Conclusion
La péritonite primitive est cliniquement indifférenciable de la péritonite appendiculaire. L'échographie abdominale peut être d'un grand apport mais l'exploration chirurgicale par voie cœlioscopique doit être réalisée devant la crainte d'ignorer une pathologie chirurgicalement curable. Elle élimine avant tout une péritonite appendiculaire, recherche un foyer intraabdominal, vérifie l'intégrité des organes abdominaux et pelviens. Ainsi un prélèvement bactériologique per opératoire peut être effectué afin d'isoler le germe et d'adapter l'antibiothérapie et enfin elle assure une toilette péritonéale facilitant les suites opératoires.

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Transient complete loss of vision after transurethral resection of the prostate

Transient blindness is an uncommon reported complication of transurethral resection of the prostate (TURP) (1, 2). Herein we report a case and discuss the possible etiologies of this complaint, which is a symptom of the "TURP syndrome."

Case report:
A 75-year-old man with a history of hypertension was admitted because of sever lower urinary tract symptoms secondary to prostate hypertrophy. Digital rectal examination revealed an enlargement of the prostate and abdominal ultrasound showed a prostate of 56 ml with normal aspect of the upper urinary tract. Preoperative electrolytes, glycemia and creatinine were within normal levels. Under spinal anesthesia, a TURP was performed using 1.5% glycine as irrigating fluid and resecting an estimated 40 gr in fifty-eight minutes. During the operation, several large open venous sinuses were noted by the operator. Vital signs remained stable during the procedure. The estimated blood loss was 150 cc. But at the end of the resection, the patient reported that suddenly he could not see at all. We stopped the resection after a short haemostasis. The patient's conscious sate was well, his blood pressure and pulse remained stable and bleeding was well controlled. Treatment consisted of 40 mg. parenteral furosemide and intravenous infusion of normal saline. At that time, his electrolytes were: sodium 121 mEq., potassium 4.7 mEq. and chloride 81 mEq. Hyponatremia was slowly corrected by intravenous saline solution. The cérébral CT scan exhibited any anomaly. Eyesight returned completely normal after 5 hours. Serum electrolytes on the second postoperative day were normal, and the patient made an uneventful recovery.

Conclusion
Patients with visual disturbances during or immediately after transurethral prostatectomy should be suspected of having a TUR reaction. They should be early diagnosed and correctly treated.

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Coexistence of a malignant stromal tumor of the stomach with an adenocarcinoma of the lung in a patient with neurofibromatosis type 1

Malignant gastrointestinal stromal tumors (GIST) are specific mesenchymal tumors that may occur anywhere along the gastrointestinal tract [1]. Majority of GIST are positive for CD117 and vimentin in immunohistochemical staining [2]. Coexistence of malignant GIST and other malignancies have been reported in some unique cases. Such cases always require differential diagnosis for metastatic GIST [2]. In addition, association of GIST with NF1 is increasingly described [3, 4]. The case we report represents a coexistence of a GIST of the stomach with an adenocarcinoma of the lung in a patient with NF1. To our knowledge, the coincidence of GIST and lung cancer has rarely been reported in the literature.

Case Report
A 57-year-old male, great smoker, with a history of gastric operation- in 1987- for a gastric ulcer complicated with perforation, was admitted to our department for the exploration of melena with stomach ache and weight loss evolving since July 2009. On physical examination, the patient looked thin and pale. There were numerous "café au lait" spots (more than 10, with 2 to 10cm of large) (figure 1), two cutaneous neurofibromas and multiple freckles on armpits and trunk (figure 2). The questioning revealed, in fact, a family history of "café au lait" spots in a sister and in a brother who died 3 years ago when explored for cerebral tumor (which seemed to be a glioma on CT scann) associated to a lung cancer. The

ophthalmologic examination showed Lisch nodules. There were no neurological abnormalities. A neurofibromatosis type1 (NF1) was, then, diagnosed. Biologic findings were: anemia (hemoglobin 3.5 g/dl) with positive indicators of systemic inflammation and low albumin level in the blood (22g/l).The upper endoscopy, performed after transfusion, revealed an ulcerative mass of the antrum. The histopathological examination with immunochemistry found it to be a GIST. It demonstrated, indeed, positive staining for c-kit (CD117), CD34, S-100 protein and actin. It was classified as a GIST of high malignant potential.

