Figure 3 : Photo de la ponction-biopsie du rein (coloration au Trichrome de Masson). Flèche A : Prolifération endo-capillaire Flèche B : Nécrose fibrinoïde Flèche C : Epaississement mésangial Flèche D : Prolifération extra-capillaire

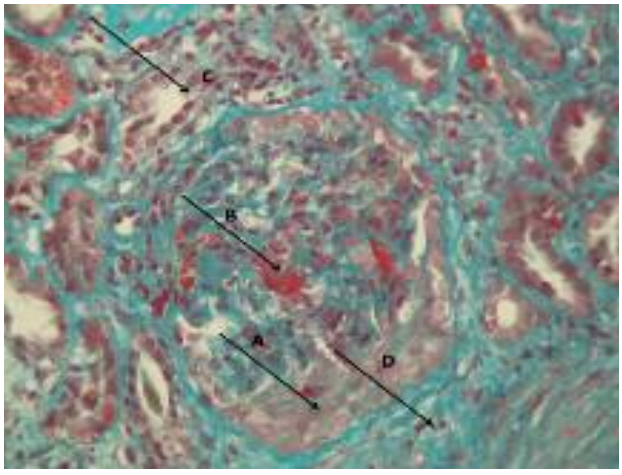
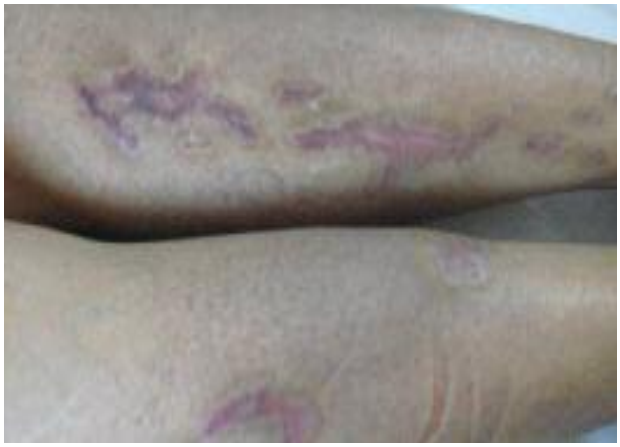


Figure 4 : Photo des deux jambes après traitement : Aspect cicatrisé des ulcérations cutanées.



Conclusion

L'association BTU et vascularite à ANCA est actuellement bien connue. La possible survenue d'une atteinte rénale induite par les ATS lors du traitement d'une maladie de Basedow justifie un dépistage systématique d'anomalies urinaires ou une évaluation de la fonction rénale, afin d'interrompre cette prescription et d'engager rapidement un traitement efficace.Par ailleurs, il serait souhaitable de rechercher les ANCA en cas d'apparition de manifestations systémiques au cours d'un traitement par les ATS.

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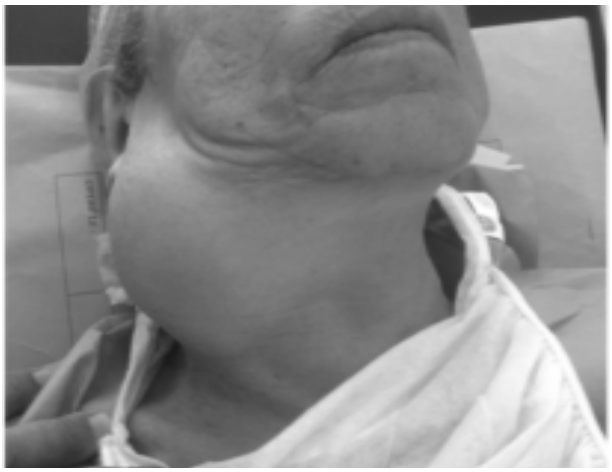
Anesthetic management of a giant extracranial internal carotid artery aneurysm

Extracranial internal carotid artery aneurysms (EICA) are uncommon. Among all carotid procedures, they only represent 0.1 to 2% [1]. They can be atheromatous, dysplastic, infective, posttraumatic, or iatrogenic [1]. The clinical course of EICA is dominated by neurological thromboembolic events. Nevertheless, uncommon presentations such as compression of cranial nerves and adjacent organs, or more rarely, rupture were described especially with giant EICA [2, 3]. Giant EICA are those that exceed 5 cm of long axis [1]. Their treatment is challenging: not only the surgical strategy but also the anesthetic management. In this report we describe the perioperative management of a giant EICA in an elderly woman.

