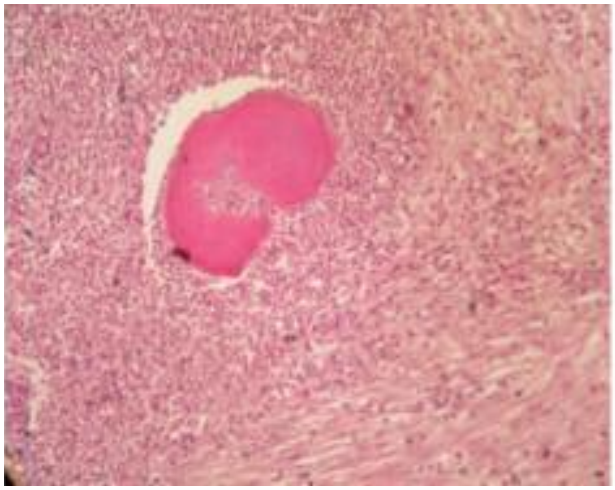
exploratrice a été réalisée objectivant la présence d'un magma ganglionnaire mésentérique rétractant le méso des anses iléales et le colon transverse. Il n'y avait pas d'ascite, de carcinose ou de lésions hépatiques. L'examen anatomopathologique de la masse mésentérique réséquée avait montré la présence de nombreux ganglions répondant à un tissu ganglionnaire dont l'architecture était globalement conservée. Les follicules lymphoïdes étaient nombreux, volumineux et à centre germinatif large et actif. Entre ces centres germinatifs, on observait des structures filamenteuses et granulaires basophiles formant un feutrage d'aspect radiaire et entourées d'une couronne de lymphocytes et de polynucléaires neutrophiles souvent altérés (Figure 2). Cet aspect morphologique avait permis de conclure à une adénite mésentérique granulomateuse et suppurée avec surinfection actinomycosique. Par ailleurs, il n'y avait pas de signes histologiques de malignité. Le patient a été mis en post-opératoire sous antibiothérapie à base de pénicilline G avec une bonne évolution clinique.

Figure 2 : Etude histologique de la masse mésentérique. Coloration PAS x 40. Structure filamenteuse basophile de l'Actinomyces entourée par une couronne lymphocytaire. .



Conclusion

L'actinomycose abdominale est une affection rare qui mérite d'être connue. Sa découverte est souvent une surprise tant sa traduction clinique et radiologique est non spécifique et trompeuse. La laparotomie avec étude anatomopathologique sont souvent indispensables pour confirmer le diagnostic et le traitement repose sur l'antibiothérapie prolongée par la pénicilline G.

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Synchronous primary rectal and prostate cancers

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Background

Primary prostate and colorectal carcinomas are the leading malignancies in males in western (1). Furthermore, in elderly people, advanced age increases the occurrence of multiple synchronous or metachronous cancers (2). However, few cases of synchronous prostate and rectal malignancies have been reported. In most of those reports, surgical approach has been applied. We report a new case of synchronous prostate and rectal and prostate cancer treated by combined chemo-radiotherapy and hormone therapy.

Case presentation

A 66-year-old man presented with hematuria, pollakiuria and dysuria. Work-up showed a suspicious prostatic lesion histologically confirmed as Gleason 7 adenocarcinoma, while serum prostate specific antigen (PSA) was at 80 ng/ml. Pelvis CT-scan showed an enlarged prostate, with thickening of the rectal wall associated with iliac, precaval and lombo-aortic lymphadenopathies sized between 18 and 23 mm. The occurrence of synchronous hematochezia and the presence of rectal thickening on CT-scan indicated a rectoscopy, showing a lesion of the anterior rectal wall, located at 6 cm from the anal margin. Biopsy concluded to a moderately differentiated adenocarcinoma. Bone scintigraphy, chest and abdominal CT scan were normal.

Thus, our patient presented 2 synchronous non-metastatic high-risk prostate adenocarcinoma and rectal carcinoma staged T3N2M0. Treating team proposed a concomitant radiochemotherapy as patient refused surgery: he received a conventional 2D pelvic radiotherapy at the dose of 45 Gy in 25 fractions delivered by opposed anteroposterior enlarged fields, targeting prostate, rectum and pelvic lymph nodes and concomitant to 2 cycles of FUFOL(5-fluorouracil and folinic acid). He, then, had received complete androgen blockage for 6 months, until serum PSA normalization. Hormone therapy was then stopped and the patient had been regularly followed for 33 months. After this period of complete remission, a biological PSA progression occurred associated to a rectal cancer local relapse. He received a palliative chemotherapy by FOLFOX (5-fluorouracil, folinic acid and oxaliplatin) protocol for 6 cycles followed by abdominoperineal resection. Another symptomatic local rectal cancer progression occurred after three months treated by second line FOLFIRI (5-fluorouracil, folinic acid and irinotecan). Patient progressed and died 40 months after initial diagnosis of both cancers.

Conclusion

Synchronous presentation of rectal and prostate cancers requires a multidisciplinary approach. The use of innovative surgical techniques and of intensity modulated radiotherapy would optimize patient outcome in terms of disease control and post -treatment quality of life.

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