The post operative course was uneventful. Observation of the patient by physical examination and ultrasonography of the abdomen postoperatively showed no evidence of recurrence at 4 years of follow up.

Conclusion

Although lipoblastoma is rare, and omental one is an uncommon localization with a wide variety of clinical manifestations, this diagnosis must remain in the mind of the surgeon in cases of intraperitoneal neoplasms or abdominal mass. Clinical and imaging evaluation is essential but the final diagnosis will likely be made by microscopic or cytogenetic analysis in borderline cases. Resection is the only known definitive treatment and the prognosis is excellent. Exception may be taken in infants with lesions that would require extensive operations for excision. In either situation, close follow-up is necessary.

References

1. O'Connor H, Lamy J, Bonneau H. Lipoblastoma of the greater omentum and popliteal, mediastinal and epiploic lipoblastomas. Mars Chir 1959;11: 431–434
2. Beebe MM, Smith MD. Omental lipoblastoma. J. Pediatr Surg 1993;28:1626-7.

Y. Ben Ahmed, M. Ben Dhaou, S.Ghorbel , A. Charieg, F. Nouira,S.Jlidi,
Department of paediatric surgery B, Children Hospital of Tunis. Tunisia.

A giant liposarcoma of the neck and the mediastinum

Liposarcoma is a primary malignancy developed from mesenchymal tissue with ability to attain enormous sizes [1]. It ranks second among soft tissue sarcomas and it generally involves members and retroperitoneum [2]. Its occurrence in the head and neck region is rare. Involvement of both neck and mediastinum is exceptional [3].

Observation

An 81 years old smoker man was admitted in our department to explore a giant anterior cervical mass which appeared 6 years ago, grew larger and became painful over the previous 2 years. He also reports asthenia, anorexia and weight loss without dyspnea, dysphonia nor dysphagia. Physical examination showed a huge and fatty swelling of the anterior cervical region. This mass measured 30 cm and was painful, unmovable and adherent to the underlying structures without signs of inflammation (Fig.1). Chest X ray showed opacity of the cervical region plugging on the upper mediastinum. Cervical ultrasound examination concluded to a hyper echoic and heterogeneous cervical mass extended to the thoracic anterior wall independently of the thyroid. Computed tomography confirmed the presence of a parietal cervicothoracic tumor measuring 29 cm. This tumor was heterogeneous, had both tissular and fatty density and considerably plunges into the antero-superior mediastinum. These aspects suggested liposarcoma. It also showed multiple and bilateral pulmonary nodules evocating pulmonary metastases (Fig. 2). Microscopic examination following transcutaneous biopsy confirmed diagnosis. A complete resection of the tumor was carried out through a large cervicotomy (Fig. 3). Despite of malignancy, tumor was easily cleavable of the surrounding tissues. Pathological examination concluded to mixed liposarcoma (well-differenciate/myxoid) (Fig.4). Patient stills alive 5 months after diagnosis without local relapse. He refused postoperative radiation therapy.

Figure 1: Huge swelling measuring 30cm of the cervical region

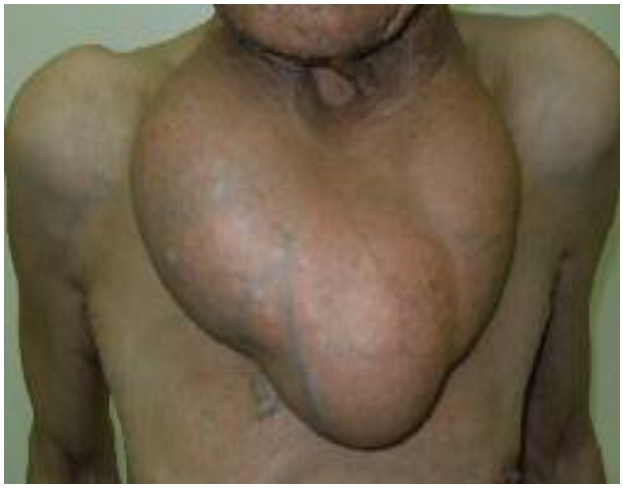


Figure 2: CT scan (reconstitution): parietal cervicothoracic tissular and fatty tumor measuring 29 cm and plunging into the mediastinum

