Correspondence

Parasitic origin of a solitary necrotic nodule of the liver

We read with interest the report by Tsui *et al*, suggesting a parasitic origin for some solitary necrotic nodules of the liver.¹ We have seen one such lesion with a parasitic round worm in the centre.

The patient was a 68 year old caucasian male who underwent elective cholecystectomy for biliary colic. At operation, a subcapsular nodule 1 cm in diameter was excised from the anterior surface of the right lobe of the liver. When cut, the nodule had a grey centre and a fibrous wall. The histological features were similar to those described in solitary necrotic nodule.^{1,2} There was a dense fibrous capsule about a necrotic centre containing focal areas of dystrophic calcification (figure). Serial sections in one transverse section of the nodule also revealed, a partly degenerate, but clearly recognisable, coiled parasitic worm (figure).

The parasite was identified as a filarial or metastrongylid nematode. In Australia, *Dirofilaria immitis* is a documented cause of lung nodules similar in appearance to the liver nodule presented.³ There was insufficient preservation, however, to determine the species and it remains unclear whether this represents aberrant migration of *Dirofilaria* or a rarer parasite such as *Angiostrongylus cantonensis*, possibly acquired during overseas travel. Specific questioning of the patient showed that he had travelled to Hong Kong on three occasions, most recently three years before surgery. He had also had a hookworm infestation in New Guinea during World War II.

This case reinforces the view that solitary necrotic nodule of the liver may result from parasitic infection, even in a caucasian population. Furthermore, taking serial sections through such nodules may increase the rate of detection of parasites.

A D CLOUSTON
N I WALKER

Department of Pathology,
The University of Queensland,
Medical School,
Herston Qld 4006

P PROCIV

Department of Parasitology,
The University of Queensland,
St Lucia Queensland 4067
Australia

1 Tsui WMS, Yuen RWS, Chow LTC, Tse CCH. Solitary necrotic nodule of the liver: parasitic origin? *J Clin Pathol* 1992;45:975-8.

2 Shepherd NA, Lee G. Solitary necrotic nodules of the liver simulating hepatic metastases. *J Clin Pathol* 1983;36:1181-3.

3 Neafie RC, Connor DH, Meyers WM. *Dirofilaria immitis*. In: Binford CH, Connor DH, eds. *Pathology of tropical and extraordinary diseases*. Vol 2. Washington, DC: Armed Forces Institute of Pathology, 1976:509-16.

Dr Shepherd comments:

Tsui *et al* have clearly shown that solitary necrotic nodules in the liver may be caused by larvae. I, too, am aware of two cases occurring in British subjects in which effete larvae were clearly shown within the lesions. Berry wrote some time ago that, "it is interesting to note Shepherd and Lee's adherence to larvae as a cause of these lesions; I am sure they look forward to finding some evidence to support their contention".¹ I am sure Professor Berry will be pleased to note that we did not have to wait very long.

1 Berry CL. Solitary necrotic nodule. *J Clin Pathol* 1990;43:348-9.

Solitary necrotic nodule of liver with dystrophic calcification (small arrow) and a central coiled nematode (large arrow and inset) (haematoxylin and eosin).

Appendix specimens: modification of the trimming technique

The appendix is a commonly received specimen in diagnostic histopathology laboratories. Carcinoid tumours are found in one out of 300 routine appendectomies, most of which occur within the distal third, close to the tip. Hence the standard teaching that a longitudinal section should be taken from this region. In the series reported by Morel *et al*, however,¹ 7% of tumours were located at the base of the organ. Over the past three years we have diagnosed 10 carcinoid tumours of the appendix in our department, two of which were located at the base (fig 1). By following the standard teaching,^{2,3} we would not have been able to report on the adequacy of excision of such tumours and, in fact, one patient had to have a subsequent limited right hemicolectomy. We therefore report a modification of the standard trimming technique which has been designed to overcome this problem.

The standard recommendations for trimming the appendix are shown below (fig 2).

Figure 1 Carcinoid tumour located at proximal end of appendix.