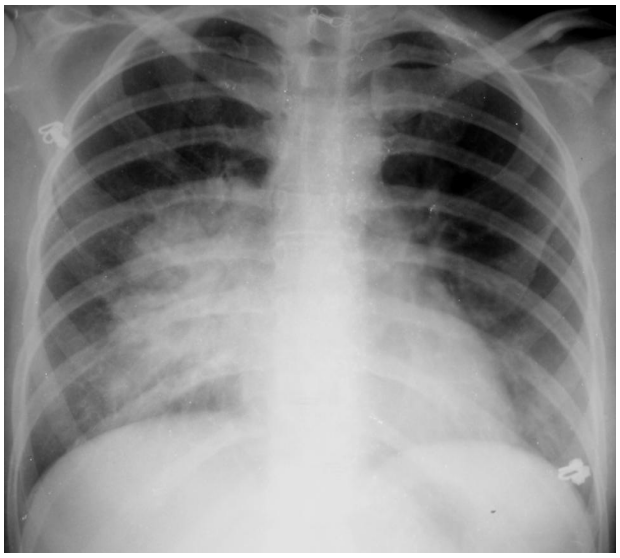
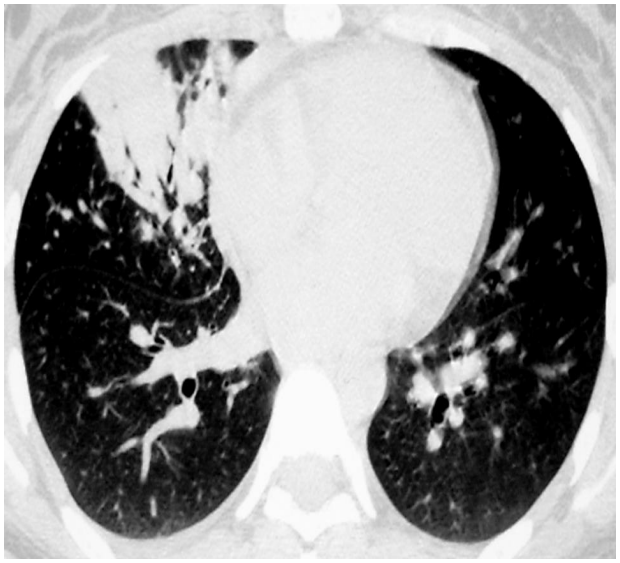
Figure 1: Chest X-ray: Right-sided heterogenous paracardiac opacity



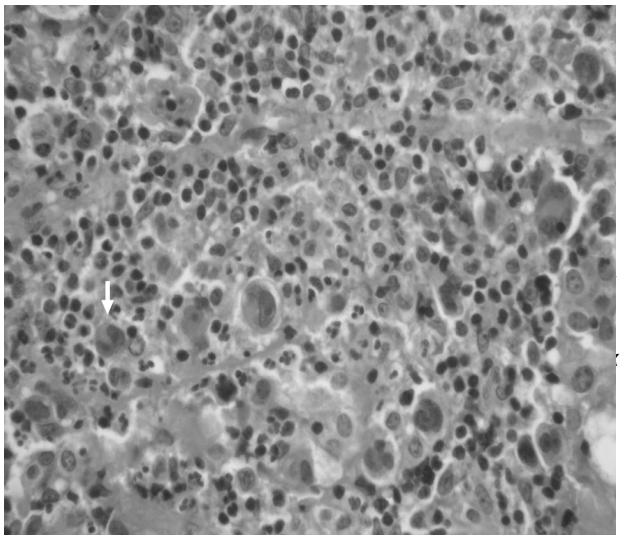
Bronchofibroscopy revealed bilateral inflammation of the tracheobronchial tree mucosa, and the bronchial biopsy revealed granulation tissue only. We strongly suspected tuberculosis and the patient received anti-tuberculosis treatment. Two months after, a clinical worsening was noted. CT scan shows the enlargement of tissular condensation associated with bilateral ill-defined micronodular lesions and pleural effusion without any enlargement of lymph nodes. Due to difficulties in establishing the aetiology, surgical biopsy of the lung was performed. Morphological findings of wedge-shaped lung biopsies of the upper and lower lobes showed comparative findings.

Figure 2: Axial thoracic CT scan: Tissular consolidation with a cavity in the upper and middle right lobes.



The lung tissue was infiltrated by mononuclear Hodgkin cells and multinuclear Reed-Sternberg cells residing in a rich inflammatory background (Figure 3). The reactive cellular infiltrate contained non-neoplastic small lymphocytes, eosinophils, histiocytes and plasma cells. Tumor cells were positive for CD15 and CD30 and negative for CD20 and LMP1 (Latent membrane protein 1). Diagnosis of pulmonary mixed cellularity classical Hodgkin lymphoma was made. The patient received aggressive chemotherapy regimens, including 12 courses of ABVD (Adriamycin, bleomycin, vinblastine, and dacarbazine). One year after diagnosis, the patient is well and remains in complete remission.

