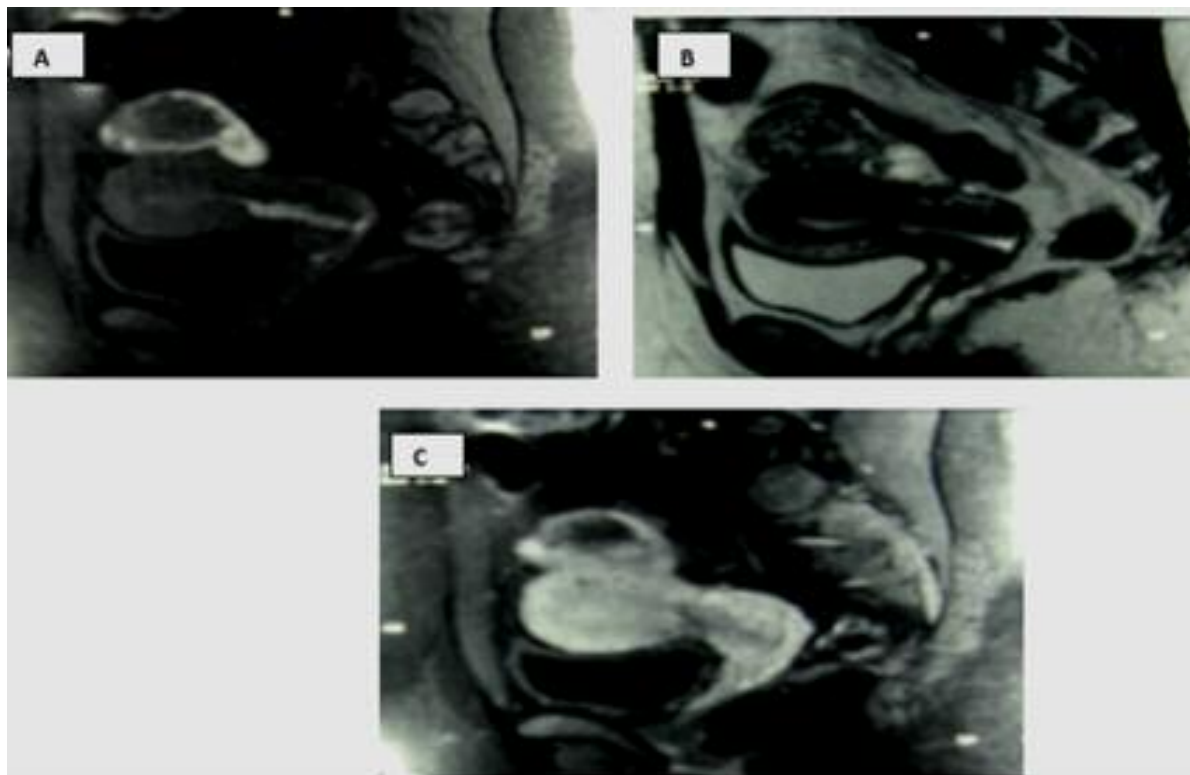


**Figure 2 :** Aspect en IRM de l'hématocèle : (A) en pondération T1, (B) en pondération T2 : image multiloculaire à doubles composante avec prédominance du contenu hémorragique, (C) prise de contraste périphérique après injection.



L'annexe gauche était d'aspect normal. L'ovaire droit était aussi normal tandis que la trompe droite était boudinée et à son incision on a objectivé un saignement ancien caillouté. Le traitement a consisté à une salpingectomie droite avec ablation de l'hématocèle et une toilette péritonéale. Une ablation de l'implanon a été pratiquée au même temps. L'examen anatomopathologique a confirmé la présence de tissu trophoblastique aussi bien au niveau tubaire ainsi que dans la masse dans le douglas (hématocèle enkysté). Les suites opératoires ont été simples et la patiente est sortie à J2.

### Conclusion

L'implanon reste un moyen contraceptif efficace. Ni notre cas ou celui décrit au paravent ne peut remettre en question cette efficacité, mais ca incite le clinicien à être attentif et savoir évoquer le diagnostic d'une grossesse ectopique sous cette contraception.

