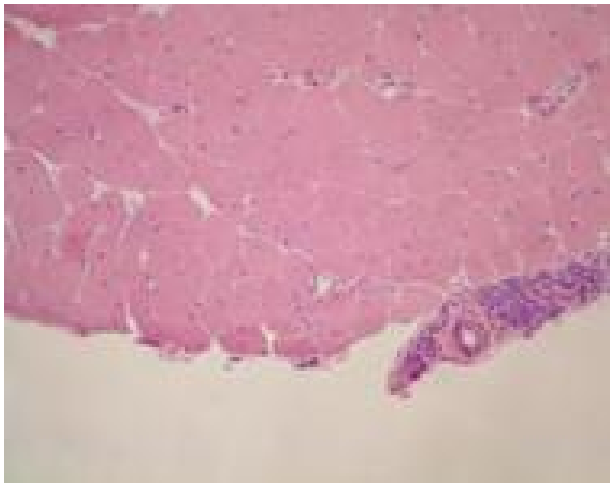
Figure 2 : Muscle biopsy specimen: fragmentation of perimysial connective tissue and perifascicular myopathic changes near connective tissue, compatible with myositis.



Conclusion

The association of antisynthetase syndrome and sarcoidosis is uncommon. To our knowledge, only one case of systemic sarcoidosis associated to antisynthetase syndrome has been reported in the English and French literature (1). The diagnosis of such association needs different investigations and multiple biopsies of the all affected organs. The characteristic feature of our patient is that multiple systems were affected in a mosaic pattern and biopsy specimens showed lesions consistent with both diseases.

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Vascular reconstruction following an oncologic resection of a sarcoma of the groin: about two cases

Soft tissue sarcoma of the groin represents a real problem both for diagnosis and management. Its diagnosis is misleading especially in this location because it should be differentiated from common entities such as inguinal hernia or adenopathy. In the past the vascular structures invasion constitutes an indication for limb amputation but in recent years with the development of vascular reconstruction techniques, the limb sparing surgery becomes possible [1]. The 5-year survival rate ranges from 63 to 75% which demonstrates that the vessel involvement in itself does not represent a bad prognostic factor for overall and disease free survival when the tumor resection is wide enough [2].

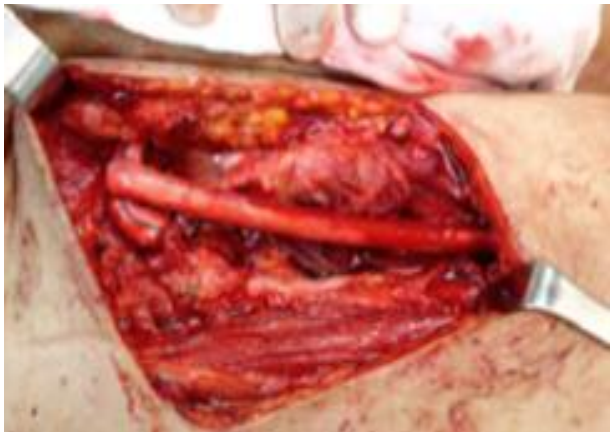
Schwarzbach recommended synthetic grafts for arterial and venous vascular substitute to reduce the operative time and to preserve the great saphenous vein (GSV) [3]. The venous reconstruction in case of groin sarcomas is unnecessary because of the establishment of collateral venous circulation due to the chronic tumoral compression.

We report the outcome of two cases of groin sarcomas that were completely resected with vascular reconstruction using synthetic grafts.

Case 1

A 57 year-old man had been referred in 2008 for a recurrence of an epithelioid hemangioendothelioma of the gluteal region two years after the initial treatment. We performed a reexcision of the tumor bed and an inguinal lymphadenectomy. The pathologic examination found a microscopic site of tumor with one positive lymph node. Adjuvant radiotherapy was delivered at the dose of 54 Gy. One year later, a second inguinal 30 mm recurrence was treated by wide excision. Eighteen months later, the patient presented a thrombophlebitis of the lower limb in which we discovered a deep third relapse. We performed a wide excision of the mass with arterial reconstruction using a PTFE graft. The patient is free of disease six months later.

