ABSTRACTS

CLINICAL CASES

DEPARTMENT OF SURGERY AND SEMIOLOGY no.3

1. PRIMARY HYDATID CYST OF SKELETAL MUSCLE: A CASE REPORT

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Background. Hydatid cyst, also called hydatidosis, is caused by Echinococcus granulosus. It is still a major health problem in many parts of the world with 2-3 million cases confirmed each year. Most of these cases involve liver (50-70%) and lungs (20-30%), but some of them have rare locations, such as skeletal muscles (0.7-5%). The absence of specific clinical signs and symptoms makes it difficult to establish a diagnosis, while first signs may appear as neurovascular lesions due to compression. The most useful method of diagnosis is ultrasound with high sensitivity (93-98%), followed by CT and MRI. There are two types of treatment: open surgery and percutaneous drainage, both associated with Albendazole and Mebendazole or Albendazole and Praziquantel administration.
Case report. A 33-year-old patient was admitted to Department of general surgery with a lump on the inner proximal part of the right thigh that patient discovered six month ago, which interfered with the patients daily activities. The patient underwent ultrasound exam of the lump and internal abdominal organs, plain chest X-ray, lump puncture for bacteriological test and general blood and urine analysis. All results came normal and with no imagistic findings, except a multicystic lesion separated by septae that can be attributed to Gharbi type III hydatid cyst. The patient underwent surgical treatment with no early postoperative complications and received chemotherapy with Albendazole and Mebendazol.
Conclusions. Hydatid cyst should be included in the differential diagnosis of a patient with slow growing subcutaneous masses. Imaging data are required when cystic mass are suspected. Surgical treatment associated with chemotherapy must always be a fist priority for better results with minimal recurrence.
Key words: hydatid cyst, ultrasound, differential diagnosis.

DEPARTMENT OF INTERNAL MEDICINE, CARDIOLOGY

2. LEFT ATRIAL MASS IN A PATIENT WITH MITRAL STENOSIS AND ATRIAL FIBRILLATION-THROMBUS OR MYXOMA?

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Background. The discovery of a large left atrial mass through echocardiography obliges the clinician to perform a differential diagnosis to distinguish tumor from thrombus. In fact, magnetic resonance imagery could be useful to identify the mass but it could not distinguish tumor from organized thrombus. Certainly, surgery is the best solution for a successful diagnosis.

Case report. The 67-year-old woman was admitted to cardiology department with dyspnea, orthopnea, palpitations, and fatigue. Anamnesis: 10 years of atrial fibrillation and type 2 diabetes and 15 years with arterial hypertension. By the time of addressing, the patient has been administering anticoagulants for several months with warfarin while maintaining INR-2. Physical examination revealed an irregular pulse, at a rate of 110 beats/min. The electrocardiogram revealed an atrial fibrillation with rate 150-100 b/min. The chest X-ray - pulmonary congestion. TTE - revealed a severe mitral stenosis (GPmax – 33 mm/hg, area - 0,6 cm^2) with third degree mitral regurgitation and left atrial mass (50*36 mm), third-degree tricuspid regurgitation. Left atrium was enlarged (67*84 mm), severe pulmonary arterial hypertension. These findings were confirmed by TEE. The preoperative coronarography showed neovascularization among the mass and huge fistula from the circumflex artery in the tumour mass and left atrium. We strongly suspected a vascular tumor, especially myxoma. Preoperative decision was made to perform cardiac MRI - "hook"- shaped mass formation, fixed to the upper rear wall of the LA, 7 cm long, massive thrombus. Cardio-surgical intervention was performed: MV prosthesis MDT "Hancock-II ultra" N29, complex plastic repair of TrV, removing the massive thrombus from the LA. After surgery, the patient had uncomplicated recovery.
Conclusions. Atrial mass management will be based on clinical history (mitral stenosis, permanent atrial fibrillation) and echocardiographic data. If atrial mass persists during treatment with anticoagulants, cardiac MRI and coronarography are useful for diagnosis. However, the final diagnosis is established during cardiac surgery.
Key words: atrial fibrillation, atrial mass, MRI, coronarography, surgery

3. SITUS INVERSUS WITH DEXTROCARDIA AND AORTIC VALVE REGURGITATION: A CASE REPORT

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Background. Dextrocardia with situs inversus is a rare congenital condition with less than 1 person in 10 000, in wich the internal organs are mirrored inside the human body. The majority of the patients with dextrocardia and situs inversus are phenotypically normal and have a normal life without any complications related to their congenital condition. About 5-10% of the these patients develop another congenital defects. There are only few published cases of the patients with situs inversus with dextrocardia associated with aortic valve regurgitation.
Case report. The 33 years old male with dextrocardia and situs inversus diagnosed in the childhood was consulted during routine medical examination. Chest radiography showed dextrocardia and situs inversus. The electrocardiogram showed sinus rhythm with right axis deviation and reverse R-wave progression in the precordial leads. He was examined by transthoracic echocardiography and third degree aortic regurgitation was found, moderate dilatation of the sinus of Valsalva – 43 mm, and no dilatation of the ascending aorta – 35 mm. There were no data for aortic dissection. The ejection fraction of the left ventricle was 55%. Computer tomography (CT) showed reversed positioning of mediastinal and abdominal organs – complete situs inversus and dextrocardia. On CT there were no signs of stenosis or dissections of the thoracic and abdominal aorta. The patient was referred to cardiac surgery for correction of valvular pathology. A complex aortic valve repair was performed. Postoperative period was without complications. On control echocardiography after one month there was no important aortic regurgitation.