Sonuç olarak Phlegmasia cerulea dolens tedavisinde birinci basamak non-operatif tedavidir. Non-operatif tedavi elevasyon, hidrasyon ve antikoagülasyonu içerir. Derin ven trombozu ve onun ileri formlarının tedavisindeki gelişmeler kadar, risk grubunda olan hastalarda uygun şekilde yapılacak profilaksi yaklaşımlarının da gelecekte DVT ve onun komplikasyonlarını daha da azaltacağını düşünmekteyiz. Akut venöz tıkanıklık tespit edilen hastalarda yetersiz ve uygunsuz tedavi ile ilgili ekstremitenin ve hasta sağlığının ciddi risk altına gireceğini hiçbir zaman unutmamalıyız.

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Aortic aneurysm: a rare complication of ulcerative colitis

Aortik anevrizma: Ülseratif kolitin nadir görülen bir komplikasyonu

Ulcerative colitis is an idiopathic chronic inflammatory disorder localized in the colon and rectum. Systemic and extraintestinal complications of ulcerative colitis are arthritis, delayed growth and sexual maturation, nutritional deficiency secondary to malabsorbtion, mucocutaneous lesions, renal disease, hepatobiliar disease and ocular complications (1). Cardiac complications including myocarditis, pericarditis and increased risk of infective endocarditis may be rarely seen during the clinical course but aortic aneurysm is an extremely rare complication of ulcerative colitis (2- 4).

A 16-year-old boy was admitted to our hospital because of delayed growth, pruritic mucocutaneous lesions, bloody diarrhea and seizures.

Medical history revealed that he had apparently been well until one year old. It was learned that pruritic mucocutaneous lesions first began on face and trunk and aggravated with sun exposure. Bloody diarrhea, abdominal pain, tenesmus, and tonic-clonic convulsions were also noted by his parents after age of one year old. There was no history of exposure to tuberculosis, sick persons, or animals, and there was no family history of allergy. Parents were first-degree relatives.

His axillary temperature, pulse, respiratory rate, and blood pressure were 36.8 °C, 123/min, 28/min, and 106/56 mmHg, respectively. His height was 124 cm (below the 3rd percentile), and his weight was 21.8 kg (below the 3rd percentile).

Physical examination revealed chronic dermatitis on trunk and face and a perianal fistula.

Hemoglobin, hematocrit, mean corpuscular volume, white cell count, erythrocyte sedimentation rate, and serum C-reactive protein levels were 7.4 g/dl, 25.9%, 53.4 μm^3, 15.200/ml, 36 mm/hr, and 22.3 mg/dl, respectively. He had thrombocytosis. Hypochromic and microcytic erythrocytes were observed on stained blood smear. Stool examination revealed occult blood. Urinalysis was normal.

Serum aspartate aminotransferase, alanine aminotransferase, and alkaline phosphatase levels were 12 U/L, 5 U/L, and 425 U/L, respectively.

Serum total protein, albumin, globulin, immunoglobulin G and E levels were 7.3 g/dl, 3.1 g/dl, 4.2 g/dl, 14.2 g/l, and 907.3 IU/ml, respectively. Pathergy test and VDRL were negative. Test for perinuclear antineutrophil cytoplasmic antibodies (pANCA) was positive.

Cardiac examination was normal but telecardiography showed a prominent aorta. Echocardiography revealed aneurysm of both ascending and descending aorta.

Rectosigmoidoscopy revealed a pale, edematous and fragile mucosa and loss of vascular pattern. Rectal biopsy showed crypt

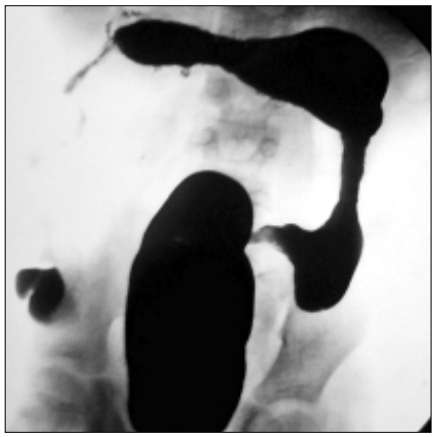

Figure 1. Barium enema shows pseudodiverticula and lead pipe sign in the transverse colon

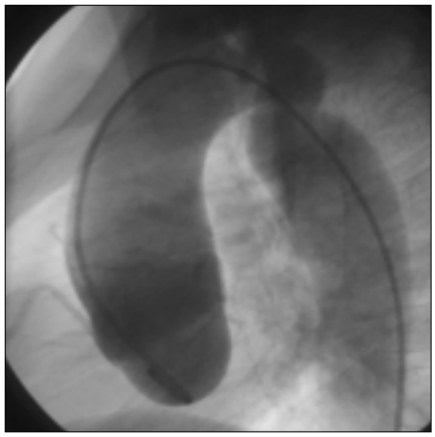

Figure 2. Aortogram shows aneurysm of ascending and descending aorta

distortion and cryptitis, with heavy mixed inflammatory cell infiltration (mostly plasma cells and eosinophils) within lamina propria.