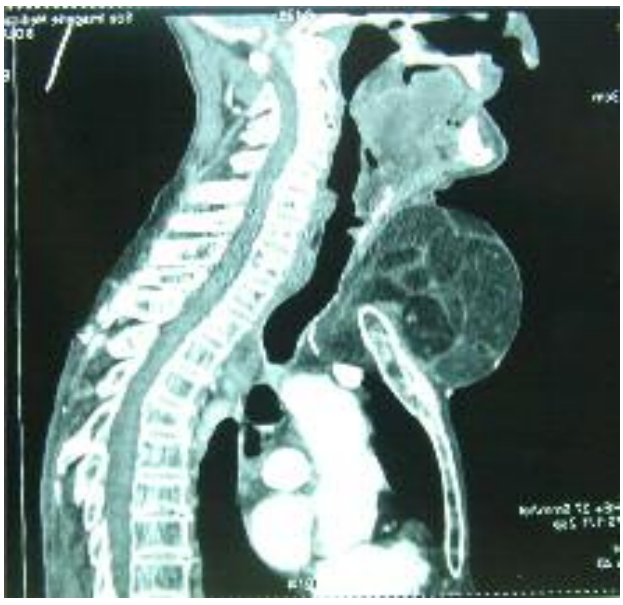


Figure 3 : Tumor after surgical resection

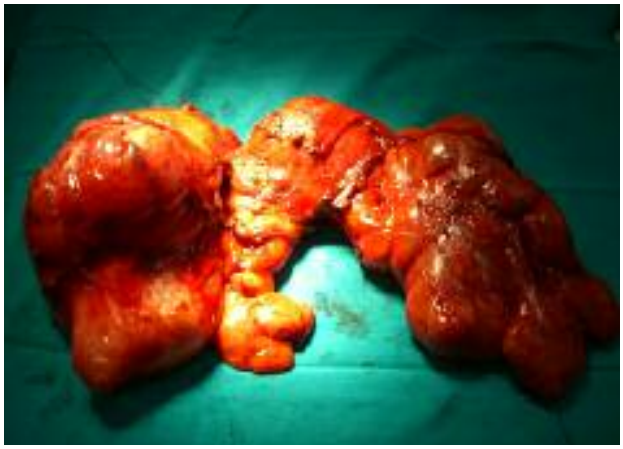
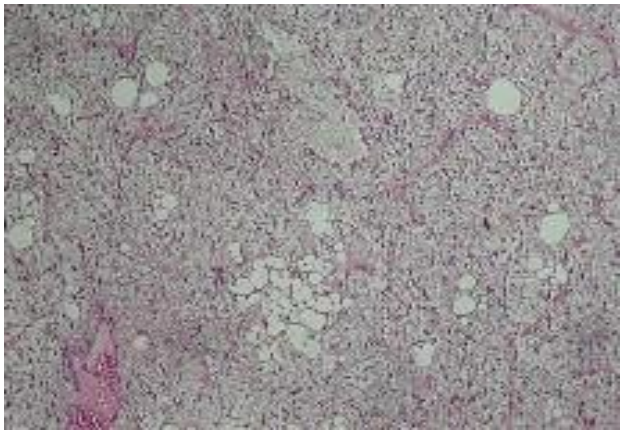


Figure 4 : Histological findings: mixed liposarcoma (well-differenciate/myxoid)



Conclusion

Liposarcoma comprises approximately 20% of all soft-tissue sarcomas and 1% of all cancers. First described by Virchow in 1857, it had been frequently reported in the literature but remains exceedingly rare in the head and neck region. Among pathologic subtypes, pleomorphic and round cell types are most aggressive, with a high risk of local recurrence and distant metastases [4]. Most frequent metastases are pulmonary, pleural, hepatic and node lymphatic [2]. The mainstay of treatment of liposarcomas is surgical excision [5]. In case of cervico-mediastinal localization, surgical resection is more difficult because of anatomic difficulties [6]. This case is particular by the extremely rare location of the liposarcoma in the anterior neck, the medistinal involvement and the easy of the resection despite the malignant nature and the giant size.

Reference

1. Doean R, Ayrancioglu K, Aksu I. Primary mediastinal liposarcoma: A report of a case and review of the literature. Eur J Cardio-thorac Surg 1989;3:367-70
2. Maamouri N, Cheikh I, Ouerghi H et al. Giant retroperitoneal liposarcoma. One case report. La revue de médecine interne 2005;26:145–8
3. Mssrouri R, Benamra S, Essadela A. A concomitant cervical and mediastinal liposarcoma. Feuillets de Radiologie 2006;46:349-53
4. Iqbal M, Posen J, Bhuiya Ta, Lackner Rp, Steinberg Hn, Rossoff LJ. Lymphocyte-rich pleural liposarcoma mimicking pericardial cyst. J Thorac Cardiovasc Surg 2000;120:610–2.
5. Gritli S, Khamassi K, Lachkhem A et al. Head and neck liposarcomas: a 32 years experience. Auris Nasus Larynx 2010;37:347-51
6. Ebbe M. A 6-kg retroperitoneal liposarcoma in a 42-year-old woman, case report. Scand J Urol Nephrol 1993;27:409–12.

Nawel. Chaouch1, Meriem. Mjid1, Sadok. Boudaya2, Mourad. Zarrouk1, Emna. Brahem3, Sana. Cheikh Rouhou1, Hajer. Racil1, Abdellatif. Chabbou1

1: Pneumology department, pavillon 2, Abderrahmane Mami Hospital, Ariana, Tunisia

2: Cardiothoracic surgery department, Abderrahmane Mami Hospital, Ariana, Tunisia

3: Pathology department, Abderrahmane Mami Hospital, Ariana, Tunisia

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Preoperative clinical diagnosis of an amyand's hernia

Amyand's hernia (AH) is diagnosed by finding the vermiform appendix in a groin hernia. It is a rare disease, named after Claudius Amyand, founder of London's St George's Hospital who was the first to describe the presence of a perforated appendix within the hernia sac (in1735) of an 11 year old boy. AH constituted 1% of all inguinal hernias, whereas only 0.13 % of all cases of appendicitis [1] [2]. Right inguinal hernias are the most frequent sites for the development of AH, although it has also been described on the left side [3]. AH is reported in infants even as young as six weeks [4].

Clinical presentation is variable, it is usually confused with a strangulated inguinal hernia, with torsion of the testis or with epididymo-orchitis [1] [5].

The diagnosis of AH is difficult and it is often discovered only during the operation. Only one case of AH out of 60 could be correctly diagnosed preoperatively from 1959 to 1999 in old male [6].

Clinical diagnosis of AH is very rare. Surgical procedure used depends on the pathology found. The presence of a normal appendix does not require appendectomy, whereas acute appendicitis necessitates appendicectomy with hernial repair. We present such a case of AH discovered pre-operatively at the physical examination in a nine-month-old baby.

Case report

MH, nine- month-old boy was admitted to our Division of Paediatric Surgery with the diagnosis of right inguinal hernia. He was clinically well and had a weight of 10kg. He had no fever.

The physical examination revealed a reducible swelling in the right groin with an appendix seating on the scrotum (fig.1). The surgical exploration of the hernial sac revealed an uninflamed vermiform appendix, caecum within the sac (fig.2).