Six months later, follow-up computed tomography scanning with contrast was performed and showed persistent small aneurysms. Azathioprine was switched to cyclophosphamide. After a two-year follow-up period, the patient returned to our clinic asymptomatic and serial control scans show no aneurysm formation.

Conclusion

Pulmonary artery aneurysms (PAA) are reported to indicate poor prognosis and high mortality. CT of the chest and angiography are the most common diagnostic procedures used in the diagnosis or evaluation of PAA. Immunosuppression is the main therapy for the treatment of PAA in BD and should be associated to embolisation. Anti-TNF factors are indicated in case of unresponsiveness to immunosuppressive drugs.

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Urinary peritonitis caused by gangrenous cystitis

Gangrenous cystitis (GC) is an uncommon but it is life threatening condition that ranges in severity from necrosis of the mucosa and submucosa to necrosis of the entire bladder wall (1). With the widespread use of antibiotics, only sporadic cases have been reported in the recent literature (2). The aetiology of this condition is probably multifactorial and it is difficult to identify a unique cause (3,4). Presenting symptoms are usually non-specific, and accurate diagnosis may be extremely difficult (2,3,5,6). Upon suspicion, CTscan is very helpful in the establishment of correct diagnosis (2,5). As soon as the diagnosis is made, treatment should be early and aggressive. The removal of all necrotic tissues is mandatory (4,6).

Herein, we report on a rare case of urinary peritonitis secondary to GC, and support it with a brief survey of the literature on this topic.

Case report

A 36-year-old man was admitted to the emergency intensive care unit with a diagnosis of acute peritonitis. His past medical records did not indicate any major illness except chronic alcoholism.

During 3 days, the patient complained of severe abdominal pain, abdominal distension, nausea, vomiting, total hematuria and many episodes of urinary retention.

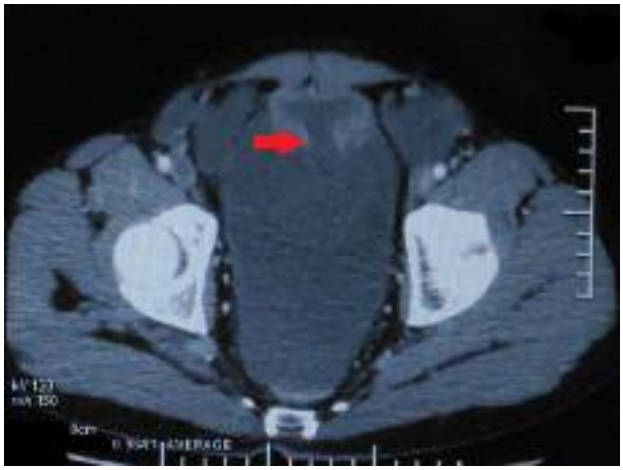
Physical examination revealed board-like stiffness and rigidity of the abdominal wall, with absence of bowel sounds. He was hypothermic (36,6°C). In addition, he has tachycardia (104 beats per min) and tachypnea (26 breaths per minute). An urethral catheter was inserted into the bladder. It drained residual bloody urine mixed with debris.

Blood analysis indicated high leukocytes count (18,000 wbc) with normal Hb (11.3g/dl) and platelets (467000/mm^3) levels. Hepatic and pancreatic blood analysis revealed high values of (AST/ ALT: 81/36 UI/L, amylasemia: 166 U/L, lipasemia > 10 x nl, CRP: 176.6 mg/l, prothrombin ratio: 79%, Quick's time: 35.2 s and INR: 1.16). Blood urea nitrogen was 2.67 g/l, creatinine was 103 mg/l and electrolytes values were also abnormal: Na/K: 123/6.4 meq/l. necessitating two hemodialysis sessions.

Urinary analysis showed pyuria, and culture was positive for *Escherichia coli*.

The abdominal X-ray showed multiple hydroaeric shadows in the small intestine, without free gas below the diaphragm. The computer tomography scan showed dilated small intestinal loops, without apparent obstruction of the passage of the bowel contents. Besides, bladder overdistension was confirmed with bladder rupture of about 12 mm in length (Figure 1).

