succédées à trente minutes d'intervalle avec toujours une bonne récupération post critique. La biologie était normale. Une échographie doppler des membres inférieurs ainsi qu'une échographie abdomino-pelvienne sont revenue normales. Le diagnostic d'éclampsie du post -partum a été retenu. Vu la bonne évolution avec normalisation de la tension artérielle, la patiente était mise sortante six jours après son admission.

Conclusion

L'éclampsie tardive du post partum est rare. Elle est associée à un tableau prodromique le plus souvent atypique. Elle peut compliquer une grossesse de déroulement normal et peut survenir jusqu'à quatre semaines du post partum. Ce qui incite à surveiller systématiquement la pression artérielle en post partum et informer les patientes sur les symptômes devant amener à consulter ce qui peut améliorer le pronostic de cette forme atypique d'éclampsie.

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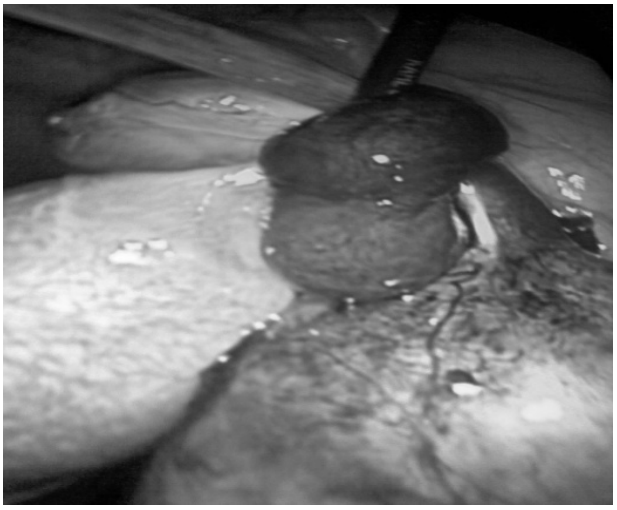
Isolated torsion of the fallopian tube in a woman of reproductive age

Isolated torsion of the fallopian tube is an uncommon gynecologic pathology, even more rare in adolescent females. The overall incidence in the literature is approximately as 1 in 1.5 million women (1). No particular or pathognomonic clinical signs, nor specific images or laboratory data are found (2). Thus, preoperative diagnosis is rarely made. It is usually made during surgical intervention, preferably by coelioscopy (3).
We report a new case of isolated torsion of the fallopian tube in a woman of reproductive age.

Case report

A 16-year-old woman, admitted in the emergency for a 2-days pelvic pain, especially in the right iliac fosse. No associated digestive or urinary symptoms were neither found nor recent gynecological plaints. She had previously regular menstruation and menarche at 13 years old. General examination noticed a 38°C temperature, a blood pressure about 100/70 mm Hg, a pulse rate about 82 beats per minute and an evident tenderness on palpation of the left lower abdominal quadrant with a palpable painful mass of 4-5 cm in the right iliac fosse. The trans-abdominal ultrasound scan showed a 6.5 cm cystic mass annexed to the right part of uterus.

Figure 1: Isolated torsion of the right fallopian tube



The b-human chorionic gonadotropin was negative. Diagnosis of left ovarian cyst torsion was made. An urgent laparoscopy was performed revealing the presence of isolated torsion of the right fallopian tube with resultant hemorrhage and necrosis. This torsion was related to a giant hydatid of Morgani cyst. The uterus, left ovary and tube, and left ovary were normal. Right laparoscopic salpingectomy was performed. Histological examination showed a 12-cm-long uterine tube, 5-cm dilated in the central portion, with extensive hemorrhage and edema of the tube wall associated with neutrophilic infiltrate. The patient had an acceptable postoperative evolution, and was allowed to live the hospital 48 hours later.

Figure 2: Isolated torsion of the right fallopian tube with giant hydatid of Morgani cyst

Conclusion
Laparoscopy is the main diagnostic and treatment tool for the isolated torsion of fallopian tube. Although this pathology is rare, it should be evoked towards any pelvic pain, in order to salvage the tube and preserve fertility.

