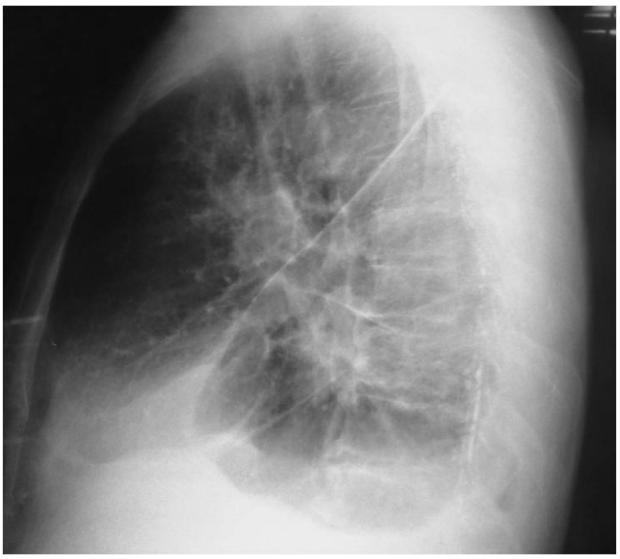
Figure 4 : Radiographie du thorax de profil : multiples opacités superposées se projetant sur le rachis dorsal.



La tonalité caractéristique de ces opacités, leur association à des opacités similaires de la face, leur projection sur le trajet d'écoulement du liquide céphalorachidien et les antécédents de myélographie ont permis de retenir le diagnostic de résidu de lipiodol.

Conclusion

La découverte de résidu de lipiodol dans le cadre du bilan étiologique d'une pleurésie purulente et 32 ans après la myélographie est une situation extrêmement rare et déroutante. La présence d'antécédent de myélographie, la tonalité caractéristique des opacités et leur projection sur le trajet d'écoulement du liquide céphalorachidien sont suffisants pour poser le diagnostic et permettent d'éviter des explorations inutiles.

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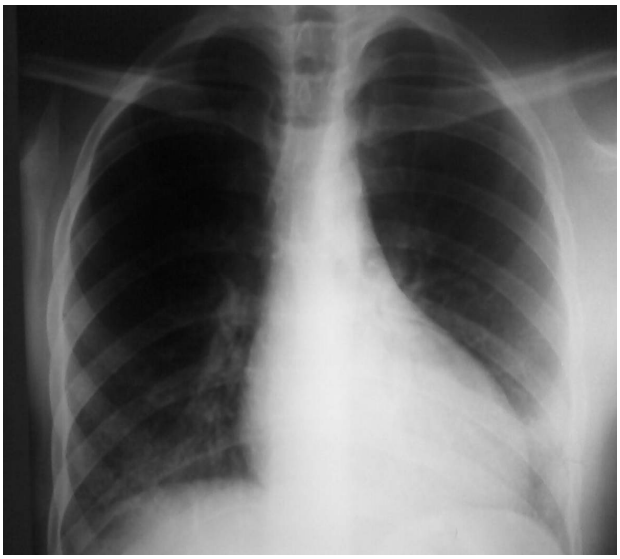
Family Dilated Cardiomyopathy associated to Celiac Disease

Celiac disease is a secondary enteropathy to gluten intolerance. It creates a chronic malabsorption in genetically predisposed subjects. Its prevalence in the general population is estimated in some studies to 0, 2 to 1% [1, 2] and it is frequently associated to other extra intestinal co-morbidities. Its association to dilated cardiomyopathy (DCM) is not common. The discovery of celiac disease in subjects presenting a DCM of non determined etiology raises the question of its possible relation of cause and effect in particular when the situation occurs in the same family. We report the case of two brothers and their sister presenting a DCM, and for whom the celiac disease was discovered whereas they presented no digestive symptoms.

Observation

A patient of 25 years, with family antecedents of a sister who died at 14 and a mother who died at 40 in postpartum in circumstances which are not determined, came for a dyspnea of effort stage III of NYHA having evolved for 9 months. The thorax X-ray shows a cardiomegaly with a cardio-thorax relation of 0, 60 (figure 1) and a normal electrocardiography. The trans thoracic echography shows a dilated left ventricle, a global hypokinesia with a systolic dysfunction attested by a low rate of an ejection fraction (EF) of left ventricular at 35% (figures 2, 3) without valvular problem and an elevated pressure filling of the left heart. The pulmonary arterial pressures were also elevated.

