to reduce hyperkalaemia in the form of salbutamol inhalation, glucose insulin infusion and sodium bicarbonate infusion was initiated. The only way to stabilize the child prior to surgery was to perform peritoneal dialysis (PD). So far peritoneal dialysis was not performed in this place and dialysis fluid is not available anywhere in the country. We had one PD catheter brought by author during one of the trips to India. As we were sure baby would not survive if no action was taken, we decided to make dialysis fluid by mixing 2 parts of normal saline with 1 part of a mixture made of 5% dextrose and sodium bicarbonate in ratio of 22:3 [2]. In place of normal 'Y' tubing, two three ways with three intravenous (IV) sets were used to make in and out channels. After taking informed consent from parents, the first ever PD of this hospital was started. The procedure was successful and by 7th cycle, child's breathing had become normal and ECG had reverted back to normal. Child regained consciousness after short while and after 20 cycles, PD was stopped and child transferred to another hospital for surgery. The child is presently doing well.

This case highlights the fact that all physicians practicing in field conditions should be conversant with peritoneal dialysis since