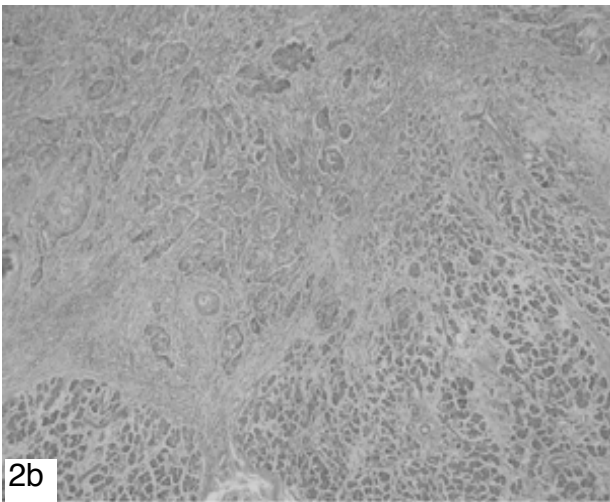




Conclusion

L'association synchrone cancer rénal à cellules claires et adénocarcinome pancréatique a été rarement rapportée dans la littérature. La prise en charge thérapeutique dépend du stade tumoral de chaque cancer alors que le pronostic dépend essentiellement du stade de la lésion pancréatique et de sa réponse au traitement.

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Combined lumbar plexus and sciatic nerve block in hip arthroplasty with severe ankylosing spondylitis

Ankylosing spondylitis (AS) is defined as an inflammatory arthritis of the spine always involving the sacroiliac joints. Later, higher levels of the spine become involved, spinal mobility becomes restricted and gross deformities may develop as kyphosis. A high risk of difficult intubations and severe neurological complications may be observed during anaesthesia (1). So, the AS patient's anaesthesia present a challenge to the anaesthetist and ask to define an anaesthetic strategy before the intervention day. We report in this observation, the successful anaesthetic and postoperative analgesic management of total

hip arthroplasty using a combined lumbar plexus and sciatic nerve block associated to a propofol general anaesthesia in patient with a severe AS.

Observation

Miss Nourra B.J, 44 year old female patient, 59 kg, 160 cm with severe AS antecedent admitted for total hip replacement. The exam found a severe limitation of flexion, extension and rotation of the neck with a thoraco kyphosis and a very limited lumbar spine motion (figure.1).

Figure 1: Thoraco kyphosis profile



Mouth opening was normal. The hard and soft palate and the part of the uvula were visible (Mallampati class II). Lateral Radiograph of cervical spine showed a stiffness of the cervical spine, ossification of the anterior longitudinal ligament and bony bridges of the inter vertebral spaces (figure 2).

Figure 2: Lateral radiography of cervical spine



A lateral Radiograph of lumbar spine showed a bony fusion of the adjacent lumbar vertebrae (figure 3).

Figure 3: Lateral Radiograph of lumbar spine



The clinical and radiological images suggested a difficult intubation and a high risk of neuraxial anesthesia failure. Biological parameters were normal. After obtaining oral patient consentment, it was decided to attempt a regional anaesthesia with an awake fiberscope tracheal intubation followed by an intravenous narcosis with propofol. Standard cardiovascular and respiratory monitoring was used. Blocks of lumbar plexus and sciatic nerve were performed in awake patient. The Patient was positioned in Sim's position. Supplemental oxygen was provided. Posterior approach was used for lumbar plexus and parasacral approach for the sciatic nerve block. The lumbar plexus and sciatic nerve were localised using a nerve stimulator (plexygon*-Aryon-Vygon Italia) connected to an 21 G, 100mm insulated needle (Vygon*- France). Successful needle placement near lumbar plexus was indicated by the quadriceps muscle contraction and knee extension and near the sciatic nerve by plantar flexion, with a current intensity lower than 0.5 mA. Mixture of isobaric bupivacaine 0.5% (12 ml) and lidocaine 2% (12 ml) were injected in single shot for either nerve block. 15 min after the second nerve bloc and to have made sure of the motor and sensitive block installation, the regional anaesthesia was followed by the intravenous (iv) 0.5 mg atropine bolus administration and a light sedation fiberscope nasotracheal intubation under 70 mg propofol iv sedation. After check of the good place of the probe, induction was performed with intravenous propofol (2 mg.kg⁻¹). Anaesthesia was maintained with continuous propofol (3 mg.kg⁻¹.h⁻¹). The patient did not receive any opiates drug during operative period. Mechanical ventilation (VT: 7 ml.kg⁻¹, RF: 12c.min⁻¹ - N20/2 with FiO2: 0.5) was performed. The narcosis end has been at 30 min before extubation and the last atracrium injection was done 60 min before extubation. The intervention and anaesthesia duration were of 105 and 150 min, respectively. Surgery, anaesthesia and extubation were uneventful. The motor and sensory block durations were of 375 min and 510

min, respectively. The patient didn't need morphine as postoperative analgesia. The postoperative analgesia was assured by combined lumbar and sciatic bloc and intravenous Perfalgan (3g/24h) during the first postoperative day then relieved the following days by the oral form. Visual analogue scale (VAS) was all along the postoperative stay lower to 30 mm. The patient was discharged after five days without any complications.

Conclusion

The combined lumbar plexus and sciatic nerve blocks may be a reasonable option for anaesthesia and postoperative analgesia for lower leg surgery in patients with AS. This anaesthetic procedure was used to avoid the potential risk of neuraxial anaesthesia complications as epidural haematoma and respiratory depression of opioids.

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Anévrisme de la crosse de la grande veine saphène simulant une hernie crurale

Les anévrismes veineux (AV) sont des lésions rares, comme en témoignent des cas isolés rapportés dans la littérature. Ils peuvent survenir à tout âge et toucher tout le système veineux. Les membres inférieurs constituent la localisation la plus fréquente. Les AV se présentent généralement sous forme d'une masse des tissus mous posant ainsi un problème de diagnostic différentiel [1, 2].

Le but de cette étude est de souligner l'importance à connaître cette pathologie qui a été source de confusion avec une hernie crurale.

Observation

Madame S.T. âgée de 52 ans, hypothyroïdienne sous traitement substitutif, a consulté pour une masse crurale droite évoluant depuis 4 ans, augmentant progressivement de volume et devenue douloureuse. L'examen a mis en évidence une masse crurale droite de 5 cm de diamètre molle, compressible, non battante et non soufflante. Elle augmentait de volume en position debout et s'affaissait en décubitus dorsal, et elle était expansive à la toux. Il existait par ailleurs des varices réticulaires de la face postérieure de la cuisse. La patiente a été admise au service de chirurgie viscérale avec le diagnostic