En per opératoire, la cavité péritonéale était propre, l'intestin grêle n'était pas identifiable sauf la dernière anse iléale. Une large perforation au niveau de la charnière recto colique qui a été traitée par une résection colique segmentaire très courte emportant la perforation avec anastomose colo rectale latéro-terminale manuelle sur bandelette par un surjet au PDS 3 /0. Par ailleurs, mise en évidence d'une hernie para duodénale gauche dans laquelle toute la masse du grêle s'est incarcérée, le sac se situe sous le mésocolon descendant, son collet est bordé par la veine mésentérique inférieure. Le grêle est repéré par transparence sous un feuillet péritonéal au niveau du mésocolon descendant dont l'ouverture nous permet de réduire le grêle puis fermeture de l'orifice para duodénal ménageant la veine et l'artère mésentériques inferieures. Les suites opératoires sont simples.

Conclusion

La fréquence des hernies internes est faible, 2% des occlusions intestinales. Il convient cependant d'y penser devant un tableau d'occlusion haute en l'absence d'antécédents chirurgicaux abdominaux et de hernie extériorisée. Il existe un nombre important de variétés de hernies internes et seule une exploration minutieuse de l'abdomen menée méthodiquement à partir de la dernière anse iléale jusqu'à la première anse jéjunale permettra d'en faire le diagnostic et d'en préciser le type. Une fois le diagnostic de hernie para-duodénale gauche est posé, la réparation chirurgicale s'impose vue le risque accru d'occlusion, estimé à 50%. Le principe basic de la réparation est la réduction de la hernie et la fermeture du défect par des sutures non résorbables, pour les grosses hernies non réductibles, il convient d'élargir l'orifice herniaire toujours dans un plan a-vasculaire.

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Primary pulmonary carcinosarcoma

Carcinosarcoma (CSA) of the lung is a rare malignant tumor characterized by a biphasic histopathological pattern of both epithelial and sarcomatous components [1]. It is estimated to account for only 0.2%–0.4% of all pulmonary neoplasms [2]. In the WHO classification of lung tumors, it is included in the group of poorly differentiated non-small cell lung carcinomas that contain a component of sarcomatoid differentiation, so called sarcomatoid carcinoma [1, 3]. There are strong associations with smoking and asbestosis. It can be divided into endobronchial and peripheral categories. In the endobronchial type, coughing and blood-tinged sputum usually occur; peripheral tumor are asymptomatic. The diagnosis is made through histopathological evidence. The prognosis is poor; a two years survival after surgical resection is not greater than 10% [3].

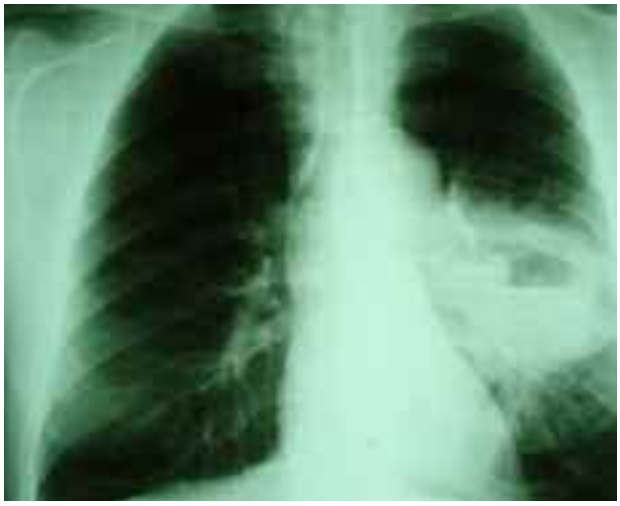
The aim of this study was to report three cases of carcinosarcoma of the lung.

Case-reports:

Case 1:

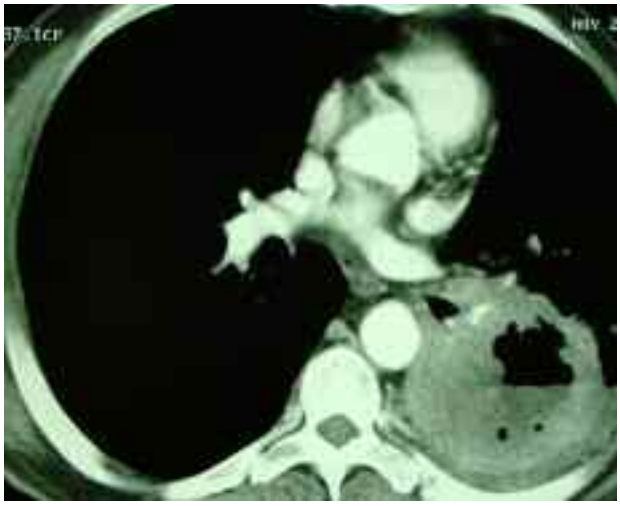
A 71-year-old man with a history of 52 years of cigarette smoking and a precious history of alcohol complained from chest pain, cough, hemoptysis and weight loss. Physical examination was normal. A chest x-ray showed an ill defined, heterogeneous mass in the left lower lobe, measuring 11 cm, with air-fluid level [Fig 1].

