Une étude immunohistochimique a été pratiquée avec les anticorps suivants : actine muscle lisse (Dako, clone 1A4, dilution 1/25), desmine (Dako, clone D33, dilution 1/50) et protéine S100 (Dako, clone Z 0311, dilution 1/50). La majorité des cellules tumorales exprimaient de façon modérée à intense l'actine muscle lisse. La desmine était exprimée de façon diffuse et intense ; alors que la protéine S 100 était négative.
L'examen anatomopathologique avait conclu à un léiomyome dans sa forme myxoïde. La patiente a été perdue de vue et elle a reconsulté 18 mois plus tard (Décembre 2002) pour une récidive tumorale sous forme d'une énorme tuméfaction de la grande lèvre gauche mesurant cliniquement 10 cm de grand axe. L'échographie pelvienne a montré une lésion anéchogène dans son ensemble sauf au niveau de son extrémité inférieure où elle était hétérogène. La patiente a eu une deuxième exploration chirurgicale sous anesthésie générale qui a révélé une formation blanchâtre de consistance molle dont la dissection de proche en proche a mis en évidence une tumeur mal limitée fusant en profondeur derrière la symphyse pubienne et la région latéro-vésicale gauche rendant l'exérèse complète impossible. La patiente a été mise sortante au 3ème jour du postopératoire. L'examen tomodensitométrique à distance n'a pas relevé de récidive .L'examen anatomopathologique de la récidive tumorale a montré un aspect histologique tout à fait semblable à celui de la tumeur primitive. Une étude immunohistochimique a été pratiquée utilisant les mêmes anticorps avec deux autres complémentaires : les récepteurs des oestrogènes (Dako, clone 1D5, dilution 1/35) et les récepteurs de la progestérone (Dako, clone PgR 636, dilution 1/50). Le profil immunohistochimique était identique à celui de la tumeur primitive. Environ 70 % des cellules tumorales exprimaient les récepteurs de la progestérone ; les récepteurs oestrogéniques étaient négatifs. L'examen histologique de la tumeur primitive et de la récidive, le profil immunohistochimique ainsi que le contexte clinique (tumeur mal limitée, de siège vulvo-périnéal, chez une femme jeune et ayant récidivé) ont permis de redresser le diagnostic et de retenir celui d'angiomyxome agressif. Revue à 3 ans, il n'a pas été noté de récidive.

Conclusion

L'angiomyxome agressif est une tumeur mésenchymateuse rare de la région pelvipérinéale de la femme. Un diagnostic adéquat ainsi qu'un traitement approprié nécessitent une parfaite collaboration entre les gynécologues et les anatomopathologistes. Le traitement est presque exclusivement chirurgical.

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Adrenal cystic lymphangioma

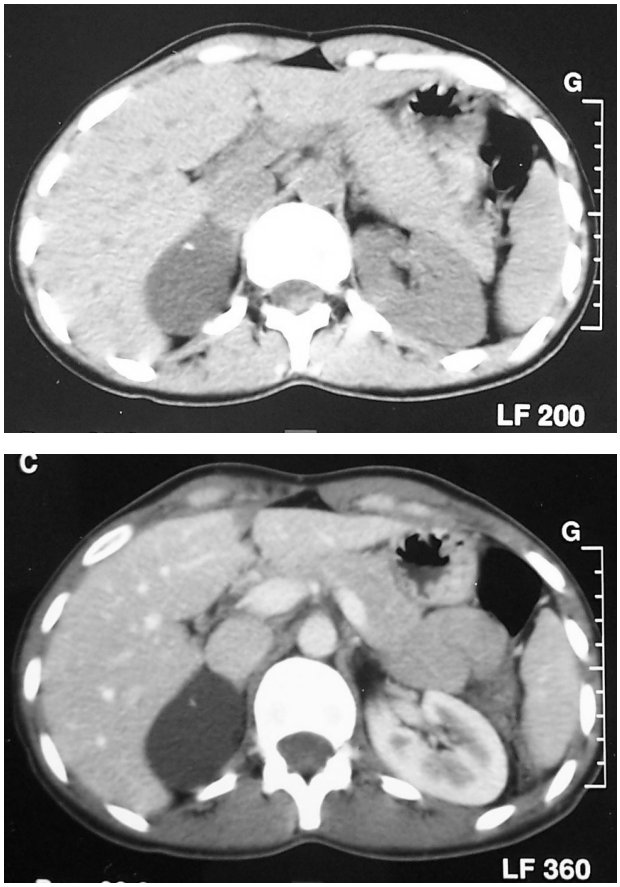
Suprarenal cyst is a rare entity. Its incidence is increasing due to large indication of radiological investigations especially ultraonography, CT Scan and MRI. It is more and more an incidental discovery (1). Cystic lymphangioma of adrenal gland is a rare lesion usually asymptomatic, diagnosed during abdominal studies due to other etiologies. Imaging tests are not specific and the diagnosis remains histological, established after surgical excision (2).
We present a new case of cystic lymphangioma.