Case report

A 72-year-old woman presented with a ten-year history of a pulsatile mass of the right side of the neck. This mass was constantly growing especially during the last year. The patient did not report a history of trauma or previous procedures on the supra-aortic vessels. She had not other chronic arteriopathy. Her only medical history was a mild persistent asthma that was well controlled. She reported a persistent dysphagia and transient headache. There was no history of cerebrovascular events or cranial nerve dysfunction. On physical examination, the mass was pulsatile and had a long axis of 8 cm. It occupied the entire latero-cervical region and extended to the angle of the mandible (Figure 1).

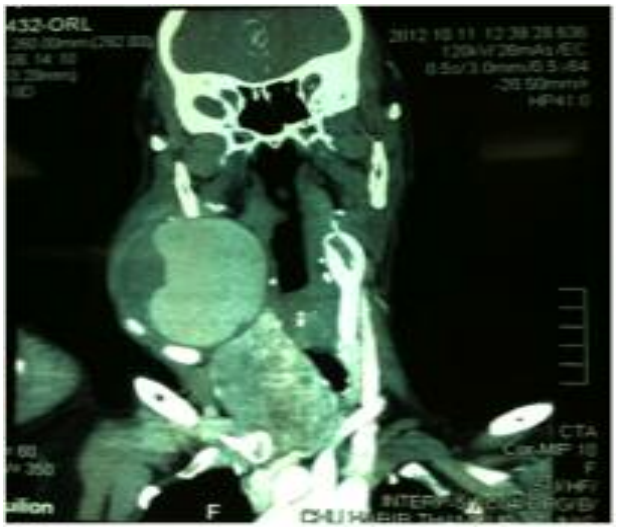
Figure 1 : Photography: giant extracranial internal carotid artery aneurysm



The thyroid cartilage was mildly deviated to the left. The mobility of the cervical spine was limited and the thyro-mental distance was under 6 cm. The Mallampati class was IV and mouth opening was limited. The lower central part of the neck presented a medium-sized homogenous goiter. Finally there were no signs of neurological deficit or cranial nerve dysfunction. The chest X-ray showed an important deviation of the trachea to the left. The diagnosis was made by computed tomography scan that revealed a voluminous oval-shaped aneurysm of the extracranial internal carotid artery. This aneurysm was sized 73 X 72 mm and mildly pushed the larynx to the left (Figure 2). It was partially thrombosed. The CT scan also showed an enlarged right lobe of the thyroid gland which was plunging into the upper mediastinum and pushing the trachea to the left (Figure 2). Finally the cerebral CT scan did not reveal signs of previous cerebrovascular accidents.

Given the multiple criteria of difficult airway, an awake nasotracheal fiberoptic intubation was done after explaining the procedure to the patient. The patient was prepared by short acting inhaled β2 agonists just before performing the intubation. There were no any respiratory complications during intubation. Then the anesthesia was induced with propofol and remifentanil. It was maintained with constant rates of sevoflurane and a continuous infusion of remifentanil. A radial arterial line was inserted to monitor the blood pressure. The neurological monitoring was done by the Bispectral Index (BIS). During the first phase of surgery, i.e. before clamping of the carotid artery, the systolic blood pressure was maintained lower than 100 mmHg by a continuous infusion of nicardipine. During this phase, the bispectral index (BIS) showed values around 55. After exposing the carotid branches, the patient was heparinized and the aneurysm was isolated by clamping both the common carotid artery and the internal carotid artery downstream of it. No intraluminal shunt was used. Immediately after clamping the carotid artery branches, nicardipine was stopped and a continuous infusion of norepinephrine was started to maintain the systolic blood pressure around 140 mmHg. The BIS did not show a significant variation.

Figure 2: Computed tomography: thrombosed EICA pushing the larynx to the left and plunging goiter pushing and compressing the trachea.



Aneurysmectomy was performed without a significant bleeding and a termino-terminal anastomosis of the internal carotid artery was done. The total duration of clamping was about 30 minutes. After removing the clamps, the patient was progressively weaned from norepinephrine. The BIS values remained without large variations. The patient was extubated in the operating room and then admitted to the post-anesthesia care unit during the first 24 postoperative hours. She did not show any hemodynamic or respiratory disorder and its neurologic examination did not find any neurologic deficit or cranial nerve dysfunction. The postoperative bleeding was insignificant. The electrocardiogram did not show any modification and the troponin levels were undetectable.