Figure 1 : Cardiomegaly with a cardio-thorax relation of 0, 60



The biological investigation shows a hypochrome microcytary anemia with a decreased ferritinemy without biologic inflammatory syndrome. Within the framework of etiologic investigation of this anemia the dosage of endomysium antibodies were positive. Celiac disease was diagnosed in spite of the absence of manifest digestive symptoms. The anatomopathologic exam of duodenal biopsy shows the aspect of a villositary atrophy stage V thus confirming the diagnosis (figures 4, 5). The diagnosis of dilated cardiomyopathy associated to celiac disease has been kept. The patient has been given a gluten free regimen as well as a treatment based on

inhibitors of conversion enzyme, diuretic, anti-aldosterone and beta blockers. The retrospective review of the medical file of his sister shows that she was taken care for a dilated cardiomyopathy combined with a celiac disease discovered in front of a microcytary hypochrome anemia at 7.6 gr/dl of hemoglobin which was explored. The etiologic investigation had revealed a positive dosage of antigliadin and endomysium anti bodies type IgA. At that point a family dilated cardiomyopathy was suspected. We asked the family to come. A transthoracic echography realized on his father was without anomaly, and on his brother aged 23 showed a starting dilated cardiomyopathy with a telediastolic diameter of LV at 59 mm and an EF kept at 58% (figure 6). The dosage of anti endomysium antibodies returned to a positive level.

Figure 2 : Trans Thoracic Echography, four cavities incidence showing a dilated left ventricle.

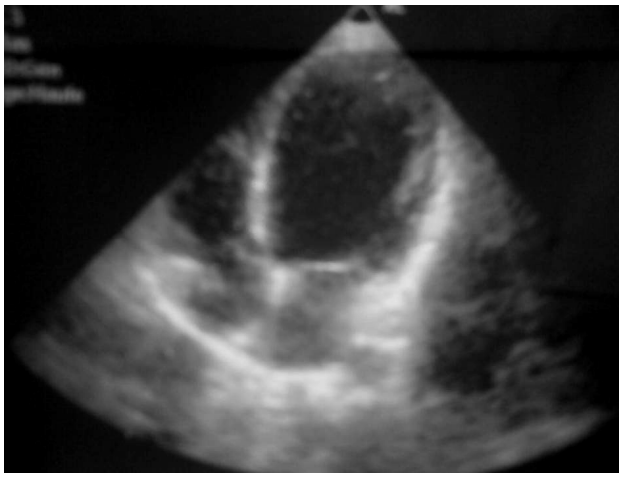


Figure 3 : Trans Thoracic echography in TM mode, the measure of ejection fraction is 35%

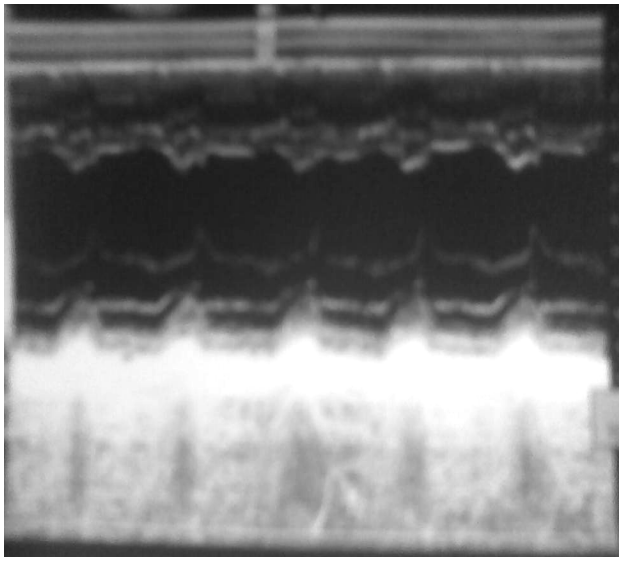


Figure 4 : Villositary atrophy grade V according to Marsh's Classification with erasing of villositary relief

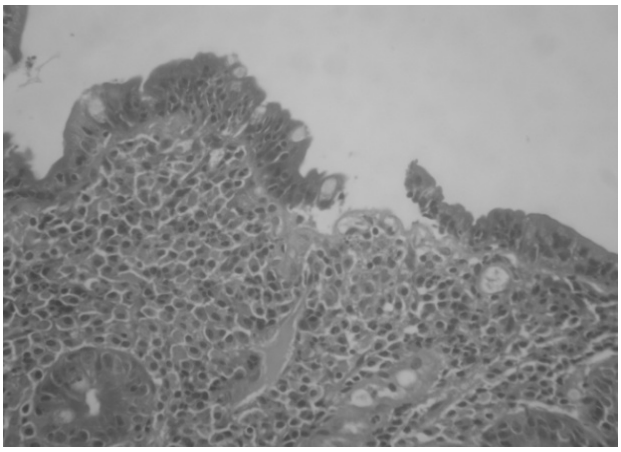


Figure 5 : Villositary atrophy grade V according to Marsh's Classification with erasing of villositary relief

