fragments and the patient was commenced on IV ciprofloxacin. Repeat fluoroscopy with oral contrast confirmed retained basket in the CBD (fig 2).

A second ERCP under general anaesthetic was performed. Cholangiogram demonstrated single calculus which was removed along with the retained fragment of basket (see fig 3). The remaining metal fragment was grasped with a further Dormia basket and removed (fig 4). The patient had no complications post-ERCP and is currently awaiting laparoscopic cholecystectomy.

Discussion: Traction wire or basket fracture, often following stone impaction, is an unusual complication of ERCP and in the past has been managed surgically. Biliary stenting leads to increased risk of cholangitis by disrupting sphincter of Oddi function. Retained metal fragments are likely to similarly disrupt sphincter of Oddi function with subsequent high risk of cholangitis.

Conclusion: We have demonstrated successful medical management of basket fracture with intravenous antibiotics and repeat ERCP facilitating endoscopic removal of the retained fragment. In experienced endoscopic teams this should be considered as an alternative to surgery.

No conflict of interest declared.

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APPENDICECTOMY COMPLICATED BY ADDISON'S DISEASE

Editor,

Acute appendicitis is the most common surgical emergency. We describe a case in which a young man underwent appendicectomy but had a complicated postoperative recovery requiring admission to ICU.

Case report: A 33 year old male presented with a fifteen-hour history of vomiting, diarrhoea, and lower abdominal pain one week after a holiday in Portugal. He had no significant past medical history. On examination he had a tanned appearance, and was tender with guarding and rebound in the right iliac fossa. Rovsing’s sign was positive. He proceeded to theatre where the operative findings and subsequent histology confirmed the diagnosis of acute appendicitis.

Over the next 24 hours he had persisting pyrexia and became tachycardic and hypotensive. Examination revealed decreased chest air entry bilaterally and abdominal distension. C reactive protein was increased to 369µg/L, from 5.0µg/L on admission. Electrolyte profile confirmed hyponatraemia. Arterial blood gas sampling showed a metabolic acidosis. He was thought to be septic. The following morning a CT scan of chest and abdomen showed, bilateral pleural effusions with collapse at both lung bases. There was free fluid in the abdomen with dilatation of the small bowel throughout its length. He was thought to have a postoperative ileus, but an atypical pneumonia was also considered.

He was transferred to ICU. Over the next 24 hours the abdominal distention increased and in view of this he returned to theatre. At laparotomy, an inflammatory mass was found in the caecum and terminal ileum, causing small bowel obstruction. A limited right hemicolecction was done. His general postoperative condition remained poor.

Further discussions with the family revealed that the patient had been of a tanned appearance since he had returned from holiday in a hot climate 10 years previous. The tanned appearance, hyponatraemia, and polyuria raised the possibility of adrenal insufficiency and a Synacthen® test was undertaken. This suggested Addison’s disease. Treatment with intravenous hydrocortisone and fludrocortisone led to an immediate clinical improvement. He was discharged home well five days later.

Discussion: The diagnosis of Addison’s disease and then Addisonian crisis in a postoperative patient is one which is fraught with difficulty. Virtually all the signs mimic other more common conditions like post-operative ileus or sepsis. A literature review indicates that these would seem to be the most widely considered initial diagnosis. It has been calculated that some degree of unsuspected adrenal insufficiency is present in up to 1 in 1000 surgical admissions, and surgeons should consider this condition when a postoperative patient fails to recover as expected. Abdominal pain as the primary complaint occurs in about 10% although a generalised gastrointestinal upset is much more common. Severe abdominal pain with tenderness mimicking peritonitis is thought to occur in about 7% of cases.

Primary adrenocortical failure is usually due to an autoimmune mediated destruction of the adrenal gland which accounts for around 90% of cases. Females are affected two to three times more frequently than males and there is an association with other endocrine deficiencies such as thyroid disease, premature gonadal failure (usually ovarian failure) and type I diabetes.

The patient should be treated in the Intensive Care Unit with
standard resuscitation measures of airway control, respiratory support, and cardiovascular monitoring. Normal saline is given intravenously to maintain the circulation, hydrocortisone 100mg is given intravenously 6 hourly and fludrocortisone is administered as a single dose of 100µg orally daily. Patient education is the key to preventing further episodes. Patients need to be fully informed about the condition and counselled with regard to appropriate replacement therapy. It might also be helpful if the patient could wear a Medicalert bracelet and carry a written record of their medications.

The authors have no conflict of interest.

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