expression of S-100 protein and HMB-45 and negative for the expression of cytokeratin AE1/AE3, CD34, CD117 CD45, actin ,desmin and synaptophysin. Computed tomography showed a thickening of the rectal wall and lymph node swelling of the circumference of an internal iliac artery; however, there was no evidence of distant metastasis. The patient was treated by abdominoperineal resection with dissection of lymph nodes. The resected specimen showed some pigmented lesions within the tumor and around the anal verge. Histopathological examination confirmed the diagnosis of malignant melanoma Pt4b N2. Postoperative adjuvant chemotherapy was administered. However, multiple liver metastases and multiple lung metastases appeared in the early phase after the operation. Metastases increased rapidly and the patient died one year after the operation.

Conclusion

In conclusion, anorectal melanoma is a rare and aggressive disease. Because of nonspecific symptoms, it is easily mistaken for hemorrhoids or rectal prolapsed. So it is imperative to have a high index of suspicion and to fully evaluate all complaints of lower gastrointestinal bleeding and pain.

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High-grade primary lymphoma of the lung and hypercalcaemia, a case report.

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Non-Hodgkin's lymphoma (NHL) and Hodgkin's disease (HD) are malignant neoplasms of lymphoid tissue. The most common extra-nodal site of presentation for NHL is the gastrointestinal tract, including stomach. Although the lung is a frequent metastatic site for HD and NHL, primary pulmonary lymphoma (PPL) is extremely rare (1), accounting for only 0.4% of all malignant lymphomas (2), 1% of NHL, and only 0.5–1% of primary pulmonary malignancies (3, 4, 5). The current definition of primary pulmonary lymphomas (PPL) covers low-grade B-cell or MALT lymphoma, large B-cell lymphoma and lymphomatoid granulomatosis (3).

PPL is most commonly represented by MALT lymphoma. Large B-cell PPL, a high grade lymphoma, is less frequently detected representing only 11 to 19 % of LPP (2). Hypercalcaemia is a rare and severe complication of lymphoma associated with poor prognosis and high resistance to treatment. We report a case of high-grade PPL-B, associated to hypercalcaemia. Through this observation, we illustrate the rare nature of the disease and its poor prognosis, especially when associated to hypercalcaemia.

Observation

We report a case of 70-year-old non smoking woman, with past medical history of diabetes, arterial hypertension and atrial fibrillation. She was admitted for cough, chest pain, cough and poor general status of three weeks duration. Clinical examination was normal; especially no peripheral lymphadenopathy was detected. Chest X ray showed multiple confluent ill-defined consolidations of right lung. Abnormal findings on laboratory investigations were dominated by hypercalcaemia at 3.18 g/l associated to inflammatory syndrome with wight blood cells account of 11000 elements / ml and high level of C - reactive protein (CRP) at 200 mg/l. Diagnosis of infectious pneumonia was initially retained; antibiotherapy including Amoxicillin-clavulanate was established without clinical or radiological improvement. Bronchus endoscopy was normal. Sputum smear and bronchial aspiration were negative for acid-fast-bacilli. Viral serology was negative. CT scan revealed several masses in upper and lower right pulmonary lobes associated to homolateral mediastinal nodes (figures 1, 2).

Figure 1 : Computed Tomography section: parenchymatous window: several masses of lower right pulmonary lobe

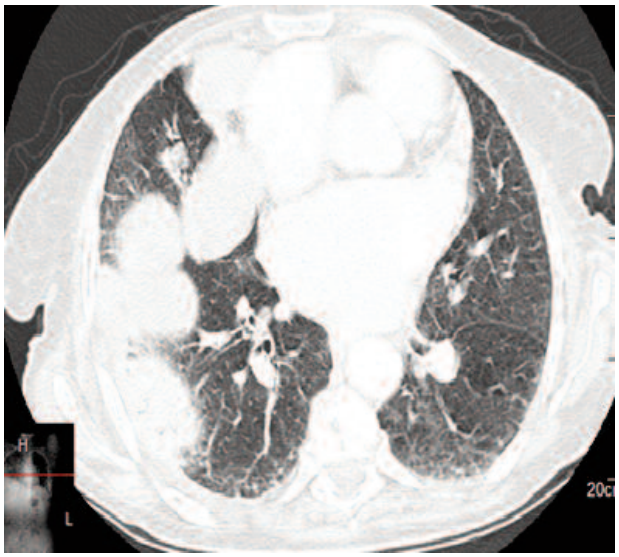
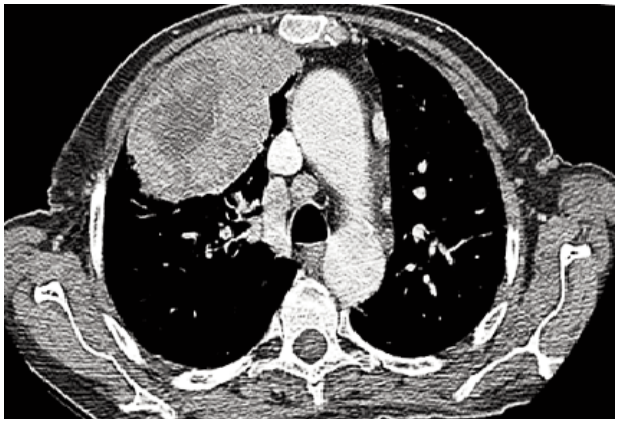