Figure 1: Chest x-ray: ill defined, heterogeneous mass in the left lower lobe, with air-fluid level.



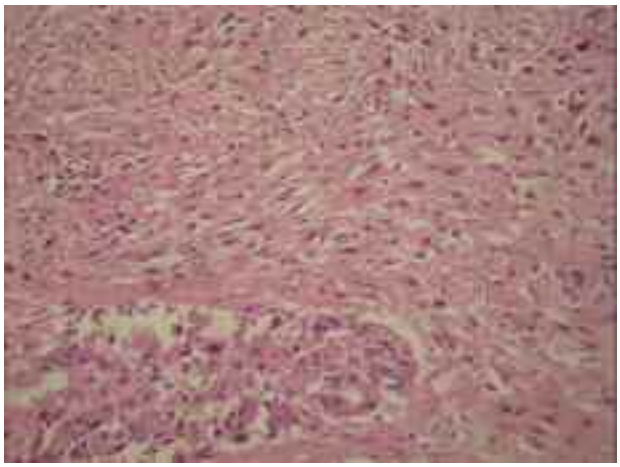
No pleural or pericardial effusions were noted. A chest computerized tomography (CT) revealed a largely excavated and invasive mass [Fig 2]. A bronchoscopy revealed an infiltration of the Nelson. A microscopic examination of the biopsy specimen concluded to a non small cell carcinoma. A CT of the head and bone scan revealed no metastasis.

Figure 2: Chest computerized tomography (CT): largely excavated and invasive mass.



He subsequently had a thoracotomy with a left pneumonectomy. Gross pathologic findings consisted in a pneumonectomy measuring 22 x 17 x 4 cm which comported at 1,2 cm of bronchial section a partially necrotic tumor, measuring 9 x7,5 x 5 cm with a tan-white appearance. It infiltrated the pleural surface which seems thickened. Histological examination revealed an infiltrating neoplasm with a biphasic pattern with epithelial and sarcomatous components [Fig 3].

Figure 3: Pathological examination (HEx100): biphasic histopathological pattern consisting of both epithelial and sarcomatous components



The carcinomatous component showed predominantly adenocarcinoma with foci of squamous cell differentiation. The sarcomatous component showed specific heterologous tissues, such as rhabomyosarcoma and osteosarcoma [Fig 4a]. The tumor involved the pleural surface and regional lymph nodes. Immunohistochemical study revealed that the epithelial component expressed the Cytokeratin antigen [Fig 5a] while, the sarcomatous component expressed Vimentin antigen and the rhabdomyosarcomatous component was marked by the Desmin antibody [Fig 5b]. According to these findings, a final diagnosis of pulmonary carcinosarcoma was made. The pathological stage was therefore T3N1M0 or Stage IIIA. The patient died within a four -month follow-up period.

Figure 4a: Pathological examination (HEx400): microscopic sections showing osteosarcoma
Figure 4b: Pathological examination (HEx400): Microscopic sections showing chondrosarcoma.

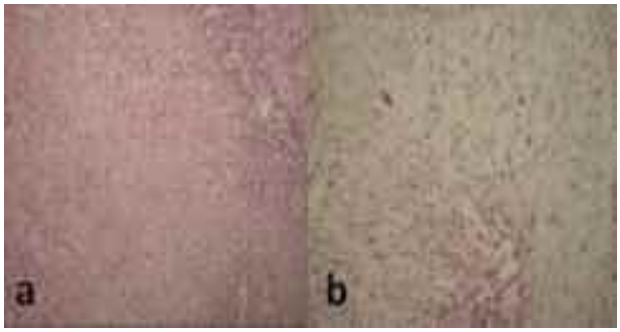
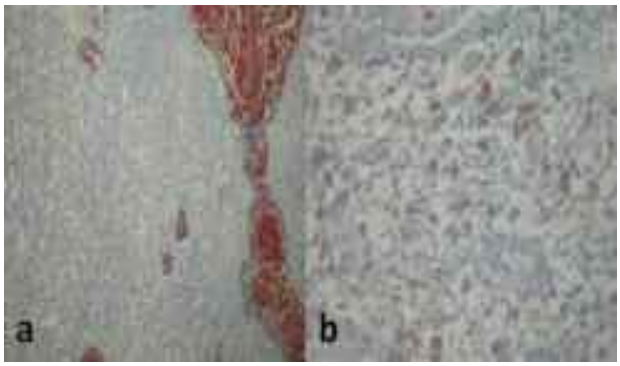


Figure 5a: Immunohistochemical staining: the epithelial component was cytokeratin-positive
Figure 5b: Immunohistochemical staining: the rhabdomyosarcomatous component was desmin-positive