Figure 1 : "Café au lait" spots

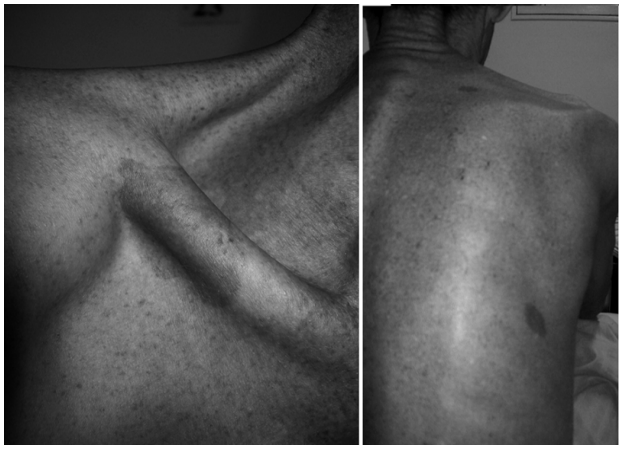
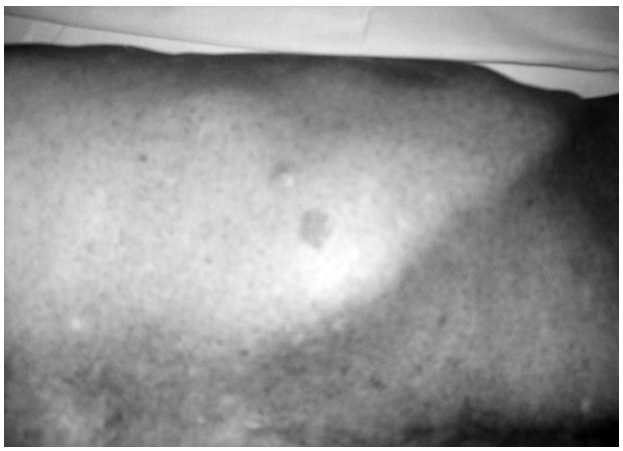


Figure 2 : Cutaneous neurofibroma (arrow)



Neither the small bowel follow-through nor the colonoscopy identified any intestinal coexisting masses. To determine extent and spread of disease, a computed tomography (CT) scann of the chest, abdomen and pelvis was indicated. It revealed a tumor infiltration of the pancreas, extension to the hepatic hilum, three peritoneal nodules and two bilateral adrenal masses measuring 5 and 5.5 cm (Figure 3). Furthermore, it showed a 3.8cm large excavated solid mass of the left lung (Figure 4).The lung mass was not accessible on the bronchoscopy. It was, then, biopsied under scannographic control. The histopathological examination concluded to a few differentiated primitive adenocarcinoma of the lung. The problem was to determine if the adrenal masses corresponded to metastases of the gastric stromal tumor, to metastases of the lung tumor – witch would be not operable- or to pheochromocytoma- witch can be associated to the NF1. Analysis of methoxylated derivatives was negative excluding the last hypothesis. We proceeded, then, to an adrenal biopsy under scannographic control and the histopathological examination concluded to metastases of a pulmonary adenocarcinoma.

The stromal gastric tumor being locally infiltrating and metastatic (peritoneal metastases), a medical treatment by imatinib was indicated. For the pulmonary adenocarcinoma with adrenal metastases, a curative treatment could not be prescribed and a palliative chemotherapy (navelbine, cispaltine) was started. The patient died after three months.

Figure 3 : CT scan: Antrum neoplasm with tumor infiltration of the pancreas, extension to the hepatic hilum and peritoneal nodules (arrow).

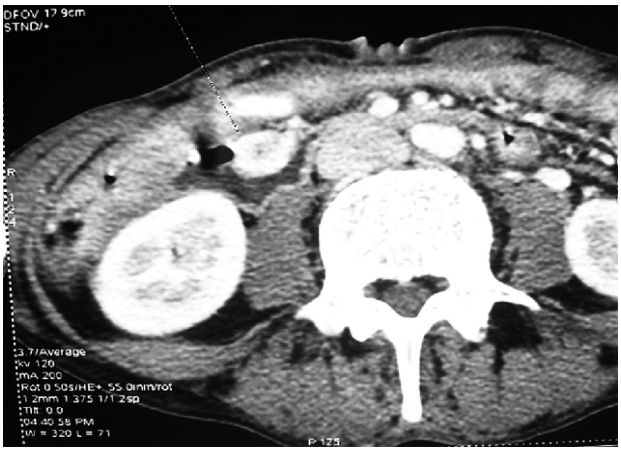
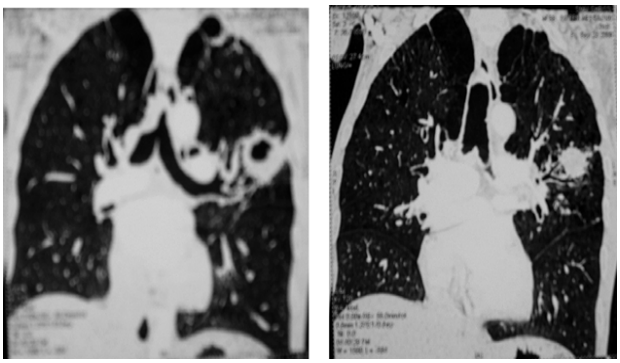


Figure 4 : CT scan: Excavated solid mass of the left lung



Conclusion

The synchronous occurrence of GISTs and other gastrointestinal malignancies in patients with type 1 neurofibromatosis is more common than it has been considered.