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### Internal iliac vein thrombosis: a rare and multifactor complication in Crohn's disease

Thromboembolic complications during the course of inflammatory bowel disease are frequent. They are mainly found in young patients and are associated with a high morbidity and mortality (1). The etiopathogenesis of these complications has been widely debated and the existence of coagulation alterations and fibrinolysis has been suggested (1). Iliac vein thrombosis is rarely reported in inflammatory bowel diseases (2). Control of the inflammatory process is thought to be the key factor in risk reduction for thrombotic events. Prophylactic use of anticoagulants is not universally

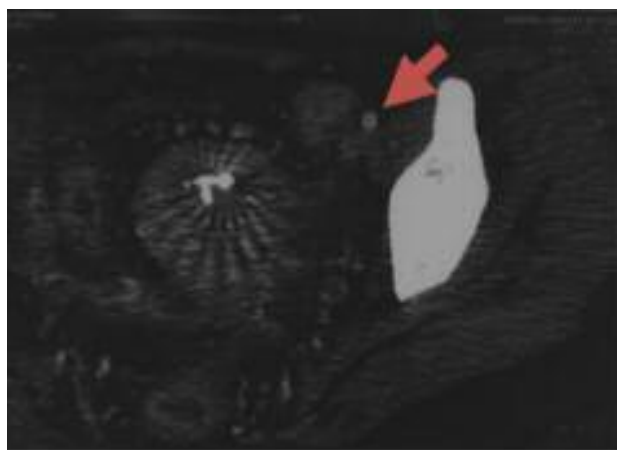
recommended, but possible use should be reviewed in an individual patient after evaluation of the risks, such as hemorrhage, compared to potential benefits (3).

We report here a case of 35-years old woman with Crohn's disease and internal iliac vein thrombosis and heparin induced thrombopenia.

### Case report

A 35-years old woman, with no familial or personal history of inflammatory bowel disease, was hospitalized for diarrhea more than 6 bloody stools daily with abdominal pain which was predominant in pelvic region. She was not smoker and was not at any contraceptives. On presentation, the initial physical examination found an axillary's temperature of 38° C, tachycardia to 100/min, pallor conjunctiva, hypogatric sensitivity on abdominal palpation. Laboratory tests found an inflammatory process with sedimentation rate of 102 mm/h and C reactive protein 35mg/l. Complete blood count revealed anemia with hemoglobin of 8g/dl, platelet of 500000/mm<sup>3</sup> and normal white blood count. Albuminaemia was 24 g /l. Colonoscopic examination showed evidence of active colitis with ulcers and erosions in all colonic segments with patchy distribution of lesions. The ileum was normal. Histopathological examination of colonic biopsy specimens showed local irregularities in the crypts, cryptitis, lymphoplasmocytic and neutrophil leucocytic infiltrations in the lamina propria with feature of epithelioid granuloma. Bacterial and viral superinfections were ruled out and initial abdominal CT not found any intra abdominal abces but found a regular thickening of the entire colon with infiltration of against fat and the presence of a left internal iliac vein thrombosis (Figure 1). I

**Figure 1:** CT-scan showing internal left iliac thrombosis



In the etiologic framework of pelvic thrombosis, the gynecological examination of the patient was normal and thrombophilia screen including protein S, protein C activity, antithrombin III activity, lupus anticoagulant and factor V Leiden mutation was negative. Homocysteine level was normal.

We perform a lower-limb ultrasound to rule out a deep-vein thrombosis which was normal. The patient was treated with first line intensive treatment, based on absolute parenteral nutrition, corticosteroids intravenously at a dose of 1mg/Kg/day and low molecular weight heparin (LMWH) at an hypocoagulative dose. The evolution was marked by clinical and biological improvement in the seventh day of treatment allowing the switch to oral corticosteroids and the association, of warfarin. Otherwise, on the tenth day of treatment with LMWH (and the third day of warfarin), laboratory screening test found a thrombocytopenia at 98000/mm<sup>3</sup> with NRI of 3. Heparin was, so, strongly incriminated and the diagnosis of heparin induced thrombopenia (HIT) was strongly suspected. Repeated doppler ultrasonography demonstrated no evidence of lower limb thrombus and normal blood flow in the left internal iliac vein. So we decide to stop LMWH but warfarin was continued and platelet count returned to normal on the fourth day of discontinuation of LMWH. Two months after the diagnosis, repeated colonoscopy showed completely normal macroscopic findings. Prednisolone was tapered slowly and azathioprine (1.5 mg/kg/day) was prescribed. Three month after the diagnosis patient was already on warfarin and azathioprine treatment with clinical remission.

### Conclusion

Our patient developed a symptomatic form with combined risk factors for the development of thrombosis which were active Crohn's disease, treatment with high doses corticosteroid and heparin induced thrombopenia. The particularities of our case are the site of the thrombosis and the HIT developed after LMWH prophylactic therapy which constitutes an additive risk factor needing a specific management. Our patient developed initially iliac vein thrombosis before LMWH treatment and was successfully management with improving the inflammatory process.

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### Concha bullosa pyocele

Concha bullosa, a pneumatized middle turbinate, is a common anatomic variant found in the paranasal sinuses. Its incidence varies from 14 to 53% (1). When a concha bullosa becomes obstructed, it can form a mucocoele and, eventually, a