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

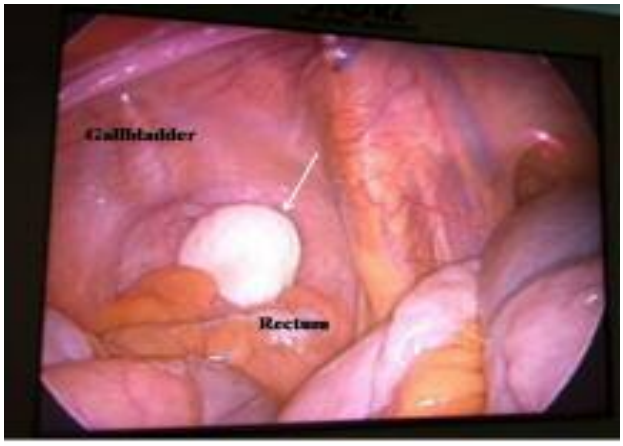
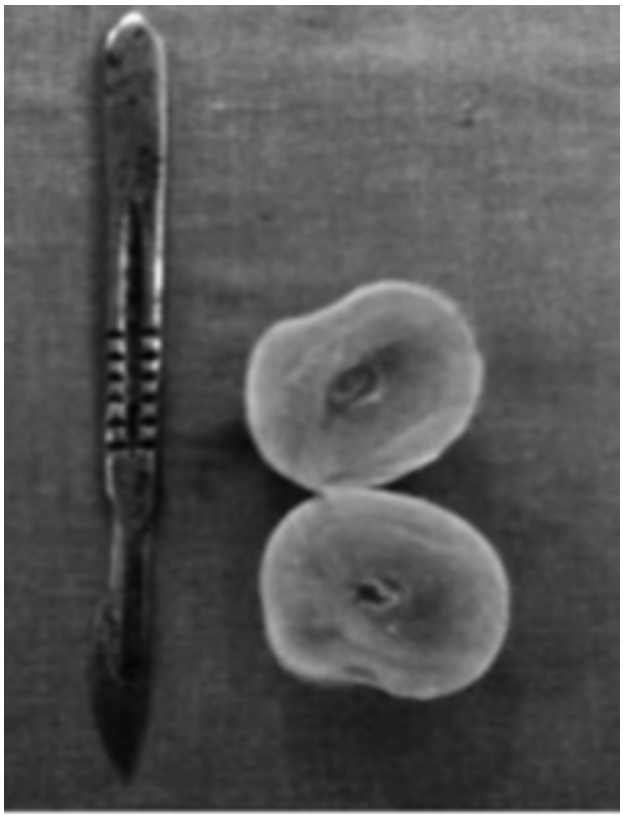


Figure 3: The specimen photograph showing a cyst entirely covered with a fibrous and firm capsule and filled with an amorphous white creamy substance.



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

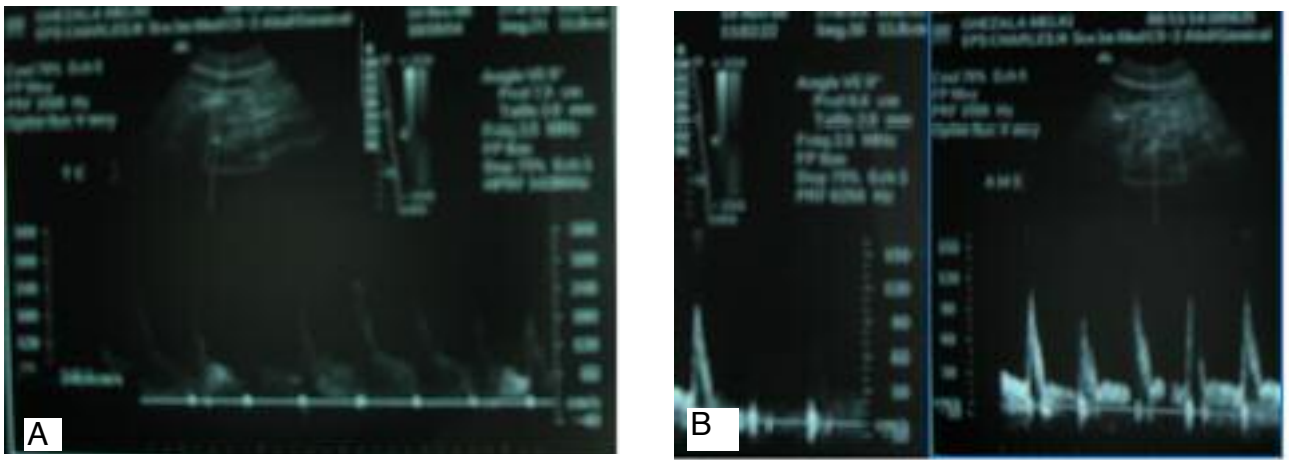
The median arcuate ligament syndrome (MALS) (or celiac artery compression syndrome) was first described in 1963 by Harjola [1]. It is a rare disorder resulting from extrinsic compression and narrowing of the celiac artery by the arcuate ligament. This anatomical anomaly may result in partial obstruction 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

[5]. Through this case of MALS in a 58 year-old-woman, we highlight the physiopathology of the syndrome, the clinical and radiological approach to establish the diagnosis of this rare entity.