Case report

A 29-year-old female, with a background of lumbar trauma one year ago, presents with continuous and aggravating pain in right lumbar area and with no other associated symptoms.
Physical examination revealed minimal tenderness to deep palpation at the right flank. Arterial pressure was 11/7 and pulse: 84/min.
Hematocrit was 34.6%, haemoglobin was 11.3 g/dl, and platelets were 212.000/Ìl. Serum electrolytes: sodium: 147 meq/l, potassium: 3.76 meq/l. glycemia: 0.99g/l and creatinine: 11 mg/l. azotemia: 0.19/l. Intravenous pyelography showed curvilinear calcification in region of upper pole of right kidney with downward displacement of the right kidney.
Abdominal ultrasonography revealed a lobulated cyst (3.6 x 5.8 x 7 cm) with septae, with scattered peripheral echoes demonstrating posterior acoustic shadowing and sharp contours at the upper pole of right kidney. A suprarenal hydatid cyst was suspected. A computed tomographic (CT) scan of the abdomen disclosed a 3,5x6x5 cm right adrenal cystic lobulated mass with several septations containing small punctate calcifications and internal low density (Figure 1 and 2). Her plasmatic suprarenal hormones values were within normal limits so were the 24-h urinary excretion of metanephrine and normetanephrine. Synacthen test was also normal. Hydatid cyst serology was negative.
By open surgery, the patient underwent excision of a 6 cm cyst which right adrenalectomy.
Her post-operative recovery was uneventful. She was

discharged from the hospital three days later with normal physical and laboratory findings.

Figure 1 and 2: Contrast-enhanced helical CT scan: a 5 x 4 cm in diameter, hypo dense, lobulated, and well-marginated and none is enhancing cystic mass of the right adrenal gland.

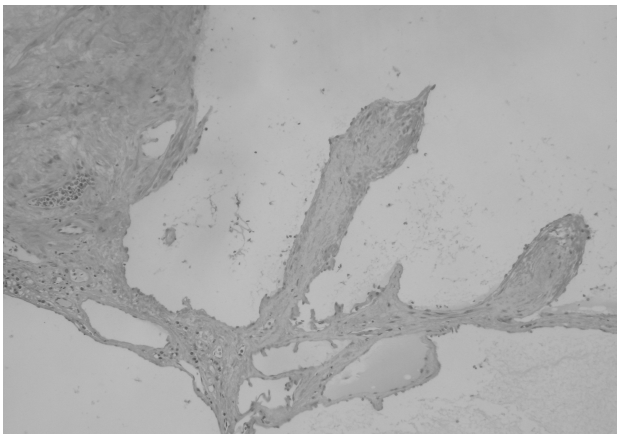


On pathologic examination, the adrenal gland contains a large cystic component. Cut section revealed a serous filled cystic cavity. The cystic spaces were filled with proteinous fluid. Histologic sections revealed multiple cystic spaces lined by flat endothelial lining. The surrounding adrenal tissue appeared normal. The cellular lining of cyst displayed no evidence of atypia (Figure 3). Immunohistochemically, these cells stained positively for CD31 and CD34. The cells were positive for smooth muscle actin, which circumscribed the cyst. Overall, the findings were consistent with benign cystic lymphangioma of adrenal gland. A follow-up abdominal ultrasound examination 17 months later did not reveal any evidence of recurrence. The patient's clinical symptoms disappeared.

Conclusion

Adrenal lymphangiomas are very rare, benign lymphatic neoplasms. They are more and more found incidentally as cystic masses. They necessitate surgical removal to rule out other types of adrenal neoplasms. Histological examination is mandatory to confirm the diagnosis.

Figure 3: Histopathologic specimen: multiple cavernous lymphatic vessels lined by smooth endothelium adjacent to the normal-appearing adrenal gland. (H and E, x100)



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Leiomyoma of the vulva

Leiomyoma is a relatively rare but most common benign solid tumor of the vulva. It represents only 0.03% of all patients with gynecologic neoplasms [1]. These tumors are considered to originate from smooth muscle within erectile tissue, blood vessel walls, the round ligament, the dartos muscle, or the erector pili muscle.Complex morphological features of these tumors of the vulva often resemble other soft tissue tumors of the vulva, leading to diagnostic difficulties. They tend to become pedunculated, especially if large and lymphadenematous, and the pedicle may become solong that the growth dangles between the limbs [2]. In the literature, only a few cases have been reported [3, 4]. For this reason, we consider that this case is of interest and worthy of reporting.

Case report

A39-year-old G2P2 female presented with a vulvar mass. Medical history revealed that she had 2 to 3 cm wide solid mass on her external genitalia for 4 years and during the last 6 months she developed enlargement of the lesion measuring about 15 cm