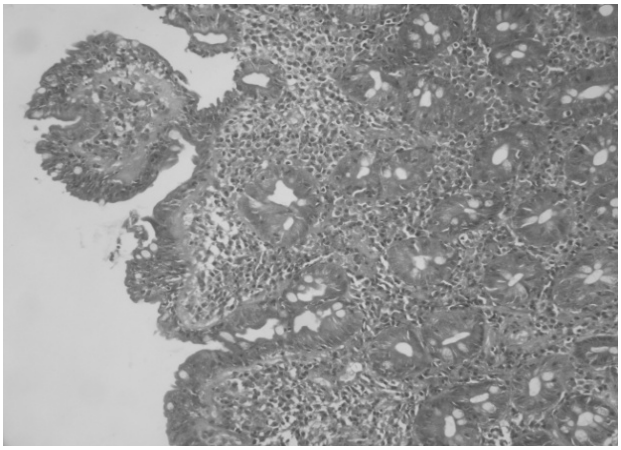
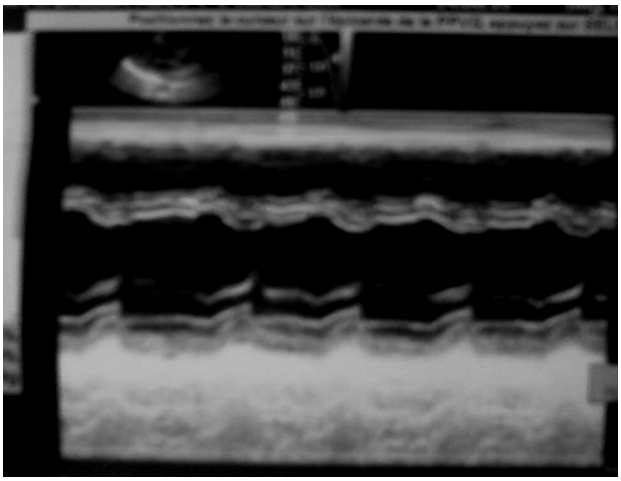


Figure 6 : Trans thoracic echography in TM mode showing a dilated left ventricle with a telediastolic diameter of LV at 59mm



Conclusion

The discovery of celiac disease in subjects presenting a dilated cardiomyopathy of non determined etiology raises the question of its possible relation of cause and effect in particular when the situation occurs in the same family. This finding incite advanced research to clarify mechanism of this association in the goal of new therapeutic option.

Références

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Sarcomatoid carcinoma of the urinary bladder

Sarcomatoid carcinomas of the urinary bladder are rare malignant neoplasms. The histologic composition of these tumors is variable, but the diagnosis requires the presence of both epithelial and mesenchymal malignant components. These neoplasms behave as highly aggressive tumors and actually the majority of authors prefer to refer to these lesions the term sarcomatoid carcinoma.

We herein report a case observation diagnosed at an early stage with no evidence of disease 12 months after transurethral resection.

Observation

A 75-year-old man with a 62-pack-year history of smoking presented with gross hematuria. Pelvic ultrasound showed a large and heterogeneous mass measuring 5,2 x 2,6 cm. Cystoscopy revealed a polypoid tumor on the trigon and the lateral bladder wall. The tumor was removed via transurethral resection. On pathologic examination, the tumor showed a biphasic composition. It was composed predominantly of malignant mesenchymal component characterised by oval to spindle shaped cells proliferation in fascicles and bundles. The epithelial part of tumor consisted of high grade papillary transitional cell carcinoma with foci of squamous metaplasia. The muscular layer was not invaded. Pathological staging of this tumor and grading of the component of transitional cell carcinoma was pT2 and G2, respectively. Immunohistochemically, transitional cell carcinoma stained positive for cytokeratin, but the sarcomatoid components stained negative. The sarcomatoid component stained positive for vimentin, and the carcinomatous area was negative for vimentin. A small number of cells react with SMA (smooth

Figure 1 : Various histologic profiles of the tumor. (A) Surface of the tumor shows the invasive growth of the transitional cell carcinoma intermingled with many mesenchymal cells. (B) Squamous metaplasia located in the transitional cell carcinoma component. (C, D) Biphasic appearance of the carcinoma and sarcomatous elements. Note the transition between carcinoma and sarcoma.

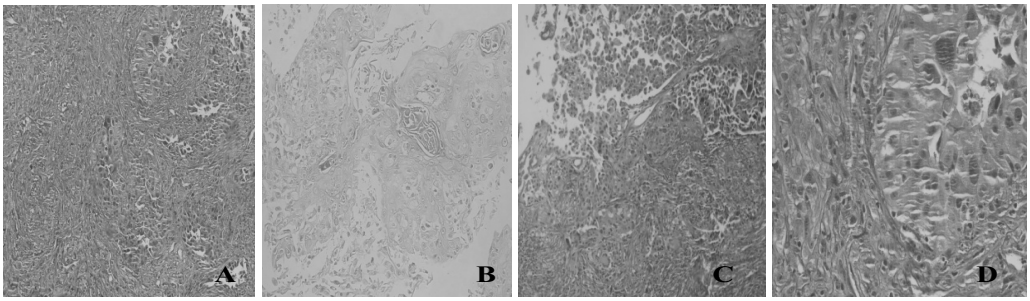

Figure 2 : Immunostaining by cytokeratin (A), vimentin (B) and smooth muscle actin (SMA) (C). Serial sections show distinct areas of both cytokératin (A) and vimentin (B) immunoreaction. SMA positive cells occasionally intermingled with carcinoma cell nests (C).