Conclusion

Sarcomatoid carcinomas of the bladder present as high-stage malignancies and exhibit aggressive biologic behavior, regardless of the treatment employed. The pathologic stage appears to be the best prognostic factor; however, more cases with longer clinical follow-ups are needed to determine if certain histologic features can predict even more aggressive biologic behavior. The optimal treatment is uncertain. Because of the rarity of this variant of urothelial carcinoma with poor prognosis, there are currently no reports to support the use of different therapeutic approaches other than cystectomy and chemoradiation, as for locally advanced conventional urothelial carcinomas. Presently, the histologic recognition of this variant is therefore more important for predicting prognosis than for tailoring therapy.

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A case of mature teratoma of the douglas

Lefkowitch et al described the first dermoid cyst of the Douglas pouch in 1978 [1]. During early fetal development, there is migration of germ cells from the yolk sac along the hindgut toward the genital ridge [1]. If the germ cells become arrested in their migration between the yolk sac endoderm and the dorsal mesentery then, as the paramesonephric ducts fuse in the midline, they may become trapped in the retrouterine pouch of Douglas [1-6]. Ushakov et al. [7] mentioned that autoamputation of an ovarian dermoid cyst was the most common etiology of omental teratomas. In the present case the tumor had no apparent feeding vessel, which could make it a candidate for a cyst autoamputated from other intraabdominal organ. We found only six cases in the English literature [1-6], making this the seventh. We believe this to be the first report of a benign cystic teratoma of the Douglas pouch in a man. We reviewed and summarized the findings from reported cases of mature teratoma of Douglas as indicated in the English literature, as well as presenting the findings from our case (see Table 1).

The aim of this study is to report a new case of a benign cystic teratoma of the Douglas.

Observation

A 55-year-old man, presented to the outpatient clinic with lower abdominal pain. On admission, the patient's vital signs were within normal limits and physical examination revealed no specific abnormal findings. Pelvic examination was normal. Abdominal ultrasound showed a heterogeneous cystic mass measuring 2*2 cm in the Douglas. Abdominal computed tomography confirmed the presence of the tumor, and showed calcifications in its wall (Figure 1).

Figure1: Abdominal computed tomograph scan demonstrated a heterogeneous mass in the Douglas (arrow). This mass contained a central necrosis and calcifications in its wall.

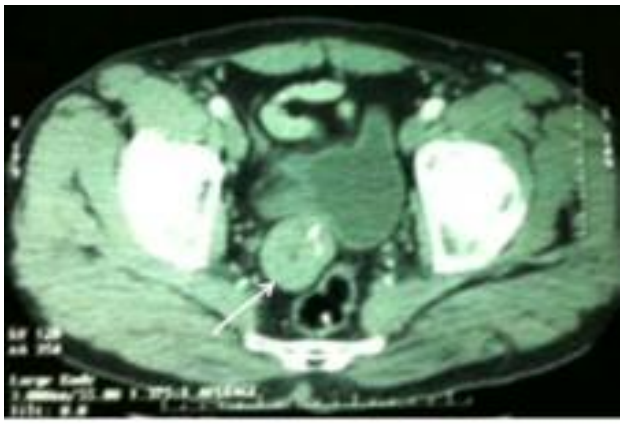


Table 1. Up-to-date review of cases of mature teratoma of Douglas.

Case n	Source	Age (sex)	Symptoms	Size (mm)	Therapy
1	Lefkowitch et al (1) 1978	29 (female)	Urinary retention	50	Excision (Laparotomy)
2	Turhan et al (2) 2000	30 (female)	Fortuitous	50	Excision (Laparoscopy)
3	Chen et al (3) 2004	61 (female)	Lower abdominal pain	45	Excision (Laparoscopy)
4	Kobayashi et al (4) 2006	61 (female)	Lower abdominal pain	200	Excision (Laparotomy)
5	Khoo et al (5) 2008	29 (female)	Fortuitous	40	Excision (Laparoscopy)
6	Bartlett et al (6) 2009	29 (female)	Fortuitous	80	Excision (Laparoscopy)
Present case	Makni et al 2011	55 (male)	Lower abdominal pain	20	Excision (Laparoscopy)

Figure 2: Operative photograph showing a well circumscribed tumor of 2*2 cm in the Douglas.

