d'adénopathies périphériques inguinales et de métastases osseuses confirmées par la scintigraphie osseuses. Elle décédait trois mois après le diagnostic.

Conclusion

La linite rectale primitive est une tumeur rare mais extrêmement agressive. En raison de son potentiel infiltrant et invasif d'une part, et de son évolution insidieuse d'autre part, le diagnostic est souvent tardif. La recherche d'une localisation extra-rectale doit être systématique avant de retenir le caractère primitif de la tumeur. Une meilleure connaissance de cette entité permettrait d'en améliorer le pronostic qui demeure péjoratif.

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Thyroid tuberculosis: a case report

Besma Ben Dhaou1, Wafa Garbouj1, Ines Hriga2, Zohra Aydi1, Fatma Daoud1, Lilia Baili1, Sonia Ketari1, Chiraz Mbarek2, Fatma Boussema1

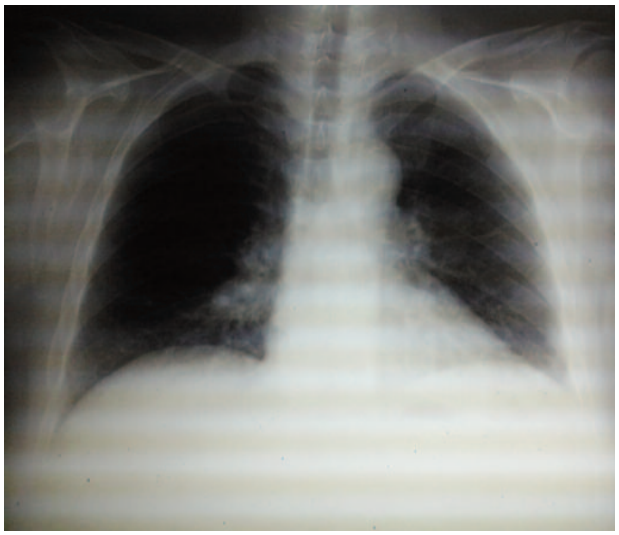
1 Service de médecine interne hôpital Habib Thameur Tunis Tunisie
2 Service d'ORL hôpital Habib Thameur Tunis Tunisie
Faculté de médecine de Tunis

Tuberculosis involving the thyroid gland is a rare occurrence. Rankin and Graham detected tuberculous bacilli in only 21 cases (forming 0.1%) on the histological examination of 20,758 resected thyroid specimens (1). This is due to the ability of the gland to resist infection (2). The involvement of the gland is mainly through haematogenous spread from an extra-thyroid focus or direct extension from adjacent nodes (3). Isolated involvement of the thyroid is extremely rare (4). Clinical and radiological features are nonspecific, and a histological examination is required for accurate diagnosis. We report the case of thyroid tuberculosis associated to lymphadenopathy tuberculosis.

Case report :

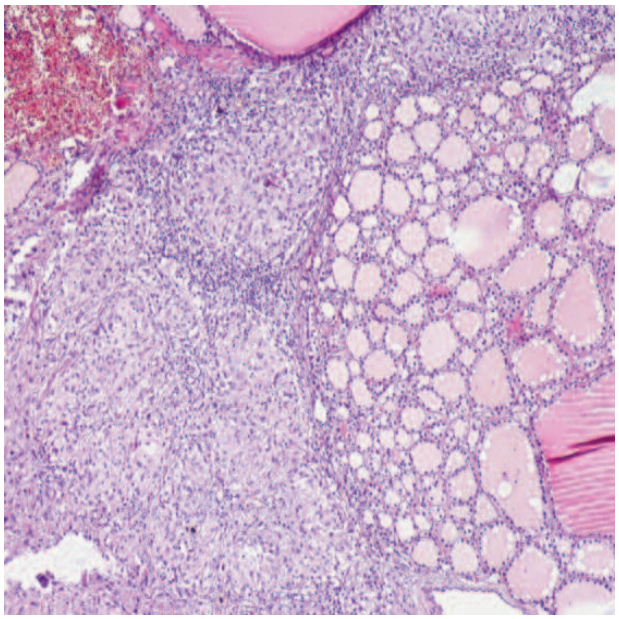
A 68-year-old women, presented with a 6 months history of fever, night sweats and weight loss. There was a past history of hypertension and mellitus diabetes treated by antagonists of angiotensin 2 and oral antidiabetic. On examination, a non-tender, firm midline anterior neck swelling was noted, which moved with deglutition, suggesting that it originated from the thyroid. She did not have any clinical features of hyper- or hypothyroidism. Routine blood investigations showed that heamoglobin was 12.9 g/dl, and the total count was 9090/mm³, with neutrophils comprising 5970/mm³, lymphocytes 2260/mm³ and eosinophils 300/mm³. The erythrocyte sedimentation rate was 22 mm. Thyroid function tests showed a total T4 of 10.8 pmol/l(normal range7 - 16) and a thyroid-stimulating hormone of 1.09 mU/l (normal range.30 – 5.6). Chest radiography showed hilar opacities and interstitial syndrome of the lung bases (figure 1). Ultrasonography of the neck showed multinodular goiter, a 2 cm nodule of the left lobe and a 0.7 cm nodule of the right lobe of the thyroide gland. The two nodules were centered by microcalcifications. The multinodular goiter was not vascular and no cervical lymphadenopathy was found.

