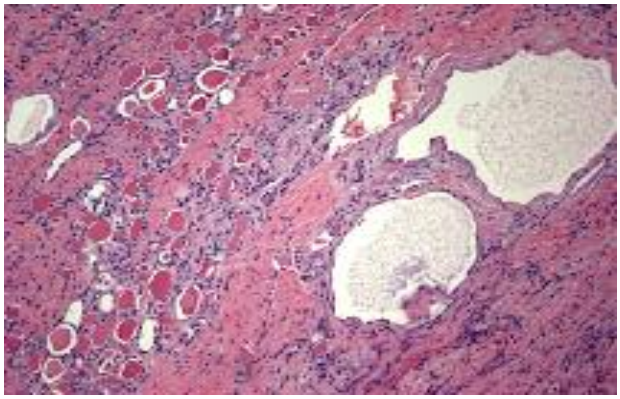
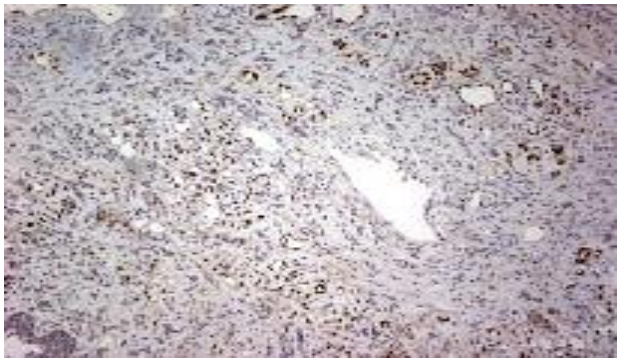
Figure 2 : Tubules and cysts contain focally eosinophilic secretions "colloid like". (H.& E. stain, x 250)



Most tubules and cysts with have flattened cuboidal cells without atypia. But some tubules are lined with hobnail cells. Mitotic figures are absent. Tumor cells were positive with PAX2 (Fig. 3).

Figure 3 : Nuclear positivity of tumoral cells for PAX2 (IHCx100)



We followed up the patient 24 months after the initial diagnosis of NA. During this time, he didn't relapse. On imaging, there was no evidence of masses involving the bladder wall. Currently, the patient is asymptomatic, undergoes regular check-ups for the bladder tumor and urinary tuberculosis.

Conclusion

Nephrogenic adenomas of the bladder are rare benign lesions that should not be viewed as a premalignancy. Treatment consisted in endoscopic resection and regular follow-up.

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Colo-colonic intussusception secondary to a colonic lipoma : Report of two cases

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Intessusception is well recognized in children but only 5% of reported cases are in adults (1, 2, 3). In two-third of adult cases, intessusception is caused by a malignant tumour, with begnin tumours accounting for only a few (1). We present two rare cases of symptomatic submucosal lipoma of the ascending colon causing intestinal obstruction that were surgically resected.

Case reports

Patient HZ, a 49-year-old man was seen because of painful umbilical hernia. There was history of abdominal distension and constipation a few months ago. On physical examination; distended abdomen and protruding and deformed umbilicus were detected. The swelling was tender and irreductible. Bowel sounds were normal. Urgent surgery was performed.

An incarcerated omentum in the umbilical defect was found, the bowel was viable. The non viable omentum was resected, and herniorrhaphy was performed for the fascial defect. Immediate postoperative outcome was uneventful.

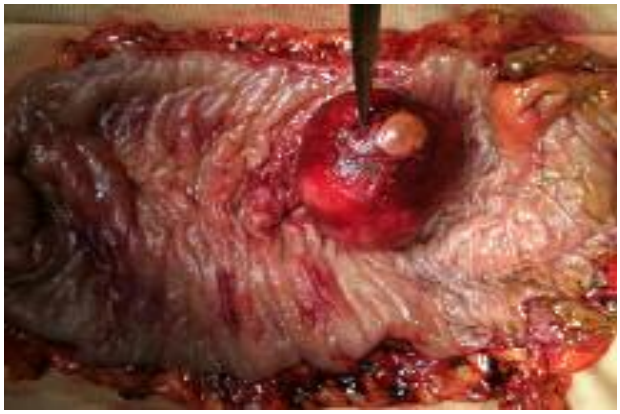
Ten days later he complained of colicky abdominal pain, distension, and increasing constipation. An urgent CT scan outlined a soft tissue mass in relation to hepatic flexure with ring-like appearance of contrast around it indicating intussusception. On laparotomy, colo-colic intussusception was found. The intussuscepted bowel was not reduced. Right hemicolectomy according to oncologic principles followed. Histological examination revealed submucosal tumor lesion composed of lobulated mature adipose tissue. After the surgery and 4 years of follow up, no complications were observed.