Case report:

A 58 year-old-woman presented with a history of recurrent post prandial, peri umbilical abdominal pain over a two year period. Pain started 30 minutes after meals and lasted for two hours, it did not respond to analgesics. This was associated with diarrhea three to four times per day, and loss of body weight of 20 kilograms in the two years due to fear of eating and inappetance. No nausea nor vomiting were reported. The patient's medical history included insulin depending diabetes, hypertension and dyslipidemia. She was not smoking or consuming alcohol. Abdominal examination was unremarkable, with no audible bruit, mass or hepatosplenomegaly. Laboratory investigations revealed normal value of complete and differential blood count, serum albumin, Thyroïd Stimulating Hormone (TSH) and Free Thyroxine (FT4), liver enzymes and calcemia, except a disturbance in the lipid and glucose samples. The patient underwent upper and lower gastrointestinal endoscopy, abdominal ultrasound, all of which were normal. Under the suspicion of ischemic bowel disease because of the risk factors of atherosclerosis, a doppler US was performed. It showed a celiac axis stenosis, an increased blood flow (Figure 1a, b) and an atherosclerotic aorta. A CT angiography pointed out a focal narrowing in the proximal celiac axis estimated at 95% (Figure 2a, b, c).

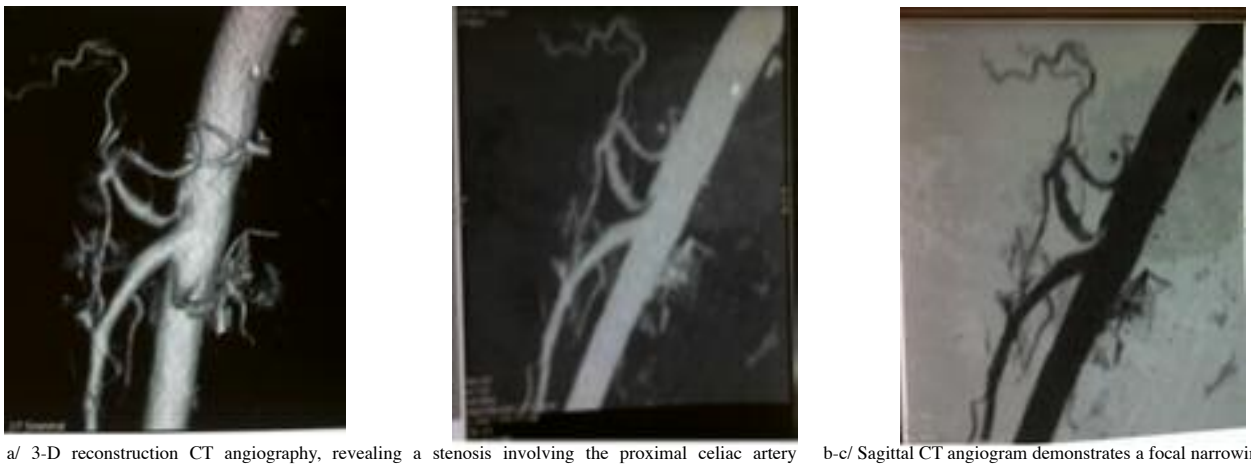
Figure 1 (a/b) : Doppler ultrasound demonstrating an increased blood flow of the celiac artery (240,6cm/sec)(a), in contrast to a normal blood flow of the superior mesenteric artery (b) , on expiration



Doppler ultrasound demonstrating an increased blood flow of the celiac artery (240,6cm/sec)(a), in contrast to a normal blood flow of the superior mesenteric artery (b) , on expiration

Figure 2 (a/b/c) : a/ 3-D reconstruction CT angiography, revealing a stenosis involving the proximal celiac artery compatible with median arcuate ligament syndrome

b-c/ Sagittal CT angiogram demonstrates a focal narrowing in the proximal celiac axis, creating a hooked appearance.



a/ 3-D reconstruction CT angiography, revealing a stenosis involving the proximal celiac artery compatible with median arcuate ligament syndrome

b-c/ Sagittal CT angiogram demonstrates a focal narrowing in the proximal celiac axis, creating a hooked appearance.

Surgical treatment was indicated but the patient refused. To date, the patient has been symptom free for two years, because of dietary modification and symptomatic treatment including vessel dilator. Surgery therefore became unnecessary.

