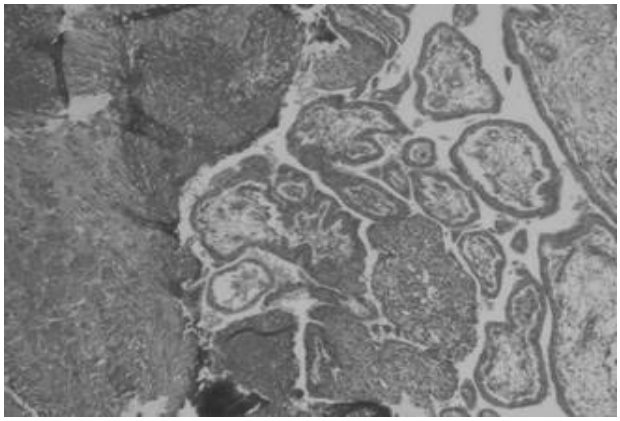
As injection of methotrexate was to be unsuccessful because of the mass' size and local findings, we decided to perform a laparotomy. Conservative management was carried out with surgical enucleation of the invaded myometrium. Right salpingectomy was performed because of the anatomical lesions. The patient had an unenventful postoperative course. Anatomic pathological findings confirmed the intramural ectopic site of the pregnancy (Figure 1).

Figure 1: Presence of immature placental villi in myometrial tissue.



Conclusion

Intramural pregnancy remains a rare but serious ectopic pregnancy. Diagnosis is often delayed because of its confusing sonographic findings. Prognosis for survival as well as for the patient's fertility depends on early diagnosis based on ultrasound findings revealing intramural ectopic gestational sac completely surrounded by the myometrium and independent from the endometrial complex. Conservative management either surgical or medical can be adopted with an acceptable success rate. This particular ectopic pregnancy can also be revealed by an uterine rupture and the adapted treatment should be hysterectomy.

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Successful pregnancy and delivery in patient with artery bypass grafting for coronary lesion caused by Kawasaki disease

Kawasaki disease or mucocutaneous lymph node syndrome is an acute febrile illness affecting young children characterized by bilateral conjunctival congestion, changes of lips and oral cavity, polymorphous exanthema, changes of peripheral extremities and acute no purulent cervical lymphadenopathy. It is an acute vasculitis syndrome of unknown etiology that primarily affects small and medium sized arteries, particularly coronary artery which is responsible for the illness severity [1, 2]. Some patients who had Kawasaki disease accompanied by cardiac involvement including coronary aneurysm are now adults and of childbearing age. There is no complete guideline in management of pregnancy and delivery in patient with coronary artery disease treated by bypass grafting [3, 4].

We report a successful pregnancy and delivery in patient with artery bypass grafting for coronary lesion caused by Kawasaki disease.

Case report

Ms FL, a 32 years old woman was admitted to obstetric department at 37 weeks gestation in order to plan her delivery. This is her first pregnancy after 5 years of infertility. She had been suffering from coronary insufficiency triggered by acute myocardial infarction in antero-septal territory since January 2002. Coronary angiography performed after this incident showed aneurysm lesions and stenosis affecting the anterior inter-ventricular (AIV) and the right coronary artery (RCA). These lesions evoke Kawasaki disease. In May 2002 the patient was subject to a 2nd acute myocardial infarction crisis; consequently a quadruple bypass grafting was applied using the left internal thoracic artery and the right saphenous vein. Postoperative courses were simple. Excluded aneurysm histopathology examination was in favor of Kawasaki disease. Etiological check-up of Kawasaki disease and thrombosis accident leading to ischemic heart consisting of an immunologic test (ANA, DNA native, and rheumatoid factor), hematological test (Protein S, Protein C, and Antithrombin III), bacterial and virology test were normal. Since she was infertile, she was followed up for five years. Results had showed that hyperprolactinemia was the sterility cause. In order to check her gestation ability, she was sent to cardiovascular department to assess her cardiac performance, and the results were as the following:

At the physical examination, heart rate was 80 beats/min, blood pressure was 110/60 mmHg, and there had been no recent episodes of effort angina. Echocardiography (figure 1) showed neither dilated nor hypertrophic left ventricular. Left ventriculography showed a reserved left ventricular function (ejection fraction = 57%). Electrocardiogram (Figure 2) showed no abnormal Q wave and normal sinus rhythm. A treadmill exercise tolerance test showed no ischemic change on the electrocardiogram. The patient was in New York Heart Association functional class II. As the examination results did not contraindicate pregnancy, therefore, the patient had undergone a Prolactin-inhibitor bromocriptin. After 3 months of treatment the patient was pregnant and she has been under anticoagulant therapy (Aspirin, low molecular weight heparin) since the primary weeks of gestation. The antenatal check up and the course of pregnancy were normal. In the 37 weeks pregnancy and after a multidisciplinary decision (obstetrician, cardiologist and anesthesiologist), elective caesarean section

was made under epidural anesthesia, and done after aspirin arrest seven days before. Heparin was discontinued 6 hours before the section began and restarted 8 hours after delivery was completed. Surgery proceeded uneventfully and a healthy baby boy (weight 2.7 Kg) was delivered with Apgar scores of 8 and 10 at 1 and 5 min respectively. The postoperative follow up was normal. Subcutaneous administration of low molecular weight heparin was continued during puerperium.