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Leiomyosarcoma of the cervix uteri with Osyeoclastic like giant cells

Leiomyosarcoma arising in the uterine cervix is an exceedingly rare tumour. It represents the most common primary sarcoma even less than thirty cases have been described in the literature (1). To our knowledge, we report herein the first example of cervical leiomyosarcoma with numerous admixed osteoclastic like giant cells.

Case report
A 60-year-old Tunisian woman was admitted with the complaint of vaginal bleeding and lower abdominal pain for five months. Pelvic physical examination revealed an irregular, mobile, firm, multilobular mass about 10 cm in size infiltrating the entire uterine cervix. The uterus corpus was moderately enlarged. The vagina and parametria were free from any lesion. The biopsy of the cervical lesion revealed a leiomyosarcoma. Pelvic tomography confirmed the presence of a 10x 8 cm solid and necrotic pelvic mass felt to be of cervical origin. Chest X-ray showed multiple pulmonary metastases. The patient underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Upon gross examination of the resected uterus, an approximately 10x8x6 cm size exophytic tumour was seen in the uterus cervix (Figure 1). Histological examination showed a proliferation of spindle-shaped atypical smooth muscle cells with large hyperchromatic nuclei having variable amounts of mitotic activity and tumor cell necrosis (Figure 2). Numerous admixed osteoclastic like giant cells were observed (Figure 3). Immunohistochemically, the tumoral cells were stongly positive for ·-smooth muscle actin and vimentin and negative for cytokeratin, epithelial membrane antigen, and S-100 protein. The giant cells were positive for CD68. The final diagnosis was cervical leiomyosarcoma with osteoclastic giant cells. The patient died three months later.

Figure 1: Macroscopic axial section of the cervix. Note the endometrial cavity (arrow). A dark congested polypoid mass arising in the endocervical canal projects.

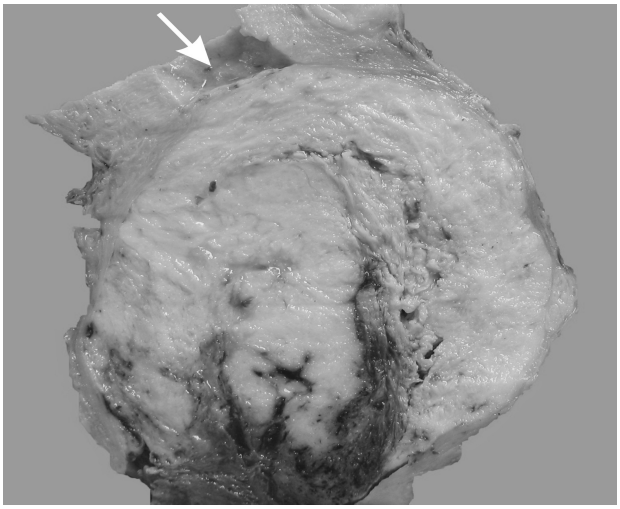
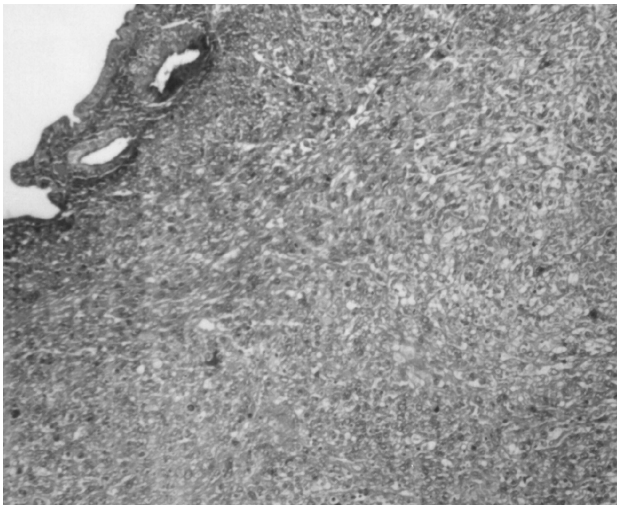


Figure 2: Proliferation of spindle cell adjacent to endocervical mucosa. (HEX200)



Conclusion
Because the number of reported cases in the litterature is still very small, the optimum means of managing cervical LMS have yet to be established. It seems appopriate that when faced with this disease process, the clinician, therefore, looks for guidance to the current accepted standards for the management of uterine LMS.