The clinician should be aware of this association. So that, in patients with von Recklinghausen neurofibromatosis the appearance of gastrointestinal symptoms should raise interest to search for gastrointestinal tumors. Further studies including molecular analysis to clarify the relationship between gastrointestinal tumors- particularly GIST-and neurofibromatosis are needed.

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Lymphome primitif T intestinal

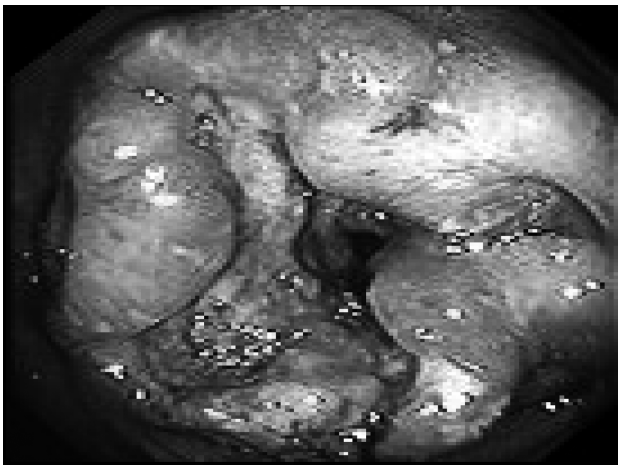
Les lymphomes T extra ganglionnaires sont rares. Ils représentent 5 à 30 % des LMNH de type T. Les localisations les plus fréquentes sont représentées par la peau, la langue et le foie. Le tube digestif est rarement atteint (<10% des cas). Le siège le plus fréquent étant le grêle (jéjunum dans 80% des cas). Les atteintes coliques et gastriques sont rares (1).
Nous rapportons quatre observations de lymphomes T intestinaux.

Observations :

Observation n° 1 :

Il s'agit d'un homme de 73 ans qui a consulté pour une diarrhée associée à des douleurs abdominales évoluant dans un contexte fébrile depuis 2 mois. L'examen physique trouvait une masse ferme sensible de 10 cm de grand axe au niveau de la fosse iliaque droite. La biologie avait montré un syndrome inflammatoire biologique (VS=130H1, CRP= 156 mg/l), une légère élévation des LDH à 1,5 N. L'échographie abdominale avait trouvé une masse tissulaire vascularisée du cæcum avec un épaississement de la graisse et des adénopathies intra abdominales. Le scanner a confirmé les constatations de l'échographie. La coloscopie montrait un aspect ulcéré et rétréci du colon droit (Figure 1).

Figure 1 : Coloscopie : aspect inflammatoire ulcéré et rétréci du colon droit



L'examen anatomo-pathologique des biopsies coliques concluait à une localisation colique d'un lymphome malin non hodgkinien (LMNH) pléomorphe à cellules moyennes et grandes de phénotype T (CD3+, CD7+, CD8-, CD20 -). Le bilan d'extension (une fibroscopie oesogastroduodénale, un transit du grêle, un examen ORL avec biopsies du cavum, une biopsie ostéomédullaire, bilan hépatique) était sans anomalie. Le patient a subi une hémicolectomie droite. L'évolution était marquée par la récidive tumorale loco-régionale deux mois après la résection avec apparition d'une carcinose péritonéale et de métastases ganglionnaires abdominales et à distance avec une aggravation manifeste de l'état général rendant le malade au dessus de toutes ressources thérapeutiques et le patient est décédé 5 mois plus tard.

Observation n° 2 :

Une femme de 28 ans, explorée pour des syndromes subocclusifs évoluant dans un contexte d'altération de l'état général depuis 6 mois. L'examen abdominal avait trouvé une masse profonde de 6 cm de grand axe. La biologie montrait un syndrome inflammatoire biologique (VS= 60 H1), une hypoalbuminémie à 30 g/l, le taux des LDH était normal. L'échographie abdominale révélait la présence d'une masse digestive à paroi épaissie de 8 cm. Le scanner avait noté une dilatation pseudoanevrysmale d'une anse grêlique avec des métastases pulmonaires dont les biopsies avaient conclu à des métastases d'un lymphome T. Les biopsies grêliques étaient non concluantes. Le bilan d'extension (bilan hépatique, fibroscopie oeso-gastro-duodénale, coloscopie, examen ORL + biopsies du cavum, biopsie ostéomédullaire) était normal. L'évolution était marquée par la survenue d'une occlusion nécessitant une intervention en urgence avec en peropératoire découverte d'une volumineuse tumeur de 15 cm du grêle envahissant le colon transverse avec des métastases hépatiques.