Patient KN, a 59-year-old woman was admitted because of progressive colicky pains since two weeks. The right upper abdomen was tender without palpable lesions or signs of peritonitis. Laboratory results were normal.

An abdominal CT scan was obtained, revealing a 6-cm low attenuation mass at the hepatic flexure. The fat density and radiographic appearance suggested a colonic lipoma, which appeared to be functioning as a lead point (Figure 1). At laparotomy, colo-colonic intussusception at the ascending colon was found. Right hemicolectomy was performed because it was not possible to reduce the intussusception. The intussusception was caused by a 6 x 5 cm polypoid mass arising from the ascending colon (Figure 2). Pathological examination showed polypoid mass arising from submucosa of the colon with stroma containing mostly fatty tissue consistent with submucosal colonic lipoma, with no evidence of malignancy. The postoperative course was uneventful.

Figure 1 : Abdominal CT : colonic lipoma

Figure 2 : Polypoid mass of ascending colon



Conclusion

Colonic lipoma is a benign neoplasm and concomitant intussusception in adults is rare, but should be considered as a cause of chronic and sub-acute abdominal symptoms due to the high incidence of associated pathological lesions. Diagnosis is difficult due to non-specific symptoms of the disease. Sonography and computed tomography (CT) are the most commonly used imaging techniques for diagnosis. Laparotomy is mandatory because malignant lesions are frequently the lead-point. In adults, intussusception usually requires treatment by surgical resection of the affected bowel [4, 5].

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Adénome hypophysaire thyréotrope

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Les adénomes thyréotropes sont rares, et représentent moins de 1 % des adénomes hypophysaires [1,2] dans les séries autopsiques ou chirurgicales. Le diagnostic doit être évoqué devant une thyréotoxicose TSH-dépendante ou lors d'un bilan hypophysaire. Le diagnostic différentiel avec le syndrome de résistance hypophysaire aux hormones thyroïdiennes peut être parfois difficile. Sur le plan thérapeutique, si le traitement d'un microadénome à TSH reste chirurgical, la présence de récepteurs à la somatostatine [3] sur les cellules adénomateuses, l'efficacité et la tolérance des analogues de la somatostatine [2,4,5], font que les formes retard de l'octréotide (Sandostatine LPW) et du lanréotide (Somatuline LPW, Somatuline AutogelW) sont une alternative médicale au traitement des macroadénomes ou des adénomes thyréotropes invasifs. Vue la rareté de cette entité clinique nous rapportons un nouveau cas d'adénome thyréotrope.

Observation

Homme âgé de 47 ans, aux antécédents d'ulcère duodénal traité chirurgicalement, qui a présenté depuis une année des céphalées, des palpitations, une irritabilité et un amaigrissement estimé à 4 kg en 2 mois.

L'examen physique à l'admission a montré un état général conservé, une TA à 110/70 mmHg et un goitre stade II homogène non vasculaire. Le bilan biologique a objectivé une hyperthyroïdie avec une FT4 à 52pmol/L et TSH à 20,56mUI/L.

L'échographie cervicale a montré une thyroïde augmentée de taille, hyper vascularisée sans nodule décelable. La radiographie du crâne a objectivé un élargissement de la selle turcique. L'imagerie cérébrale par résonnance magnétique a confirmé la présence d'un macro adénome intra et supra-sellaire paramédian droit envahissant le sinus caverneux homolatéral comprimant le chiasma optique et refoulant la tige pituitaire vers l'arrière mesurant 22 X18 X16 mm (figure 1,2).

Figure 1: IRM cérébrale (coupe longitudinale) : macro adénome intra et suprasellaire paramédian droit