ipsilateral main pulmonary artery (eparterial bronchus). The left isomerism subclass is also referred to as double left sidedness or polysplenia syndrome. It is characterized by both lungs having two lobes and the main bronchus passes inferior to the ipsilateral main pulmonary artery. Situs ambiguus is associated with CHD in 50 – 100% of cases[2].

The case of DT, an 11 year old school boy, who was discovered during routine pre-school admission medical examination to have situsinversus of the stomach, is reported. This case is reported because it is extremely rare (1 in 22,000)[3, 4] and also to demonstrate the importance of chest x-ray in routine medical examination.

Cases Report

DT is an 11 year old male Delta Ibo primary 6 pupil of the Christian faith.

He was brought by his parents to the 68 Nigerian Army Reference Hospital Yaba, Lagos Nigeria for routine medical examination as part of requirement for admission into secondary school. Thus, he had no presenting complaint.

A review of the systems revealed no significant medical information.
There was nothing of note in the past medical history, except that our case is an only child of the parents.
The pre-natal, natal and post-natal history was essentially uneventful. Mother booked at a medical center for routine ante-natal care (ANC) at 8weeks gestational age and had all prescribed routine drugs for pregnancy.

The pregnancy progressed to term but was delivered through elective Caesarean section because of small pelvis. Baby's birth weight was 3.5 kg. There was no history of birth asphyxia. He was exclusively breast fed for 6months. Our case had all the routine childhood immunization as scheduled by the National programme on immunization up to 9months of age.

The developmental milestones progressed normally; he sat at 4 months, crawled at 5 months, stood at 9 months and walked at 1 year of age. His academic record is good and he was about to start Junior Secondary School (JSS) class 1 at the time of presentation.
Family and social history showed that he is an only child. Both parents have post-secondary education and neither of them drinks alcohol nor smokes cigarette.

Clinical examination showed an apparently healthy school boy well oriented in time, place and person and in a good state of nutrition. His weight was 40kg, height 1.43m and body mass index (BMI) of 19.56 $kgm.^2$

His vital signs were essentially within normal limits. The apex beat was in the 4th left inter-costal space, mid clavicular line and S1, S2 were heard without any murmur.

The abdomen was flat, moved with respiration and was soft. There were no intra-abdominal viscera that were palpably enlarged.

The respiratory, genito-urinary and musculo-skeletal systems were all essentially normal.

Our attention was drawn to this case because of the findings on the routine plain chest radiograph done on 30 July 2013. It showed a normal heart size and contour, CTR 12/24 with apex at left hemi-thorax.

Both lungs were well aerated and showed no sign of any active disease. The thoracic cage was grossly normal. However, the gastric air-bubble was noted under the right hemidiaphragm with the marker position on the left (fig. 1).

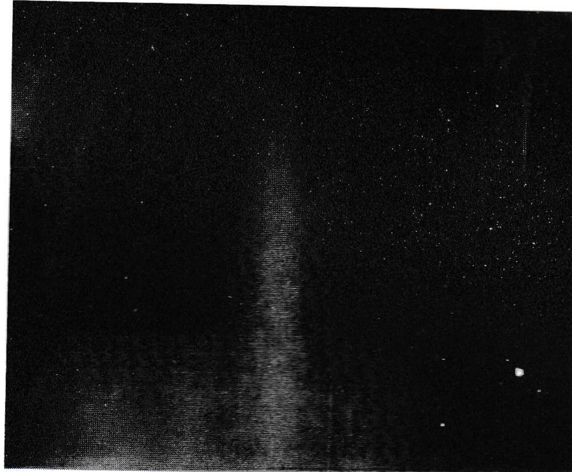

Figure 1: Frontal chest radiograph of our case, showing a normally sited heart with the apex in left hemi-thorax