Figure 2 : Computed Tomography section: mediastinal window: mass of upper right pulmonary lobe with homolateral mediastinal nodes



CT guided transthoracic biopsy of pulmonary masses had been done. Pathologic and immunohistochemical analysis showed lymphomatous proliferation made by large B-cells expressing CD20 (figures 3, 4, 5), establishing the diagnosis of pulmonary involvement by large B cell lymphoma.

Figure 3 : Pathologic analysis: lymphomatous proliferation

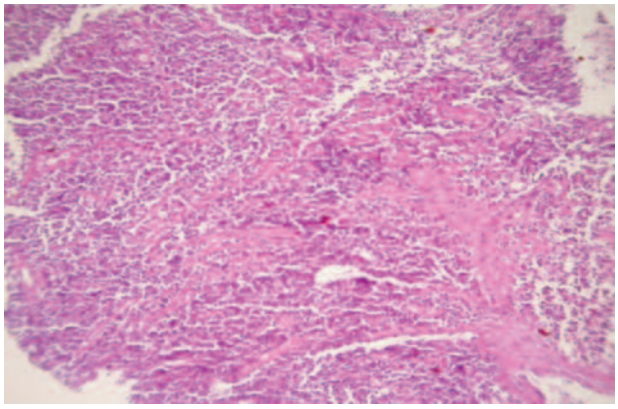


Figure 4 : Pathologic analysis: lymphomatous proliferation made by large tumor cells

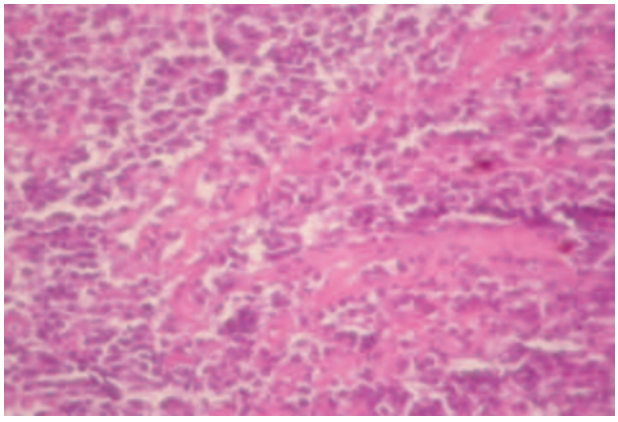
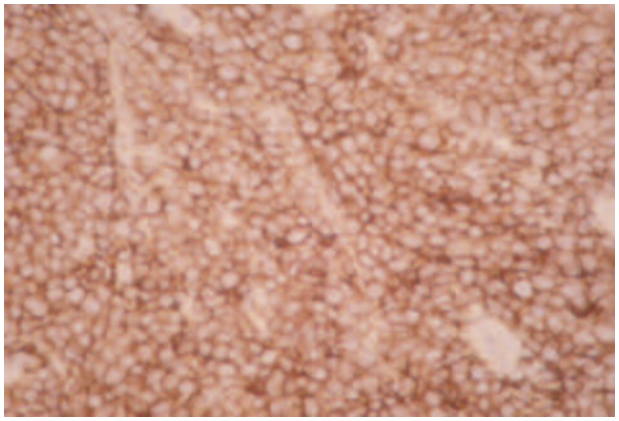


Figure 5 : Immunohistochemical analysis: tumor cells are B phenotype expressing CD20



Metastatic evaluation, including body scan, electrophoresis of proteins and bone marrow biopsy, was negative for lymphoma. As no other extra-pulmonary lymphomatous focus was detected, the patient was considered primary B cell lymphoma of lung.

About hypercalcaemia, etiologic assessment has been done counting parathormone dosage, proteins electrophoresis and bone imaging. It was negative. And hypercalcaemia was resolutive after hydration and corticotherapy.