Conclusion

Giant EICA are an extremely rare entity. Their anesthetic management is particular regarding three aspects: possible difficult airway management, high risk of massive bleeding and of embolisation during the surgical repair.

Acknowledgements:

Informed consent was obtained from the patient for publication of this report.

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Mélanome du muscle droit de l'abdomen : à propos d'un cas.

Le mélanome des tissus mous ou sarcome à cellules claires est une tumeur maligne exceptionnelle représentant moins de 1% des tumeurs des parties molles [1].

Les localisations musculaires de mélanomes sont le plus souvent secondaires et les formes primitives restent historiques [2].

Le diagnostic, qui a bénéficié de l'apport des examens radiologiques, est histologique.

Le pronostic rejoint celui des autres mélanomes dominé par le haut potentiel métastatique.

Nous présentons le cas d'un mélanome du muscle droit de l'abdomen à travers lequel nous discutons les différents aspects cliniques et thérapeutiques.

Observation

Il s'agit d'un patient âgé de 25 ans, qui présente une masse épigastrique évoluant depuis 9 mois. A l'examen, la masse était ferme, fixe, sensible et mesurant 70 mm de grand axe. Le scanner abdominal (Figure1) a montré une masse fusiforme, bien limitée, hétérogène à double composante tissulaire périphérique et liquidienne centrale avec des calcifications, mesurant 80 x 30 mm et localisée en inter-hépato-pariétal. Cette masse présentait un contact intime avec le muscle grand droit de l'abdomen, avec des adénopathies mésentériques. A l'IRM, la masse était en iso-signal T1(Figure2) musculaire et en hyper signal T2 (Figure3) se rehaussant de façon hétérogène après injection de Gadolinuim. Le bilan d'extension était négatif. La décision était d'opérer le patient. A l'exploration, il s'agissait d'une masse grisâtre de 60 mm de grand axe développée au dépens du muscle droit de l'abdomen (figure4). Il a eu une exérèse de cette masse. L'examen histologique a conclu à. Les limites d'exérèse étaient saines. Deux mois plus tard, il a présenté une récidive locorégionale. Il a eu une résection de propreté avec une chimiothérapie palliative.

Figure 1: scanner abdominal : masse fusiforme localisée en inter-hépato-pariètal

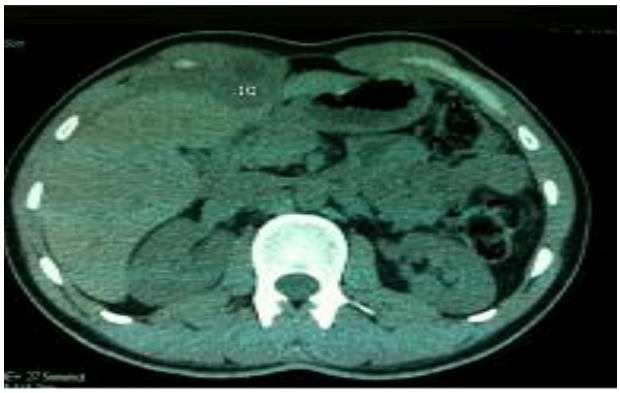

Figure 2 : IRM abdominal : masse tumorale en iso-signal T1

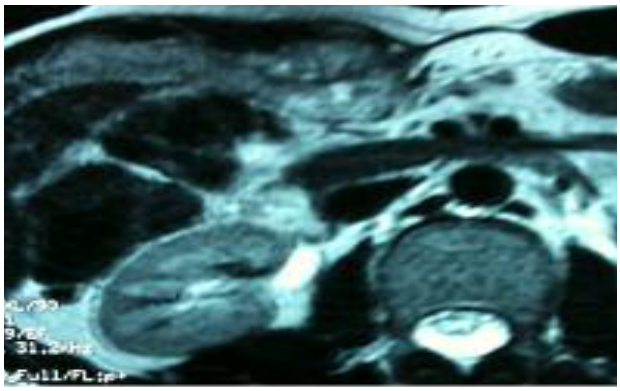

Figure 3 : IRM abdominal : masse tumorale en hyper-signal T1