Barium enema revealed pseudodiverticula and lead pipe sign in the transverse colon (Fig. 1). Cranial magnetic resonance imaging was normal. Electroencephalography revealed epileptic activity in temporal, parietal and occipital regions.

Cardiac catheterization showed aortic aneurysm of ascending and descending aorta (Fig. 2, Video 1. See corresponding video/movie images at www.anakarder.com). There was no pressure gradient between the ascending and descending aorta.

Oral prednisolone and sulfasalazine treatments were given for ulcerative colitis, metronidazole for perianal fissure, and sodium valproate therapy for epilepsia. Aortic graft surgery for aneurysm was planned after the inflammation control with prednisolone and sulfasalazine (5).

In conclusion we described patient who had aortic aneurysm as a rare complication of ulcerative colitis. If treatment is initiated earlier, this complication may be prevented.

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Spontaneous dissection of left anterior descending artery and cardiac apical mass without aneurysm

Anevrizma olmadan sol ön inen koroner arterin spontan disseksiyonu ve kardiyak apikal kitle

A 48-year-old man who was admitted to hospital because of syncope, transient ischemic attack, palpitations and chest pain. On physical examination, he had sight deficiency on the right eye. Electrocardiography revealed T-wave inversion in leads V1 through V6. The cardiac enzymes (creatine phosphokinase-MB and Troponin-T) were normal. Laboratory analysis was normal. Echocardiogram showed an apical mass resembling thrombus in apical region of the left ventricle (Video 1, 2. See corresponding video/movie images at www.anakarder.com). The coronary angiography (CAG) of the patient showed that the patient's left anterior descending (LAD) artery was irregular, dissected, and recanalized spontaneously following the dissection; it also revealed the presence of double lumen structure and no aneurysm any where on ventricle (Fig. 1). The other coronary arteries were normal. Brain computed tomography revealed infarction in the occipital region. It was judged by neurologists that this lesion would not hinder open heart surgery. Anticardiolipin antibodies were negative. There was no stigma of connective tissue disorder. Due to the prolonged existence of mass and continuance of the patient's complaints despite the maximal anticoagulant treatment (keeping INR 2-3), we decided to operate the patient with the techniques of standard cardiopulmonary bypass using moderate hypothermia and cardioplegia arrest. In the operation, a mass including thrombus with diameters of 20x15 mm adjacent to the papillary muscles on the left ventricular apical region was resected. Apical region was closed with felt (Fig. 2). However, we did not perform coronary artery bypass grafting (CABG) because of the absence of significant stenosis.

Histopathologic examination showed dystrophic calcified bond tissue and thrombus. He had an uneventful recovery and was discharged home six days after surgery. He was observed to be doing well in the two-month follow-up visit.

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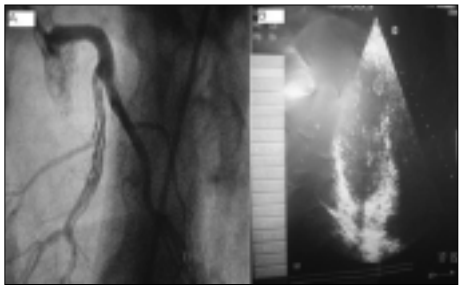

Figure 1. A- Preoperative coronary angiography shows dissection of left anterior descending artery. B- Preoperative echocardiography shows a cardiac apical mass of left ventricle

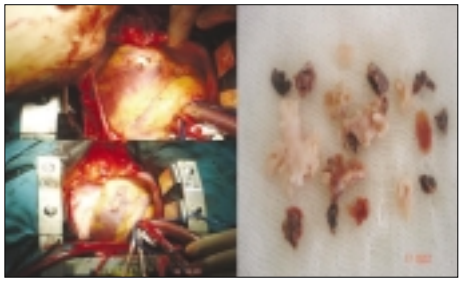

Figure 2. Intraoperative images