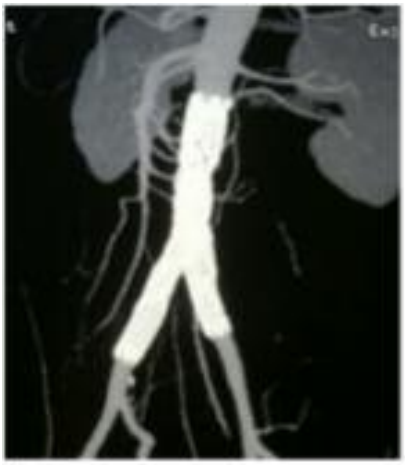
Le bilan étiologique a conclu à une maladie de Behçet. Cet AAA se prêtait bien à une cure endo-vasculaire avec un collet proximal aortique long de 30 mm malgré l'existence d'une artère polaire inferieure et des axes iliaques rectilignes et de calibre satisfaisant. Nous avons posé chez ce patient jeune présentant un anévrisme compliqué de l'aorte abdominale l'indication d'une cure endovasculaire. Quarante huit heures avant l'intervention, le patient a reçu une cure à base d'Endoxan. L'intervention a été menée sous anesthésie générale, après abord chirurgical des deux scarpa, nous avons mis en place une endoprothèse couverte aorto-bi iliaque (Excluder ; Gore). L'angiographie per opératoire a montré l'exclusion complète de l'anévrisme. Les suites opératoires étaient simples, le séjour total a été de 72 heures. Le patient a été gardé par la suite sous corticoïdes associés à un traitement immuno-suppresseur au long cours et suivi régulièrement en médecine interne. Les contrôles scannographiques réalisés à 6 et 12 mois ont montré l'absence de complication évolutive (Figure 4) et la biologie a montré un contrôle correct de l'inflammation.

Figure 4 : Contrôle scannographique au 12ème mois



Conclusion

Les anévrismes aortiques représentent la complication la plus grave et la plus létale au cours de la maladie de Behçet. La chirurgie est grevée d'une mortalité non négligeable et d'une morbidité élevée dominée par les complications anastomotiques. Le traitement endovasculaire constitue une bonne alternative lorsque les conditions anatomiques sont favorables avec de très bons résultats à court terme, des études plus larges sont nécessaires pour évaluer le long terme. Une surveillance et un traitement immunosuppresseur prolongés restent toujours indispensables.

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Cutaneous metastatic Crohn's disease of the abdominal wall: an exceptional location

Cutaneous metastatic Crohn's disease is an uncommon extraintestinal cutaneous manifestation of Crohn's disease. It is defined as sterile granulomatous skin lesions arising at sites discontinuous from the gastrointestinal tract (1). This entity is characterized by its heterogeneous behavior, both in its localization and clinical expression. It can be present without other digestive symptoms. Anatomopathologic examination is required to confirm the diagnosis. Lesions usually have a predilection for skin folds, infra-mammary area and the limbs. Abdominal involvement was not previously described. There are no treatment guidelines and various therapeutic strategies have been employed, with variable response (2). We report a very rare case of metastatic Crohn's disease affecting the abdominal wall in a 51-year-old man with longstanding ileo-colic Crohn's disease.

Case report

A 51-year-old man was admitted to our hospital for abdominal papulo-nodular eruption, resistant to antibiotics. The patient had Crohn's disease, with ileal and colonic involvement, which was diagnosed 33 years ago when he underwent right ileo-colectomy for enterocutaneous fistula. Histopathology of the resected specimen confirmed Crohn's disease. Since diagnosis was made, he has had episodes of diarrhea and mild abdominal discomfort promptly resolved with symptomatic treatment. He had family history of Crohn's disease, in both brother and sister; one of them was spontaneously in remission for several years. The skin lesion was localized in lower abdominal wall, at the right side of the umbilicus. The nodule was unique, painless, infiltrated and ulcerated (Figure 1).

There were neither clinical nor radiologic or endoscopic signs of the disease when the cutaneous manifestation occurred. Biology tests were all within the normal range, especially there was no inflammatory biological syndrome. A computed-tomography scan of the abdomen was performed and denied intra-abdominal abcesses or enterocutaneous fistula. It had shown two nodules: one of them was intra peritoneal, measuring 14×9 mm. The other was localized within the abdominal wall, and measured 21×22mm. Both of the lesions were enhanced in arterial phase, suggesting in this context, granulomatous lesions (Figure 2). The patient received a biopsy of the skin lesion.

