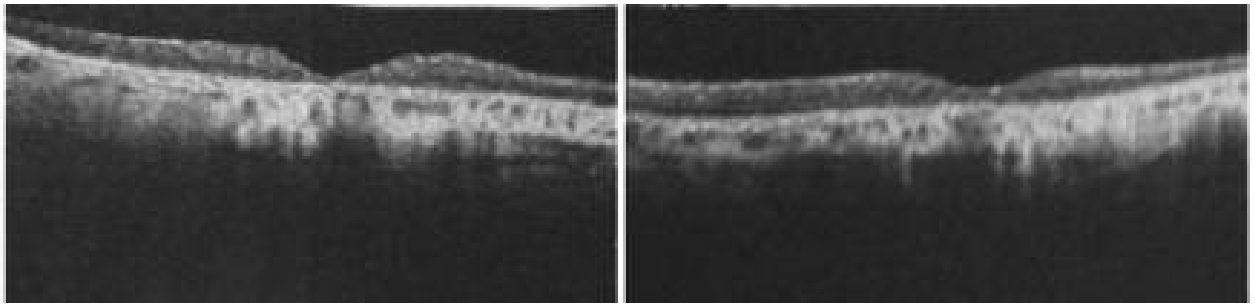

Figure 3 : TD-OCT OG : Atrophie rétinienne diffuse sans signes d'exsudation + ombrage post : effet shadow

Conclusion

La RP est une dystrophie rétinienne potentiellement cécitante par atteinte des photorécepteurs.

Aucun cas d'hémorragie maculaire isolée n'a été décrit jusqu'à aujourd'hui.

L'origine de l'hémorragie maculaire au cours de la RP est peu connue et n'est imputée à la maladie qu'après avoir éliminé les autres étiologies plus fréquentes.

Calcified amorphous tumor in right atrium presenting with syncope

Tumeur amorphe calcifiée de l'oreillette droite symptomatique de syncope

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Calcified amorphous tumor of the heart (CAT) is an unusual non-neoplastic cardiac mass that can mimic a more malignant lesion(1). Composed of calcified nodules with amorphous fibrous material, it can cause symptoms of embolization or obstruction of calcified fragments (2).

We Report the case of a 5-year-old patient that presented to emergency department with syncope. Clinical and laboratory investigations revealed that she had calcified amorphous tumor of the right atrium. She underwent surgery.

Case Report

A 5-year-old patient without medical history was referred to cardiology department. She complained of a sudden loss of consciousness at home. She was in a good state of health until she suddenly collapsed while standing and lost consciousness for approximately 10 seconds. She recovered spontaneously but was extremely weak. She reports that she had a similar episode in the past month. On admission, physical examination didn't reveal focal neurologic findings.

Her heart rate was regular at 110 beats/minute, her blood pressure was 106/62 mmHg without orthostatic changes, and her respiratory rate was 21 breaths/minute.

An electrocardiogram showed a regular rhythm consistent with sinus tachycardia.

Laboratory findings showed that levels of serum electrolytes, glucose, blood urea and creatinine, and complete blood counts were normal.

The patient underwent echocardiography that revealed a non-mobile right ventricular calcified mass measuring 8 mm long axis extending to the pulmonary artery and the right atrium (Figure 1). The mass originated from the interatrial septum above the foramen ovale with mild tricuspid regurgitation. Left ventricular function was preserved.

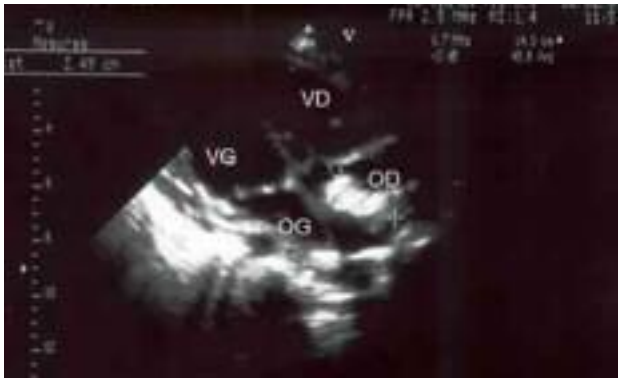

Figure 1: 2 dimensions' transthoracic echography four chambers view showing dilation of right cavities with a mass of 81 mm long axis, attached on the ventricular side of the tricuspid annulus and in the right atrium. VG=Left ventricule, OD=Right atrium, OG= Left atrium, VD=Right ventricule.