Figure 1 : Chest radiography : hilar opacities and interstitial syndrome of the lung bases



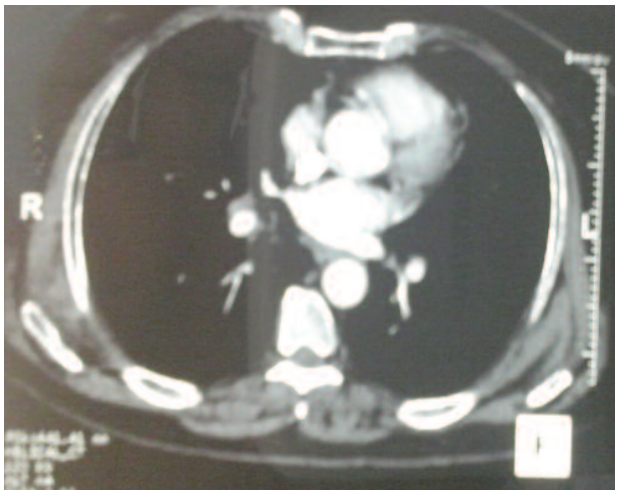
On the basis of this clinical course the patient underwent thyroidectomy. Pathological examination showed numerous granuloma with epithelial cells and a central caseous necrosis (figure 2).

Figure 2 : Pathological examination showed numerous granuloma with epithelial cells and a central caseous necrosis



These morphological signs were compatible with multiple tuberculous foci of the thyroid gland. No signs of malignancy were present. As part of the search for other TB localization, search for Mycobacterium tuberculosis in sputum was negative; the Urine culture with search for Mycobacterium tuberculosis was negative. Moreover, the thoraco-abdominal CT scan showed bilateral homogeneous mediastinal adenomegalies without parenchymal lesion, and mesenteric adenomegaly (figure 3).

Figure 3 : Thoraco-abdominal CT scan: bilateral homogeneous mediastinal and mesenteric adenomegalies



The final diagnosis was multifocal tuberculosis involving mediastinal and mesenteric adenomegalies and thyroid gland. The patient was started on quadruple antituberculous chemotherapy based on Isoniazid, Rifampicin, Pyrazinamide and Ethambutol for 2 months. The evolution was favorable with sustainable apyrexia, recovery of appetite with good clinical and biological tolerance of the treatment. She is currently at the end of three months of combination therapy (Isoniazid, Rifampicin). The control of the thoracic and abdominal imaging is expected at 6 months of treatment.

Conclusion

Thyroid tuberculosis is rare, and diagnosis is difficult based on clinical and imaging features. Definitive diagnosis requires cytological and histological examination.

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Syphilitic uveitis revealed by bilateral retinal occlusive vasculitis

Ahmed Chebil, Rym Maamouri, Mariem Ouaderni, Rym Limaiem, Leila El Matri
Department B of ophthalmology, Hedi Rais Institute of Ophthalmology, faculty of medicine of Tunis, university of El Manar, Tunis, Tunisia

Syphilis has been described as the great “imitator” or “masquerade” of a myriad of ocular conditions. It is a sexually transmitted, chronic, systemic infection caused by the spirochete treponema pallidum. It can affect all the structures of the eye causing conjunctivitis, episcleritis, interstitial keratitis, iridocyclitis, anterior, intermediate, posterior uveitis, secondary glaucoma, cataract, vitritis, chorioretinitis, vasculitis, serous retinal detachment, papillitis and optic neuropathy [1]. Uveitis represent the most common ocular manifestations of acquired syphilis [2,3]. Involvement of the eye may be the presenting manifestation of syphilis and it often associated with delayed diagnosis and treatment, which may result in irreversible visual loss and structural changes. We report a case of syphilitic uveitis revealed by bilateral panuveitis with retinal occlusive vasculitis.

Case report

A 45 year old man presented with a history of a blurred vision for 2 weeks in both eyes associated to red and painful eyes. His medical and family history was unremarkable and he was not taking any medication and had no known allergies. Ophthalmologic examination revealed visual acuity of 1/10, mild inflammatory reaction in the anterior chamber and vitreous haze in both eyes. Intraocular pressure (IOP) was 15 mm Hg in right eye (OD) and 16 mm Hg in left eye (OS). Dilated bilateral fundus examination revealed multiple intraretinal hemorrhages in the midperiphery, with areas of vascular sclerosis. Fluorescein angiogram revealed areas of peripheral nonperfusion with leakage along the temporal retinal arteriole and retinal neovascularization (figure 1).

Figure 1: Fluorescein angiography showed non-perfusion area and retinal neovascularization