Conclusion

Median arcuate ligament syndrome is a controversial entity. It should be included in the differential diagnosis of chronic abdominal pain, weight loss, and diarrhoae especially in young patients, after a thorough investigation. Diagnosis of MALS is based on clinical symptoms and radiological findings, using doppler ultrasound and CT angiography. The goal of treatment is to relieve the extrinsic compression of the celiac artery.

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Tachycardie fœtale supra ventriculaire

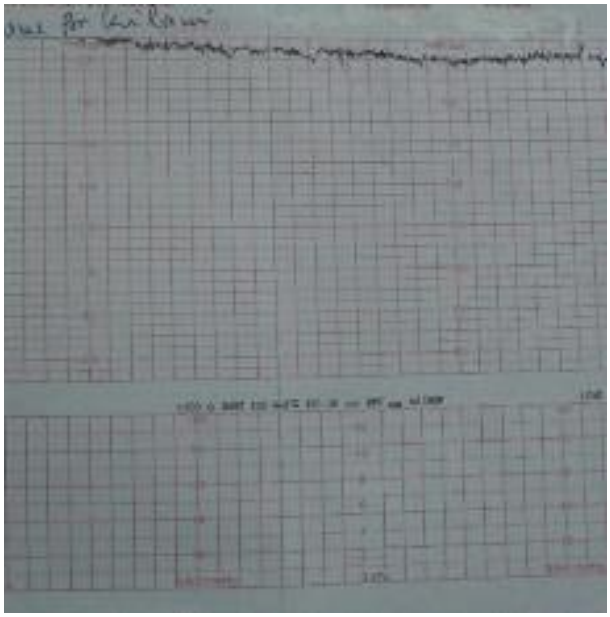
La tachycardie fœtale supra ventriculaire (TSV) est une arythmie grave définie par un rythme cardiaque fœtal supérieur à 180 battements par minute (bpm). Elle est à l'origine de 4,3 à 12,4 % des anasarques fœtaux non immunologiques [1,2] et d'une morbidité et mortalité fœtale et périnatale non négligeable : 60 % des cas [3]. Cette pathologie constitue un modèle de Médecine fœtale grâce aux différentes thérapeutiques anti-arythmiques efficaces administrées à la mère ou directement au fœtus [4].

Nous rapportons l'observation d'une TSV avec anasarque fœtale traité in utéro avec succès par la digoxine.

Observation

Mme X primipare, âgée de 35 ans, de groupe sanguin O Rhésus positif .Elle s'est présenté à un terme de 35 SA à notre consultation prénatale. La parturiente n'avait pas d'antécédents familiaux ou personnels pathologiques ainsi que son mari. Le suivi de la grossesse était jusqu'au la normal, sa dernière consultation remontait à 28 SA. L'examen clinique trouvait une hauteur utérine (HU) excessive par rapport au terme (HU = 34 cm), les pôles fœtaux étaient mal perceptibles et l'auscultation des bruits du cœur fœtaux trouvait un rythme très accéléré, incomptable par sa rapidité. L'enregistrement du rythme cardiaque fœtal trouvait un rythme de base à 200 bpm aréactif (Figure 1). L'échographie obstétricale objectivait une grossesse mono fœtale évolutive avec un hydramnios et une anasarque fœtale (épanchement pleural bilatéral, épanchement péricardique minime, une ascite et une hydrocèle bilatérale). La morphologie cardiaque était par ailleurs normale avec une fréquence cardiaque de 210 bpm. L'étude du reste de la morphologie fœtale paraissait sans anomalies.

Figure 1 : Enregistrement du rythme cardiaque fœtal avec un rythme de base à 200bpm.



L'échographie cardiaque fœtale couplée au doppler a confirmé le diagnostic de TSV à l'origine de l'insuffisance cardiaque et de l'anasarque foeto-placentaire.

L'origine immunologique de l'anasarque a été éliminée par le groupe sanguin de la mère rhésus positif et le test de coombs indirect (TCI) négatif. Le dépistage de diabète est revenu négatif. A la recherche d'une étiologie de la tachycardie fœtale; l'interrogatoire précis n'a pas trouvé la notion de prise médicamenteuse durant la grossesse (β mimétiques, atropine). La numération formule sanguine a éliminé une anémie maternelle. Le bilan thyroïdien était normal ainsi que les sérologies infectieuses (syphilis, toxoplasmose, rubéole, herpès) qui sont revenues négatives. L'examen cardiovasculaire maternel pré thérapeutique et l'électrocardiogramme sont revenus sans anomalies. Un traitement in utéro, à base de digoxine, à la dose de 0,5 mg/j a été débuté sans tarder. Le rythme cardiaque fœtal s'est ralenti à J4 du traitement. Il est devenu stable et régulier à 140 bpm. Après 7 jours de la normalisation du rythme cardiaque fœtal, la disparition complète de l'anasarque a été constatée à l'échographie, la