CHOP chemotherapy, based on cyclophosphamide, adriamycin, vincristine, and prednisone, was introduced, without improvement and patient died 4 months after.

Conclusion

PPL is defined as clonal lymphoid proliferation affecting one or both lungs (parenchyma and/or bronchi) in a patient with no detectable extra-pulmonary involvement at diagnosis or during the subsequent 3 months; pulmonary involvement with satellite nodes (hilar or mediastinal) could be seen (3), as observed in our case. High-grade PPL-B may arise from the transformation of an indolent lymphoma or occurs in individuals with an underlying disorder such as solid organ transplantation with immunosuppression, human immunodeficiency virus (HIV) infection or Gougerot- Sjôgren syndrome (2, 3). In our patient, any disorder was detected, especially HIV serology was negative.

Hypercalcaemia is a rare and severe complication of NHL, occurring in less than 15% of them and associated with poor prognosis and high resistance to treatment with more frequent and earlier progression and local or distant relapse, like our patient who died four months after initiation of treatment. Hypercalcaemia in lymphoma has multiple pathogenesis. It is often attributed to an acquired uncontrolled vitamin D 1-α-hydroxylase activity by the macrophages close to the lymphomatous cells. Influences of tumor necrosis factor α (TNF α), interleukine 6 and Parathyroid hormone-related protein (PTHrp) are also reported; thesis factors, produced by lymphoma cells, stimulate bone resorption by osteoclasts (5).

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Bilateral visual loss in patient with systemic lupus erythematosus

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Valsalva retinopathy describes a condition of hemorrhage to the retina caused by a sudden increase in intraabdominal or intrathoracic venous pressure. Increased venous pressure creates a decreased return to the heart, which in turn results in increased intracranial venous pressure [1]. Valsalva retinopathy classically presents as sudden visual loss in a healthy individual, caused by a premacular hemorrhage secondary to Valsalva stress [2]. We report a case of sudden bilateral visual loss in patient with a history of systemic lupus erythematosus.

Case report

A 23-year-old female patient presented with sudden bilateral visual loss immediately after a severe bout of vomiting the previous day in acute gastroenteritis. There was no past ocular history. The patient had a history of systemic lupus erythematosus with positive antiphopholipid antibodies for 5 years. Systemically, she was well and was on no medications

Ophthalmic examination of the both eyes noted a dense scotoma and best corrected visual acuity as hand move. Fundoscopy revealed a large pre retinal haemorrhage involving the macula (Fig. 1). Intraocular pressure, anterior segment and pupillary reactions were normal in both eyes.

A fluorescein angiography (FA) and indocyanine green angiography (ICG) were performed. Both examinations showed an area of hypofluorescence corresponding to the haemorrhage but no underlying neovascularization or retinal vasculitis or retinal ischemia or choroidopathy. Optical coherence tomography (OCT) also showed preretinal hemorrhage at the macula (Fig. 2).

Figure 1 : Colour fundus picture on presentation showing bilateral preretinal hemorrhage involving the macula

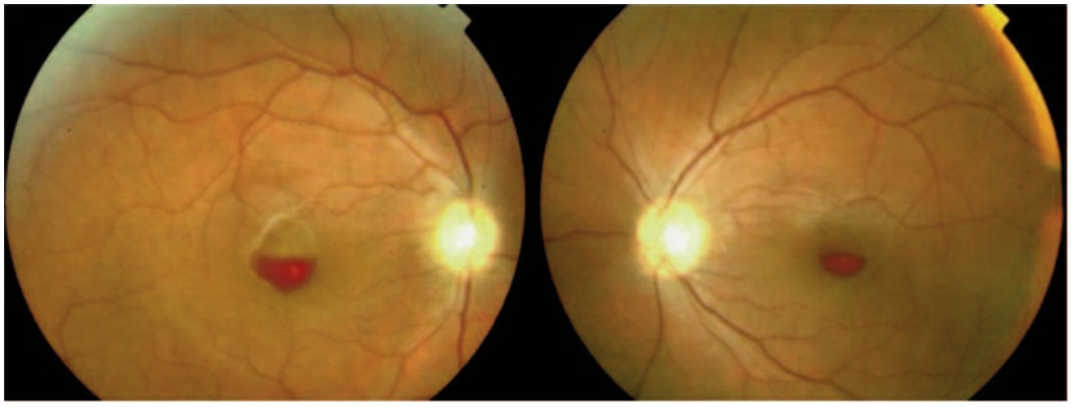

Figure 2 : Optical coherence tomography shows a lesion with high reflectivity at the macula, consistent with preretinal hemorrhage.