Figure 1 : CT Scan: Bladder overdistension with bladder rupture (arrow)



Diagnosis of urinary peritonitis due bladder perforation secondary to bladder over distention then was suspected. The explorative laparotomy revealed generalized acute peritonitis, with 1100 ml serous exudate in the abdominal cavity, and dilated intestinal loops covered by multiple fibrous coatings. The detailed revision established marked, dark greenish, necrosis and perforation of the bladder wall, which was the main cause for the peritonitis. There was no extensive necrosis in the area of Retzius or in the retroperitoneal space. As only 4 cm of the bladder dome looked necrotic, an extensive

debridement and partial cystectomy was performed with cystorraphy. Bladder suprapubic and transurethral drainage were performed as well as abdominal and Retzius drainage.
Histological examination confirmed necrosis of the bladder mucosa and the smooth muscle layers. Postoperative follow-up was uneventful, with primary healing of the operative wound. Three days post-operatively, his renal, hepatic and pancreatic functions returned to their normal values.
The suprapubic catheter was removed on the 4th day postoperatively and a urethral catheter has been left in place for 2 weeks.
The patient was treated by intravenous antibiotherapy with ciprofloxacin (800 mg/day), cefotaxime (3g/day) and metronidazole (1500 mg/day) for two weeks with good recovery.
He left the hospital on the 15th day post-operatively.
At 3 months postoperatively urine was clear and he voided only once during the night.

Conclusion
GC is a rare and dramatic condition. Severe urinary peritonitis caused by gangrene of the bladder may be a main clinical presentation. Preservation of the bladder should be tried if possible. We firmly believe that only immediate and intensive treatment, including total excision of the necrotic tissue, can guarantee a favourable outcome.

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Systemic lupus erythematosus and psoriasis: A new case

Psoriasis is a common reason for consultation in dermatology. It is a chronic dermatosis progresses in spurts whose prevalence is estimated at 2.8%. Systemic lupus erythematosus (SLE) is an autoimmune disease with highly variable clinical expression of unknown cause in which occur genetic factors, endocrine, immunological and environmental factors. The combination of SLE and psoriasis is thought to be unusual (1).

Case report
A 29-year-old woman, without notable medical history, consulted for fever, asthenia, rash of the face, arthralgia and Raynaud's syndrome lasting for 2 weeks before admission. The examination objectified a malar rash, temporal alopecia, a scalp psoriasis and arthritis in his right knee. The blood count showed a normochromic normocytic anemia at 10.5 g / dl, lymphopenia at 1300/mm3 and thrombocytopenia at 60000/mm3. The immunological results showed positive ANA at 1 / 320, anti DNAn positive at 180 IU / ml and Ac anti Ro positive. The skin biopsy revealed a granular immunofluorescence of the dermo-epidermal: IgG +, IgM +, IgA + in pathological zone and C4 + + in healthy zone. The diagnosis of SLE is held before 5 ARA criteria and diagnosis of psoriasis is chosen after considering dermatological specialist. The patient was treated by corticosteroids at 1mg/Kg/day for the thrombocytopenia and progressively degreased. She was treated also by hydroxychloroquin (Plaquenil®) at 6.5 mg/Kg/day. The association of méthotrexate was discussed, but not used. The evolution was favorable with a decline of 2 years.

Conclusion
Although rare, the association lupus - psoriasis deserves to be known given the pathogenic and therapeutic problems it raises.

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Association rare : amylose non AA et sarcoïdose révélée par un angiomyxome agressif du pelvis

L'angiomyxome agressif est une tumeur mésenchymateuse rare caractérisée par le risque important de récidive locale et le faible potentiel métastatique. Elle atteint préférentiellement la femme en période d'activité génitale et se développe principalement dans la région pelvienne (1,2). A notre connaissance, aucune affection n'a été décrite en association avec cette tumeur. En particulier, aucun cas d'association d'angiomyxome agressif, d'une sarcoïdose et d'un syndrome de Sjögren (SS) n'a été décrit dans la littérature. Nous en rapportons une observation.