Figure 3 : Tumor after surgical resection

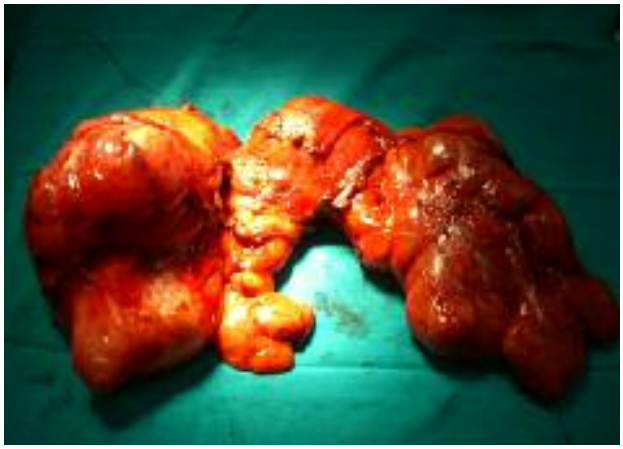
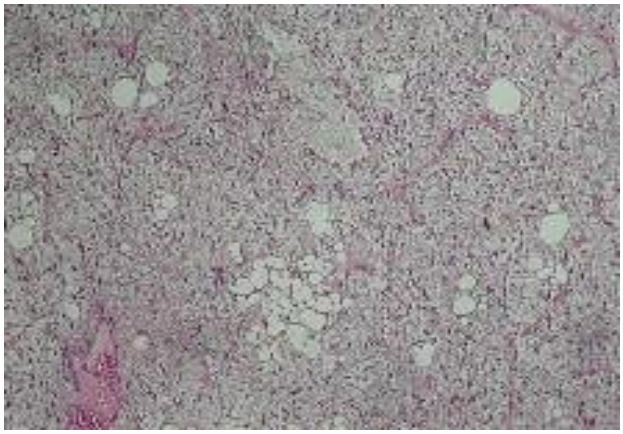


Figure 4 : Histological findings: mixed liposarcoma (well-differenciate/myxoid)



Conclusion

Liposarcoma comprises approximately 20% of all soft-tissue sarcomas and 1% of all cancers. First described by Virchow in 1857, it had been frequently reported in the literature but remains exceedingly rare in the head and neck region. Among pathologic subtypes, pleomorphic and round cell types are most aggressive, with a high risk of local recurrence and distant metastases [4]. Most frequent metastases are pulmonary, pleural, hepatic and node lymphatic [2]. The mainstay of treatment of liposarcomas is surgical excision [5]. In case of cervico-mediastinal localization, surgical resection is more difficult because of anatomic difficulties [6]. This case is particular by the extremely rare location of the liposarcoma in the anterior neck, the medistinal involvement and the easy of the resection despite the malignant nature and the giant size.

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Preoperative clinical diagnosis of an amyand's hernia

Amyand's hernia (AH) is diagnosed by finding the vermiform appendix in a groin hernia. It is a rare disease, named after Claudius Amyand, founder of London's St George's Hospital who was the first to describe the presence of a perforated appendix within the hernia sac (in1735) of an 11 year old boy. AH constituted 1% of all inguinal hernias, whereas only 0.13 % of all cases of appendicitis [1] [2]. Right inguinal hernias are the most frequent sites for the development of AH, although it has also been described on the left side [3]. AH is reported in infants even as young as six weeks [4].

Clinical presentation is variable, it is usually confused with a strangulated inguinal hernia, with torsion of the testis or with epididymo-orchitis [1] [5].

The diagnosis of AH is difficult and it is often discovered only during the operation. Only one case of AH out of 60 could be correctly diagnosed preoperatively from 1959 to 1999 in old male [6].

Clinical diagnosis of AH is very rare. Surgical procedure used depends on the pathology found. The presence of a normal appendix does not require appendectomy, whereas acute appendicitis necessitates appendicectomy with hernial repair. We present such a case of AH discovered pre-operatively at the physical examination in a nine-month-old baby.

Case report

MH, nine- month-old boy was admitted to our Division of Paediatric Surgery with the diagnosis of right inguinal hernia. He was clinically well and had a weight of 10kg. He had no fever.

The physical examination revealed a reducible swelling in the right groin with an appendix seating on the scrotum (fig.1). The surgical exploration of the hernial sac revealed an uninflamed vermiform appendix, caecum within the sac (fig.2).