The patient was operated under extracorporeal circulation; Perioperative palpation showed that there is a mass in the right atrium and another one in the pulmonary artery. Right atriotomy revealed two atrial masses: the first one was implanted on the foramen ovale (Figure 2), it was white and firm and measures 2cmx1cmx1cm, with gelatinous center and friable periphery.

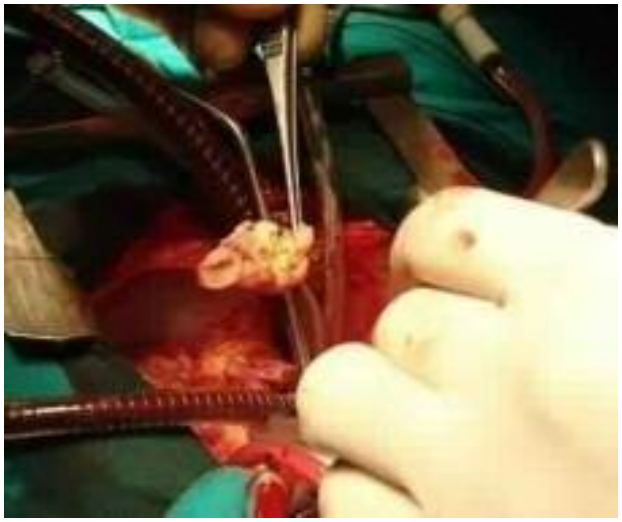

Figure 2: Intraoperative photograph of the calcified amorphous tumor

The second one has the same size, but it was implanted next to the stoma of the superior vena cava. Both masses were removed, taking the endocardium on their implantation bases.
Furthermore, there was a small mass in the right ventricle measuring 4mmx3mmx2mm implanted behind the anterior leaflet of the tricuspid valve and a second small mass implanted on the side and front wall of the pulmonary artery; It continuous with an extension which completely blocks the left pulmonary artery and rushes into 1cm (Figure 3). A total removal of this mass was performed after dissection from its attachments.

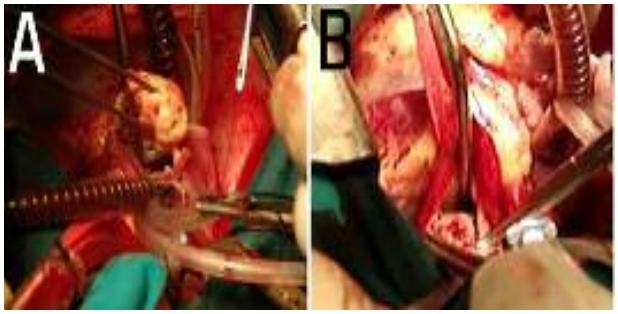

Figure 3: Intraoperative photograph: 3A: right atrium portion of the tumor. 3B: The tumor blocking the pulmonary artery.

The patient presented at third postoperative day for fever with a diagnosis of right pneumonia. Under antibiotic treatment there was a good clinical and radiological evolution.
On the basis of the pathological examination, the cardiac mass was demonstrated with calcified amorphous tumor of the heart.
Echocardiography revealed that there was an expansion of the right atrium and increase of the severity of the tricuspid regurgitation. After six months, tricuspid regurgitation became severe (grade 3-4) and the right cavities are always dilated. The patient was doing well with no evidence of the recurrence of the syncope 48 months after operation.

References

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Central serous chorioretinopathy after nasal corticosteroids in the aviator

Chorioretinite séreuse centrale après corticothérapie nasale chez le pilote

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Central serous chorioretinopathy (CSC) is a frequent unilateral maculopathy in young adults, characterized by an idiopathic retinal detachment of the neuroepithelium in the macular region. It is a multifactorial disease whose pathogenesis is still poorly understood [1]. Endogenous and exogenous glucocorticoids have been frequently implicated in the pathogeny of the CSC[1].
In the aviation medicine, where the nasal corticosteroids are commonly prescribed, CSC takes a particular importance and severity due to its negative impact on visual function of the pilot and flight status.
We report the case of two pilots who developed CSC after the use of nasal steroids.

Observation N°1:
A 40 year- old male, airline pilot, consulted for a sudden decrease in visual acuity in the right eye and metamorphopsia lasting for four days.
The patient was non alcoholic, non-smoker, non-hypertensive, with no notable medical history. Questioning revealed the use of nasal corticosteroid for sinusitis 10 days before the onset of the symptoms.
The visual acuity was 4/10 in the right eye and 10/10 in the left eye. The examination of the anterior segment was normal in both eyes. The glare test was disturbed as the test of the stereoscopic vision. Color vision was normal.
Fundus examination detected a bleb of serous retinal detachment macular at the right eye. Fundus fluorescein angiography (FFA) showed macular leakage point (Photo N°1).