caused acute large bowel obstruction. On this admission, the patient complained of acute abdominal pain, and vomited a stay of materials and gases. Physical examination revealed a prolapsed ileostomy of 15 cm (Figure 1). At this level a few black spots were observed. A peristomal circular incision was made under general anesthetic. Exploration revealed gangrene of the ileo-cecal junction (Figure 2) contained between the two walls of small bowel (Figure 3) associated with ascites of great abundance. An ileo cecal resection was performed with refashioned of an ileo-colostomy. The postoperative course was uneventful. The patient died seven months following her operation.

Figure 1 : Intra operative photograph shows a prolapsed ileostomy

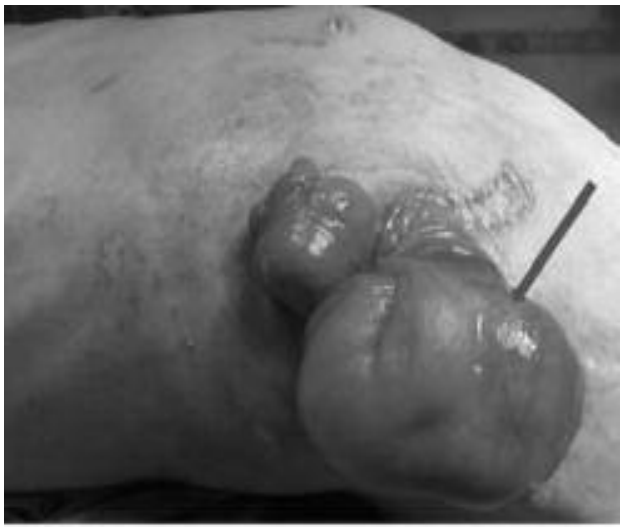


Figure 2: The specimen with superficial ulceration at its apex

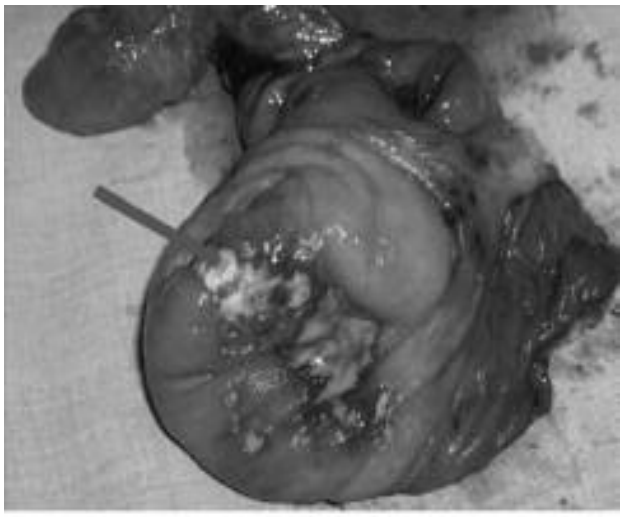
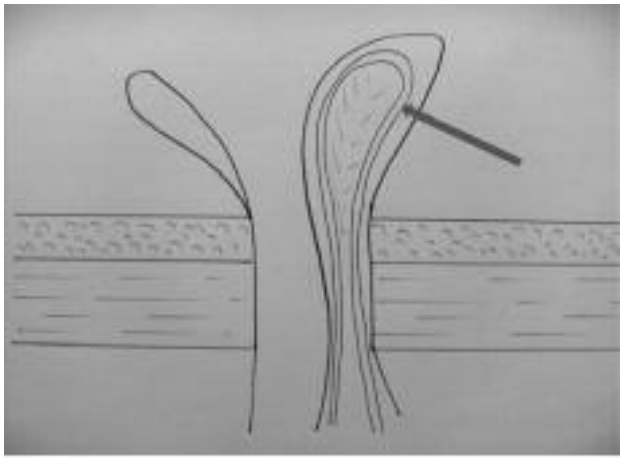


Figure 3 : Sagittal section through prolapsed ileostomy.



Conclusion

The making of an ostomy is a surgical procedure relatively easy. Only respect for these principles is the guarantee of a low complication rate.

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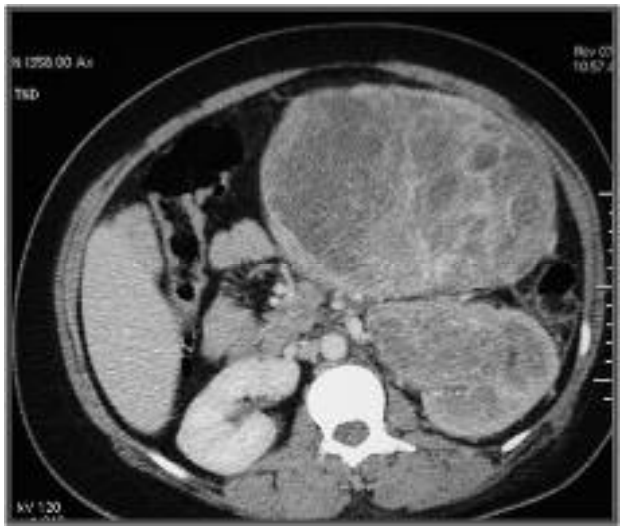
Renal epithelioid angiomyolipoma