Figure 1: Skin lesion

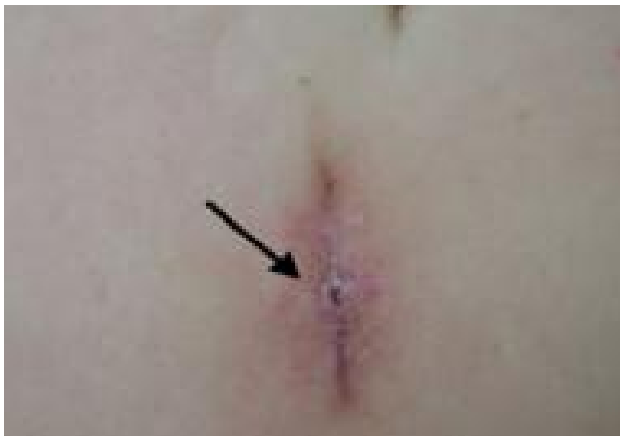
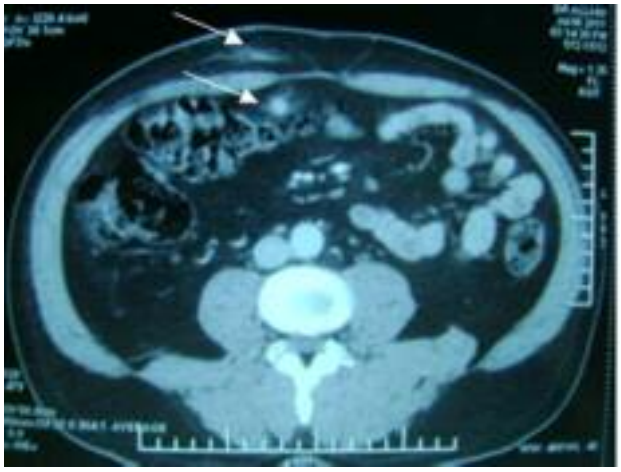


Figure 2: CT feature: Intraperitoneal and parietal nodules enhanced in arterial phase.

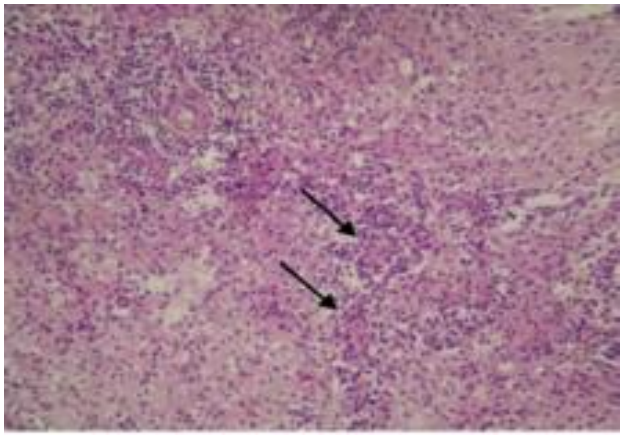


The pathologist reported the biopsy to represent a chronic non caseating granulomatous lesion consistent with a diagnosis of metastatic Crohn's disease: Histological haematoxylin and eosin sections demonstrated chronic inflammation of the dermis with admixed epithelioid and giant cell granulomas. There was no caseation *(Figure 3)*.

Furthermore, there was an absence of fungi, staining for acid and alcohol fast bacilli were negative, and birefringent foreign bodies were not seen. There were no signs of malignancy. These appearances were reported as consistent with cutaneous Crohn's disease.

During this period, the patient received no specific treatment, as the skin lesion has been spontaneously improved. After two months of follow-up, the skin lesion has lost more than 50% of its initial size without any medication.

Figure 3: Skin biopsy (x10 objective, haematoxylin, and eosin stain) showing a chronic inflammatory cell infiltrate with noncaseating epithelioid and giant cell granulomas.



Conclusion

Cutanuous metastatic Crohn's disease is extremely rare and abdominal involevement seems to be exceptional. The diagnosis may be relatively easier in patients with established Crohn's disease compared to those where the skin lesions precede bowel involvement or occur in patients in remission. In our patient, main differencial diagnosis was peritoneal carcinomatosis since it was a longstanding disease. Histology remains the gold standard tool to make diagnosis. Therapeutic options are still lacking for codification.

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Blunt trauma causing horseshoe kidney rupture: Interest of conservative management

The horseshoe kidney is a rare condition, with an estimated incidence of 2.5‰ in the general population. Males are twice more frequent affected than females (1, 2) and are more common during the 3rd and 4th decades of life. One-third to one-half of all patients with horseshoe kidney is asymptomatic, and it is found incidentally during the study of other pathologies or following an acute abdominal trauma (1, 3). This congenital