Figure 1 : Echocardiography showing neither dilated nor hypertrophic left ventricular. Left ventriculography showed a reserved left ventricular function (ejection fraction = 57%),

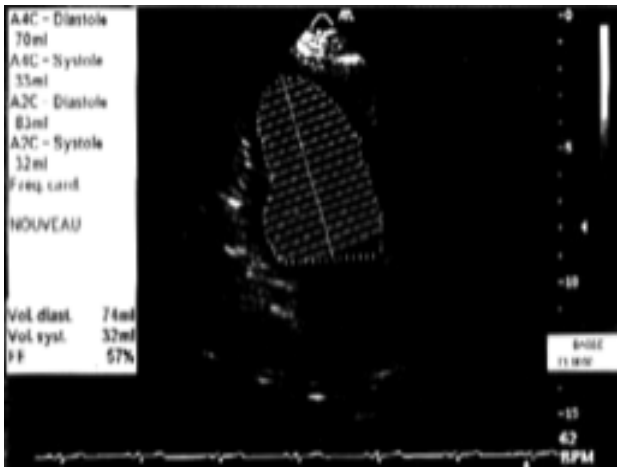
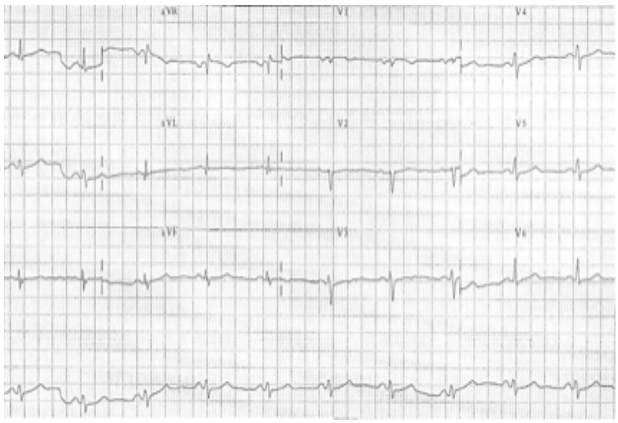


Figure 2: Electrocardiogram: normal sinus rhythm.



Conclusion

Kawasaki disease is rare where cardiovascular consequences could be fatal. Pregnancy and delivery in patient with coronary artery lesions caused by Kawasaki disease is rarely reported in the literature. However, there is no guideline to handle theses cases. For optimal outcome, a multidisciplinary team should manage those cases individually.

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Métastase mammaire d'un mélanome malin

Le mélanome cutané est une tumeur maligne développée aux dépend des mélanocytes. Il s'agit de la tumeur cutanée maligne la plus fréquente et la plus sévère, représentant 3% des cancers chez la femme [1]. Son incidence augmente rapidement. Le taux de mortalité est inférieur à 1% en l'absence de métastase [2]. L'évolution métastatique se fait vers les ganglions lymphatiques de drainage immédiat, vers des sites lymphatiques ou cutanés intermédiaires entre la lésion cutanée initiale et le premier relais ganglionnaire ou encore vers des sites à distance entrainant des métastases. Il s'agit surtout de métastases pulmonaires, médiastinales, cérébrales, hépatiques et osseuses et rarement surrénaliennes, thyroïdiennes, pancréatiques et cutanées. Le mélanome malin métastase exceptionnellement au sein.

Nous rapportons un cas inhabituel de métastase mammaire secondaire d'un mélanome se manifestant après 7 ans d'évolution de la tumeur primitive et s'associant à des localisations secondaires multiples.

Observation

Madame LF , âgée de 50 ans, ménopausée à l'âge de 49 ans, aux antécédents de mélanome supra labial opéré à deux reprises en 2001 et en 2003, s'était présentée en Janvier 2008 avec une symptomatologie faite d'une lombosciatique de type S1 d'horaire inflammatoire évoluant depuis 4 mois dans un contexte d'altération de l'état général avec un amaigrissement chiffré à 7 Kg, asthénie importante et anorexie. L'examen a noté un état général moyen et un rachis lombaire douloureux et raide. Les radiographies du rachis ont montré un aspect hétérogène du corps vertébral de la 4ème vertèbre lombaire. L'examen tomodensitométrique a confirmé le tassement malin de L4 et montré trois nodules parenchymateux pulmonaires, un foie secondaire et un nodule splénique suspect (figure 1). Par ailleurs, il existait au sein droit un nodule de 2 cm de grand axe siégeant au quadrant inféro-externe sans adénopathie satellite.