Case 2:
A 47-year-old-man with a history of 25 years of cigarette smoking presented to the hospital with chest pain, dyspnea, anorexia and fever. Physical examination and bronchoscopy examination were normal. A chest X-ray showed an excavated, rounded opacity in the left upper lung. Thoracic ultrasound showed a parenchymal mass with wall thickening without images evoking hydatid membranes. Chest CT revealed a heterogeneous mass measuring 9 cm with no distant metastasis. Possible differential diagnosis suggested pulmonary abcess or carcinoma. Thus, surgery was undertaken and a lobectomy was performed. Intra operatively, the tumor was adherent to the mediastinal artery. Its infiltration was suspected from the frozen section and therefore a left pneumonectomy was performed. Macroscopically, the tumor was largely necrotic, measuring 8

cm and consisting of whitish soft heterogeneous tissue. Routine light microscopy revealed a biphasic pattern comprising of predominant squamous cell carcinoma along with sarcomatous stromal elements. The latter comprised of pleomorphic cell exhibiting a malignant cytomorphology with areas of chondromatous differentiation [Fig 4b]. The tumor infiltrated the parietal pleura and the wall of the pulmonary artery that is blocked by numerous tumor emboli. Regional lymph node metastasis was detected. The pathological stage was therefore T4N1M0 or Stage IIIB. The patient consequently underwent three cycles of chemotherapy. He died within a three-month follow-up period after the occurrence of brain metastases.

Case 3:

A 65-year-old woman, who was followed for an interstitial pneumonia, since one year. During the follow-up, we discovered a well-defined, homogeneous mass shadow, in the left upper lung in the chest-X-ray. Chest CT revealed a solid parenchymal mass. The bronchoscopic examination showed inflammatory bronchial system with purulent discharge. Cerebral CT scan was normal. A thoracotomy with a left upper lobectomy was performed. Macroscopically, the surgical specimen consisted in a lobectomy measuring 17x13x2 cm including a yellowish-white tumor measuring 6x8x4 cm. The frozen section concluded to a non small cell carcinoma. Routine light microscopy showed a diffuse proliferation of spindle-shaped tumor cells intermingled with areas of a poorly differentiated adenocarcinoma. Chondrosarcoma component was observed within the spindle-cell component of the tumor. It infiltrated the visceral pleura and the regional lymph nodes. Immunohistochemical study showed that the sarcomatous component expressed Vimentin antigen. The diagnosis of pulmonary carcinosarcoma was established, and the clinical stage was estimated to T3N2M0 or IIIa stage. The patient didn't receive postoperative chemotherapy and died after 8 months of follow up.

Conclusion

Pulmonary CSA have a worst prognosis than conventional non-small cell carcinomas. The median survival time was 17 months and the 2-year survival rate was 38.5%. Their diagnosis is challenging and is based on microscopic study. The treatment of choice is complete resection with a clear margin [4].

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L'hémangiome caverneux : Une cause d'hématurie chez l'enfant

L'hémangiome caverneux est une tumeur vasculaire bénigne apparentée aux hémartomes uniques ou multiples, se développant probablement à partir de reliquats embryonnaires de cellules angioblastiques. Cette entité est très rare et constitue à peine 0,6% des tumeurs vésicales. Cependant son diagnostic peut être facilement établi par la cystoscopie.

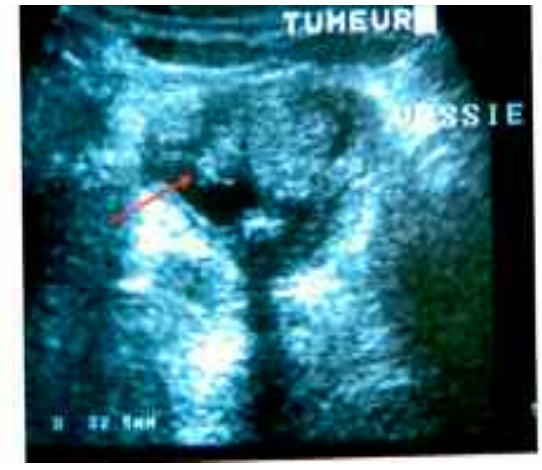
Le but de ce travail est de rapporter trois cas diagnostiqués dans le service d'urologie de l'hôpital Charles Nicolle de Tunis.

Observations

Observation 1 :

Une fille âgée de 3 ans sans antécédents a été admise dans le service en juin 1996 pour hématurie totale caillotante isolée avec anémie sévère à 4,6g/dl. L'échographie abdominale (Figure 1) a objectivé une formation vésicale hétérogène remaniée et peu vascularisée occupant la quasi-totalité de la vessie.

Figure 3: Pathological examination (HEx100): biphasic histopathological pattern consisting of both epithelial and sarcomatous components



L'uroscanner a confirmé les données échographiques en montrant la présence d'un processus tumoral avec épaississement circonférentiel de la paroi vésicale sans autre