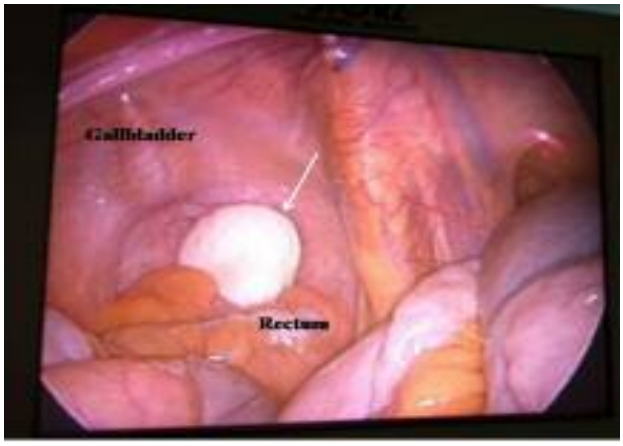
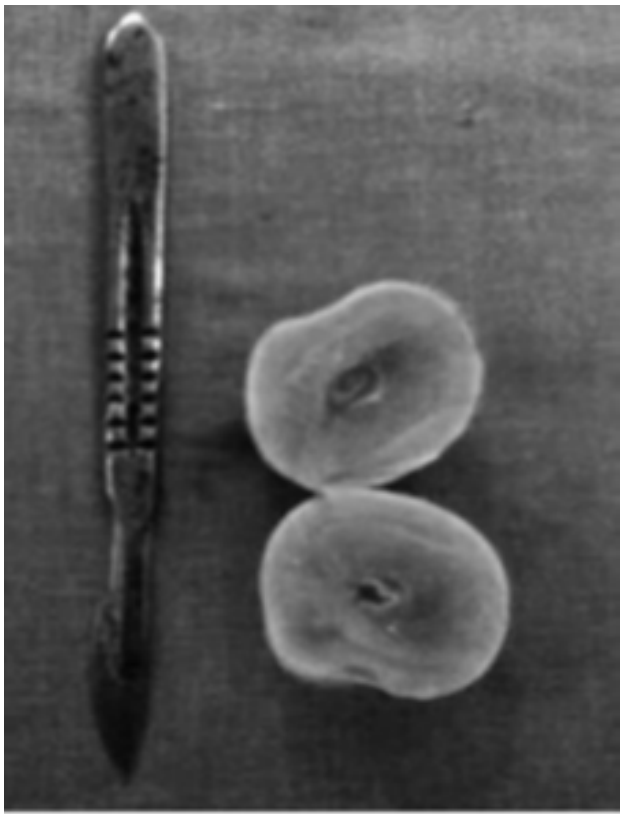


Figure 3: The specimen photograph showing a cyst entirely covered with a fibrous and firm capsule and filled with an amorphous white creamy substance.



We chose laparoscopic examination instead of laparotomy. During laparoscopy, a well circumscribed tumor of 2*2 cm was found in the cul-de sac (Figure 2). This mass had adhered with filmy adhesions to the peritoneum of the Douglas pouch. The mass in the cul-de-sac was resected. The resected tumor in the cul-de-sac was a cyst entirely covered with a fibrous and firm capsule and filled with an amorphous white creamy substance and hair-like material. Focal ossification was noted (Figure 3). A histopathologic evaluation determined that it was a benign mature cystic teratoma. No malignancy was found. The patient had an uneventful postoperative course.

Conclusion

Laparoscopy is a safe and effective method of managing teratoma of the Douglas, provided preoperative assessments are suggestive of a benign tumour.

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Median arcuate ligament syndrome: a rare cause of recurrent abdominal pain

The median arcuate ligament syndrome (MALS) (or celiac artery compression syndrome) was first described in 1963 by Harjola [1]. It is a rare disorder resulting from extrinsic compression and narrowing of the celiac artery by the arcuate ligament. This anatomical anomaly may result in partial obstruction of blood flow through the celiac artery and its distributary vessels due to its compression and tethering during respiration [2]. The MALS is a controversial entity because the clinical manifestations are often nonspecific, and isolated compression of the celiac trunk is relatively common in asymptomatic individuals [3]. In symptomatic patients, the external compression of the celiac artey leads to a wide range of symptoms that mimic those of mesenteric ischemia, including abdominal pain, diarrhae, and weight loss [4]. A firm diagnosis is difficult to establish, and is based on clinical and radiological findings, after a thorough gastrointestinal evaluation. Treatment is equally challenging, and is based on a variety of surgical modalities. Few cases were reported in the past twenty years