Renal angiomylipoma (AML) is a benign tumor, combining fat, smooth muscle and abnormal vessels, with a variable proportion and fat predominance, which gives it a pathognomonic CT scan appearance. Radiological surveillance seems to be sufficient, in most cases. Surgical treatment, often conservative, is indicated in symptomatic or large (more than 4 cm) tumors. Development of AML is slow and dominated by the risk of bleeding. When AML is monotypic, ie one of its major cellular components predominates, radiological diagnosis becomes impossible; immunohistochemical study is basic to diagnose this rare form [1]. Despite the large size they can achieve, the possibility of bilaterality, the multiplicity of lesions and regional lymph involvement, the malignant potential of these tumors has not been yet demonstrated. However, in recent years, an epithelioid variant has been

described and characterized by its aggressive behavior, difficult histological characterization and poor prognosis.
We present a case of primary renal epithelioid angiomyolipoma with diagnostic difficulties and management.

Case report
We report the case of a 38-year-old woman, with no past medical history, who presented with a 6-month history of left lumbar pain, with progressive swelling of the left hemi-abdomen, without hematuria. Evolution has been marked by the exacerbation of pain and the onset of unencrypted fever. Physical examination found fever, conjunctival pallor and a tender abdominal mass extending from the left hypochondrium to the iliac fossa ipsilateral.
Biologically, there were leukocytosis, high C - reactive protein and normochromic normocytic anemia; renal function was normal. Thoraco-abdomino-pelvic scan showed a voluminous retroperitoneal tumor, reaching the pelvis, arising from the lower pole of the left kidney or invading it, of tissue density, and which is heterogeneously enhanced, with several foci of necrosis (figure 1).

Figure 1: Abdominal CT scan, cross section: tissue mass occupying the left hemi-abdomen. It is lobed, heterogeneous, and may arise from the left kidney.



There were no other tumor sites. Given the diagnostic uncertainty, a percutaneous biopsy has been performed. Though, histological study was not conclusive because of hemorrhagic and necrotic foci. The pathologist has rather evoked an angiosarcoma. The final decision was to perform a surgical removal of the mass, and this after arteriography and arterial embolization. Arteriography showed that the tumor was mainly vascularized by two left lumbar arteries, and partially by left renal artery. An embolization of these three arteries was achieved. During the operation, we found a left renal mass with retroperitoneal expansion, descending to the pelvis and adhering closely to left mesocolon. En bloc resection of the tumor, the left kidney and the descending colon was performed, with restoration of digestive continuity (figure 2). No postoperative complications were detected. Histological study concluded to a subcapsular epithelioid renal tumor, with prominent muscular component, without cytonuclear atypia (figures 3, 4 and 5). Immunohistochemical study showed that cells express markedly actin and HMB45, and do not express cytokeratin, vimentin and CD34. Thus, the diagnosis of epithelioid monotypic renal AML could be confirmed. Our patient received no additional treatment. She is alive and well, with no evidence of local or remote recurrence, 3 years after initial diagnosis.

Conclusion
AML is conventionally regarded as a benign tumor whose diagnosis is easy and evolution is slow. It is a rare entity which can mimic renal cell carcinoma, leading to a radical treatment. Indeed, the limited means to correct preoperative diagnosis and the malignant potential of this tumor justify this attitude. Clinical and radiological postoperative surveillance is necessary.

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Infiltration graisseuse diffuse et primitive du pancréas : une cause rare d'insuffisance pancréatique exocrine.

L'infiltration graisseuse du pancréas est une pathologie rare et bénigne. Elle est parfois constatée chez l'adulte et est généralement secondaire à une obstruction du wirsung par des calcules, un cancer ou une sténose malformative et dans ces cas, elle prédomine en amont de l'obstacle (1). Elle survient également aux stades avancés de la mucoviscidose (2), chez le diabétique âgé et obèse et peut aussi s'intégrer dans un syndrome dysmorphique, notamment, le syndrome de Johanson-Blizzard et le syndrome de Schawchman (3, 4). Elle est le plus souvent asymptomatique de découverte fortuite. Dans de rares cas, elle devient massive, source d'insuffisance pancréatique exocrine, se révélant par une stéatorrhée (5). Le diagnostic de certitude repose sur les explorations radiologiques qui montrent des anomalies caractéristiques, une confirmation histologique est inutile.
Nous rapportons une cause inhabituelle d'insuffisance