10. Gauchat JF, Henchoz S, Fattah D, et al. CD40 ligand is functionally expressed on human eosinophils. Eur J immunol. 1995;25:863-5
11. Kim SH, Kim TB, Yun YS, Shin JI, Oh IY, Sir JJ et al. Hypereosinophilia presenting as eosinophilic vasculitis and multiple peripheral artery occlusions without organ involvement. J Korean Med Sci.2005;20:677-9
12. Terrier B, Piette AM, Kerob D, Cordoliani F, Tancrède E, Hamidou L et al. Superficila venous thrombophlebitis as the initial manifestation of hypereosinophilic syndrome. Arch Dermatol. 2006; 142:1606-10
13. Ohtani T, Okamoto K, Kaminaka C, Kishi T, Sakurane M, Yamamoto Y. Digital gangrene associated with idiopathic hypereosinophilia: treatment with allogeneic cultured dermal substitute (CDS). Eur J Dermatol. 2004; 14:168-71
14. Oppliger R, Gay-Croisier F, Dayer E, Hauser C. Digital necrosis in a patient with hypereosinophilic syndrome in the absence of cutaneous vasculitis. Br J Dermatol. 2001;144:1087-9
15. Hachulla E, Hatron PY, Janin A, Robert Y, Devulder B. Artérite digitale, thrombose et syndrome hyperéosinophilique: une complication exceptionnelle. Rev Med Int. 1996 ; 16 :434-6
16. Robinowitz M, Virmani R, Mc Allister HA Jr. Spontaneous coronary artery dissection and eosinophilic inflammation: a cause and effect relationship? Am J Med.1982;72:923-8
17. Ferguson GT, Starkebaum G. Thromboangiitis obliterans associated with idiopathic hypereosinophilia. Arch Intern Med.1985;145:1726-8
18. Hamada T, Kimura Y, Hayashi Sh, Nakama T, Hashimoto T. Hypereosinophilic syndrome with peripheral circulatory insufficiency and cutaneous microthrombi. Arch dermatol. 2007;143:812-3
19. Gleich GJ, Leiferman KM, Pardanai A, Tefferi A, Butterfield JH. Treatment of hypereosinophilis syndrome with imatinib mesilate. Lancet; 2002;359:1577-8
20. Kuroyanagi Y, Kubo K, Matsui H, Kagami S, Mari S, Kim HJ et al. Manufacturing and banking system for allogeneic cultured dermal substitutes. Jpn J Burn Injuries.2003;29:28-38
21. Takekawa M, Imai K, Adachi M, Aoki S, Maeda K, Hinoda Y et al. Hypereosinophilic syndrome accompanied with necrosis of finger tips. Intern Med. 1992;31:1262-6

Said Fatma, Kooli Chakib, Azzabi Samira, Boukhris Imen, Cherif Eya, Kaouech Zouleikha, Belhassine Lamia, Khalfallah Narjess
Service De Médecine Interne B, Hôpital Charles Nicolle- Tunis

---

A pyeloduodenal fistula. Report of case

Anatomically, the second portion of the duodenum and the right kidney are in close proximity. Fistulous connections between these two structures can occur, although they are unusual [1]. Few cases are reported in the literature. Spontaneousn nephro-intestinal fistulae are most commonly associated with primary disease of the renal tract [2,3].

Aim
We describe new case of pyeloduodenal fistula and we interest in clinical presentation, diagnosis and therapeutic modalities

Case
A 24 years old woman with a past history of recurrent upper tract infections secondary to an upper ureteric stone for which she had undergone multiple nephrostomies and treated with antibiotics. She presented a pyonephrosis 2 years ago treated with partial nephrectomy. She was admitted to our institution with right lumbar fossa pain with pyuria associated with vomiting but with no disturbance of bowel habit and no pneumaturia abnormal faeculant contents in his urine. Abdominal tenderness has been the only abnormal finding in physical examination. Investigation revealed an anemia of 9.6 g/dl, but white cell count, serum urea, electrolyte and creatinine levels were normal. Computed tomography of the abdomen showed a heterogeneous renal mass with adherent duodenum and air localized in kidney (fig.1). The retrograde urography showed a fistula between a second part of duodenum and the right kidney (fig.2).

Figure.1: heterogeneous renal mass with adherent duodenum

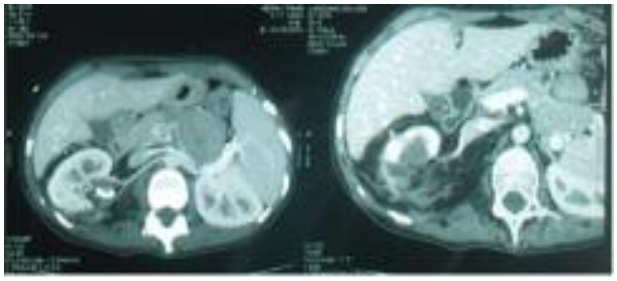


Figure.2: fistula between a second part of duodenum and the right kidney

Surgical intervention was thus instituted and at laparotomy, the fistula between kidney and the second part of duodenum was noted (fig.3). We have done a deconnection of the fistula, nephrectomy was done and the duodenum was closed by separate. Patient's postoperative course was uneventful and she was discharged in the fifth post operative day.