Figure 1 : Clinical presentation of AH

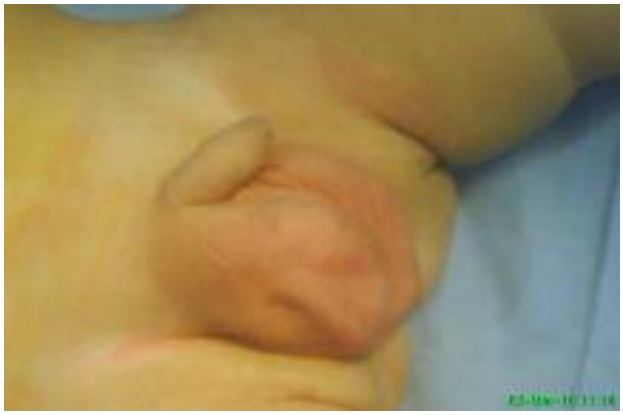
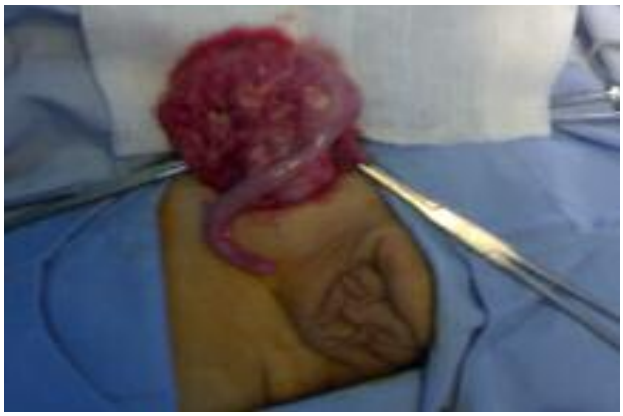


Figure 2 : Operative view of AH



The appendix was reduced into the abdomen and the herniotomy completed with ligation of the sac. The postoperative courses were uneventful.

Conclusion

We are reporting this case for its rarity of occurrence, AH is commonly misdiagnosed as an ordinary incarcerated hernia. In cases of appendical inflammation, treatment consists of a combination of appendectomy and hernia repair.

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Abcès hépatique en rapport avec un hôte inattendu!

Case report

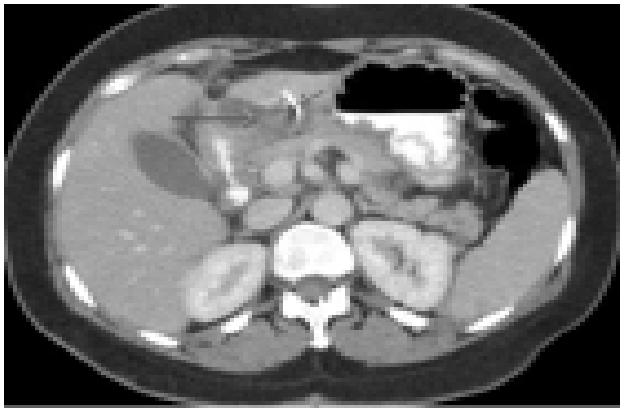
Mr K.S, 68 ans, aux antécédents d'hypertension artérielle sous traitement (Isobar) et d'ulcère duodénal traité médicalement (Inhibiteur de la pompe à proton) -l'interrogatoire n'a pas révélé d'autres antécédents, en particulier; un contage hydatique ou des coliques hépatiques- s'est présenté aux urgences pour douleur de l'hypochondre droit fébrile associée à des vomissements et une asthénie évoluant depuis 4 jours et pour lesquelles il n'a reçu aucun traitement.

L'examen physique à l'admission a trouvé une fièvre à 39 c, un sub-ictère conjonctival et une douleur de l'hypochondre droit avec un signe de Murphy positif et sans signes d'irritation péritonéale.

Le bilan biologique a montré : une hyperleucocytose à 14700 elt/mm3, une CRP à 115mg /l, le bilan hépatique était sans anomalies (pas de cytolyse ni de cholestase).

Une radiographie du thorax ainsi qu'une radiographie de l'abdomen sans préparation ont été sans anomalies. Une échographie abdominale a rapporté : le foie est de dimensions normales, siège au niveau de ses segments III et IV d'une lésion (44mm*46mm) hétérogène avec des zones centrales hypoéchogènes. Abcès hépatique ? Le scanner abdominal a apporté un diagnostic radiologique: abcès hépatique au niveau du segment IV faisant 50mm*42mm, mais la masse semble centrée par une lésion hyperéchogène ?

Figure 1 : Operative view of AH



Le patient a été mis sous antibiotiques à large spectre et a été proposé pour un drainage percutané scanoguidé qui n'a pu ramener que 10 cc de pus verdâtre. L'intervention chirurgicale s'est imposée. On a tenté un abord coelioscopique premier, mais devant la difficulté technique d'effectuer une mise à plat avec un lavage et une exploration complète, on a décidé de