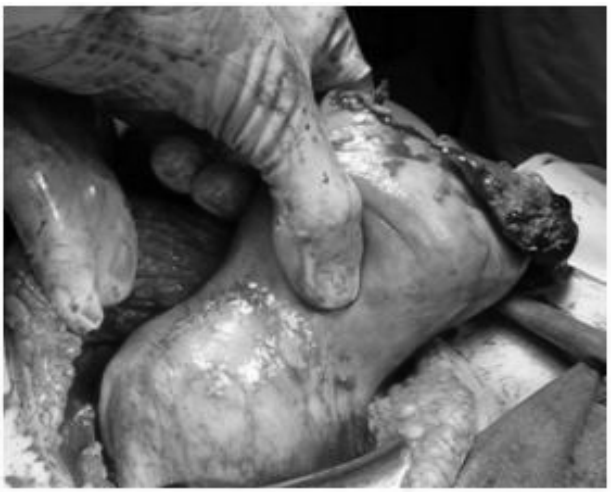
Figure 3: Tumor cells with typical binucleated Reed-Sternberg cell (arrow) in a mixed cellular infiltrate (original magnification x 400)



Spontaneous rupture of a communicating rudimentary horn at 25 weeks

Pregnancy in a non-communicating rudimentary horn is uncommon, with an estimated incidence of 1 in 100 000 [1]. Trans-peritoneal migration of fertilized ovum may result in pregnancy in the horn with eventual rupture and intra peritoneal haemorrhage. Early diagnosis before rupture is possible, but remains elusive, despite advances in ultrasound as a result of the bizarre presentation. Unless the possibility is kept in mind, early diagnosis may be missed. It can lead to catastrophic hemorrhage and death.

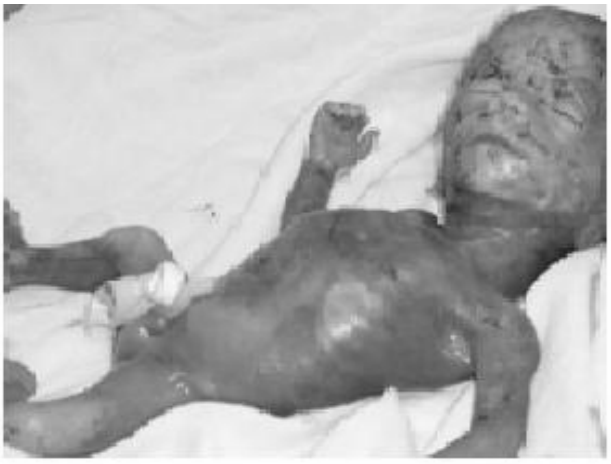
Figure 1: Peroperative aspect



Case report

A 32-year-old woman, gravida2para1 presented to the emergency department complaining of severe abdominal pain and vomiting for 3 h. She was 25 weeks pregnant. The obstetrical history consisted of a cesarean section without any complication with delivery of a full-term infant. On physical examination, the patient seemed to be inmoderate distress secondary to abdominal pain. The temperature was 37.2°C, heart rate was 110 beats/min, respiratory rate was 18 breaths/min, and bloodpressure was 100/75 mm Hg. The abdomen was soft withtenderness to both lower quadrants but greater in theright lower quadrant. On pelvic examination the cervix was soft and closed, and was felt to be pulled up in the pelvis. Sonography examination revealed a live extra uterine pregnancy entrapped in a large amountof a thick wall on the left side of anormal uterus with no communication and fluid in the pelviccavity. Immediate laparotomy revealed a 2500 cc haemoperitoneum, a pregnancy in a left rudimentary hornwhich was connected by a fibromuscular band to the uterus and ruptured on the apex (Figure 1).

Figure 2: Fetus expulsed throw the horn rupture



The intra abdominal expulsed fetus weighed 500 g and cord pulsations wereabsent (Figure 2). The left tube was normal although slightly dilated. The horn was excised (Figure 3). The kidneys were palpated and found to be normal. Postoperative period was uneventful.

Figure 3: Aspect after the rudimentary horn resection

Conclusion

Rudimentary horn pregnancy, although rare, remains a serious condition associated with much gynecological and reproductive morbidity. It requires an urgent surgical treatment in conjunction with an intensive care because of the importance of hemorrhage due to the rupture of the horn. To decrease these serious complications, diagnosis of this uterine anomaly should be made before pregnancy or at least before horn rupture. The non-communicating rudimentary horn should be always excised whenever diagnosed.

References

1. Kukreti M, SinghalVp, Kukreti R, Prakash A. Pregnancy in a rupturing non-communicating rudimentary horn masquerading as epigastric pain. Aust N Z J Obstet Gynaecol 2004; 44: 470–472.

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