Conclusion:
Spontaneous pyeloduodenal fistulas are extremely rare. Conservative management may be traying in the some selected cases when the renal function is conserved. In the other case the nephrectomy is must be necessary in association with the closure of the fistula

Figure.3: peropertivly view: fistula between kidney and the second part of duodenum

References

1- Pumphrey J D Pyelo-Duodenal Fistula:A Case Report. Annals of Surgery 1963; 158: 260-62
2- Beverley N. Duodenorenal fistula. Pediatr Radiol 2004; 34: 343–347
3- Lang EK, Hanano A, Rudman E Pyeloduodenal fistula diagnosed on parenchymal excretory phase computerized tomography. J Urol. 2010; 184(1):334.

Baraket Oussema, Lahmidi Mohamed Amine, Chaari Mohamed, Feki Med Neji,Moussa Makrem, Sassi Karim, Kort Brahim, Bouchoucha Sami

Department of general surgery. bizerte Hospital. Tunisia
University Tunis El Manar

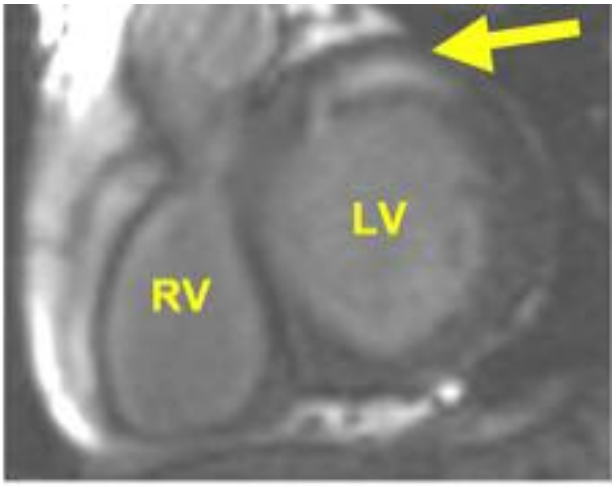
Myocarditis mimicking an acute coronary syndrome.

Myocarditis is an inflammation of myocardium usually secondary to a viral infection. Suspected myocarditis is currently confirmed using advanced non-invasive imaging and histopathologic examination of heart tissue. However, the diverse presentations of myocarditis and the lack of widely available, safe, and accurate non-invasive diagnostic tests remain major obstacles to early diagnosis and population based research(1). The clinical presentation of acute myocarditis is non-specific and mimics more common causes of heart failure and arrhythmias.Nevertheless, it may be difficult to distinguish between myocarditis and an acute coronary syndrome. Our case illustrates the usefulness of cardiac magnetic resonance imaging in such situation.

Case report

We report the case of a 42 years-old smoker man. He was admitted to our cardiology department for prolonged chest pain. Physical examination was normal. Electrocardiogram showed negative T waves in the anterior leads. Troponin dosage was positive. Echocardiography was normal without abnormal wall motion. The diagnosis of Non ST Segment Elevation acute coronary syndrome was considered and the patient received anti-ischemic treatment. Coronary angiogram was normal. A cardiac magnetic resonance (CMR) imaging has been performed. This exam showed a subepicardial late enhacement of the antero-septal wall (figure 1). The diagnosis of myocarditis was finally retained and the anti-ischemic treatment was stopped. After 6-month follow-up, the patient is still asymptomatic.

Figure 1: CMR: short-axis view showing subepicardial late enhacement in the antero-septal wall.
LV: Left ventricule, RV: Right ventricule.



Conclusion

Cardiac MRI is the gold standard for the diagnosis of myocardial infarction. It also allows easily the diagnosis of myocarditis. In some doubtful cases of chest pain, cardiac MRI could be a good alternative, avoiding an invasive strategy (2,3).

References:

1- Elamm C, Fairweather D, Cooper LT. Pathogenesis and diagnosis of myocarditis. Heart. 2012; 98:835-40.
2- Lurz P, Eitel I, Adam J, Steiner J et al. Diagnostic performance of CMR imaging compared with EMB in patients with suspected myocarditis. JACC Cardiovasc Imaging. 2012; 5:513-24.
3- Monney P, Locca D, Muzzarelli S, Hullin R, Jeanrenaud X, Schwitter J. Cardiac magnetic resonance in acute myocarditis: a new non-invasive diagnostic gold standard? Rev Med Suisse 2012 ; 8:1177-83.

Wiissem Sdiri, Dorra Mbarek, Hédi Ben Slima, Salma Longo, Mohamed Rachid Boujnah

Université de Tunis El Manar, Faculté de Médecine de Tunis, 1007, Tunis, Tunisie.
CHU Mongi Slim, Service de Cardiologie, 2046, La Marsa, Tunisie.