Figure 1 : Figure 1: per operative view of the femoro-popliteal graft



Case 2

A 78 year-old man underwent in 1987 a resection of a sarcoma of the right thigh. On the postoperative course, the patient experienced an important hemorrhage that was controlled by ligation of the external iliac artery. The lower limb did not experience any acute ischemia event. He recently presented with a mass of the right groin that measured 70 mm and was attached to the deep plane. The CT scan showed a heterogeneous inguinal mass infiltrating the external femoral vessels. The biopsy concluded to leiomyosarcoma. A wide tumor resection through an inguinal incision was done including the femoral vessels. The restoration of the vascular

continuity was performed using PTFE graft of 8 mm diameter between the left common femoral artery and the right common femoral artery associated to another graft between this latter and the ipsilateral popliteal artery just after the Hunter's canal (figure 1). In the early post-operative period, the patient developed an important lower limb edema that completely resolved within one week after physiotherapy and heparin.

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Tracheo-aortic fatal fistula after tracheostomy: a rare complication to keep in mind.

Vascular complications after tracheostomy are rare but severe, impairing the patient's prognosis and requiring prompt management [1, 2]. We report a new observation of a 17-year-old boy with a trisomy 21 and a Dandy-Walker malformation which presented 6 months after tracheostomy with severe bleeding from the cannula secondary to complex tracheo-innominate artery and tracheo-aortic fistula which was unnoticed initially but was fatal at recurrence.

Case report

A 17-year-old-boy with a trisomy 21 and a Dandy-Walker malformation was referred to our department for severe bleeding from a tracheostomy tube. He had a history of acute respiratory failure secondary to severe pneumonia which required mechanic-ventilation 10 months earlier. The patient received a tracheostomy, for prolonged oro-tracheal intubation and was discharged. Six months after tracheostomy, he presented for severe bleeding from the cannula. Fiberoptic bronchoscopy showed no abnormalities in the proximal part of the bronchial tree, but severe bleeding occured after removal cannula, preventing further exploration.

Patient underwent in emergency a cervico-manubriotomy, which showed a fistula between the innominate artery and the trachea. A trans-tracheal closure of the fistula was performed with Teflon stamps.

Third-postoperative-day chest-CT showed a diffuse circumferential thickening of the tracheal wall, which was the seat of calcification with densification of the mediastinal fat. There was no vascular leakage after contrast injection (Fig.1-2). Considering the high risk of hemorrhage recurrence, an extra-anatomical bypass using an autologous pericardium-tube graft was decided.

Through median sternotomy and a right subclavian incision, the right subclavian artery and the ascendant aorta were dissected. A 60x80 mm2 patch was taken from the pericardium and treated with glutaraldehyde. A 6 mm self-made tube graft was constructed from the pericardium patch. Under beating-heart and lateral clamping of the aorta, the pericardial tube was interposed between the ascendant aorta and the right subclavian artery, through an extra-pleural tunneled path. The innominate artery was sutured at both sides of the fistula. At the end of the procedure, a good capillary signal was detected at the right fingers. The third hour postoperatively, patient developed right fingers cyanosis with loss of the radial and humeral artery pulses. At Doppler-ultrasound, there was no blood-flow in both arteries. A CT-angiography showed thrombosis of the subclavian artery bypass, occlusion of the right subclavian artery over a distance of 37 mm at 33 mm of its origin with a normal blood flow at the distal subclavian artery, the axillary artery and the arteries of the right upper limb. The patient was reoperated through median sternotomy. An embolectomy was performed with a balloon Fogarty catheter at the proximal part of the graft with a good patency result. Post-operatively, the patient presented severe sepsis which required epinephrine support. At the second day post-operatively, he presented a severe pulsatile hemorrhage from the tracheostomy cannula. The patient was reoperated through median sternotomy. Intra-operative exploration with further dissection of the mediastinal great vessels revealed a second fistula between the posterior side of the aortic arch and the trachea which was unnoticed during the previous procedures (Fig.3). Unfortunately, the patient presented intra-operatively a cardiac arrest which was refractory to resuscitation.

Figure 1 : Diffuse circumferential thickening of the tracheal wall, with calcification between the trachea and the innominate artery.