

## Laparoscopic partial cystectomy after cystoscopical delimitation of the bladder's endometriotic nodule

Dear editor

Bladder endometriosis represents less than 1% of all cases of endometriosis

A 34-year old woman with a previous cesarean section, had a history of worsening lower abdominal pain and dysuria that worsened during her menses, during the last 12 months. The magnetic resonance imaging revealed a 4 cm full-thickness bladder nodule. There was no implication of the ureteres in the intravenous urography and MRI. Cystoscopy confirmed a 4 cm bluish-hued mass of the bladder's dome, far from the orifices of the ureters. Endometriosis was confirmed by cystoscopic biopsy.

A laparoscopic resection of the full thickness bladder nodule was decided. Before the laparoscopic partial cystectomy, a 24F transurethral resectoscope with a Collings knife was used to cut circumferentially the bladder's mucosa and muscularis around the lesion, without entering the peritoneal cavity. This cystoscopic delimitation of the lesion was used in order to detect easier the healthy borders of the nodule and to facilitate the partial cystectomy. Once the resection of the lesion was completed using laparoscopic monopolar scissors, the bladder defect was closed in two layers in a running fashion with 3-0 and 2-0 absorbable polyglactin 910 sutures. The repair's integrity was tested by instilling 120mL of methylene blue diluted in normal saline into the bladder, and no leaks were observed. The endometriotic lesion was morcellated and removed through the 12mm port.

A combined transurethral and laparoscopic approach to excise bladder endometriomas has been described previously<sup>1,2,3,4</sup>. The combination of cystoscopy to laparoscopy provides assurance of complete removal of the lesion, avoids ureter injury and facilitates the excision. The novel surgical approach is the delimitation and not the full thickness cutting of the nodule during the transurethral cystoscopy. This is helpful during the laparoscopic excision of lesions involving the vesical mucosa, because the vesical wall becomes thinner and the healthy borders of the borders of the lesions are detected more easily. Another advantage is that, on the contrary of the typical combined technique<sup>2,3</sup>, the irrigation fluid of the cystoscopy is not allowed to escape into the peritoneal cavity and there is less danger of adjacent organ injury by the resectoscope.

In conclusion, this modification of the combined minimally invasive multidisciplinary approach of full thickness bladder endometriosis may offer an easier and safer excision of the lesion.

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## Obstruction of the superior vena cava and stenosis of the right brachiocephalic vein in a patient with Adamantiades-Behcet's disease

Dear Editor,

Adamantiades-Behcet's disease (ABD) is a chronic relapsing vasculitis that presents predominantly with recurrent oral and genital ulcers, skin lesions and ocular involvement.

Other manifestations include arthritis, thrombophlebitis, central nervous system disease and gastrointestinal ulcerations<sup>1, 2</sup>. Herein, we describe a patient with stenosis of the right brachiocephalic vein that was detected due to swelling of the right arm.

A 45-year old electrician with a history of psychosis and smoking was admitted in the hospital with a diagnosis of possible facial angioedema. His past history was characterized by recurrent aphthous ulcerations of the penis and the oral mucosa with remission after the use of corticosteroids and recurrence after their discontinuation. He had been on antipsychotic drugs for the

last fifteen years. On physical examination, he had aphthous penile ulcers. Due to the swelling of the supraclavicular fovea, the jugular veins and the right arm, obstruction of the superior vena cava and the right brachiocephalic vein was suspected. Computed tomography of the chest and magnetic phlebography of thoracic vessels showed thrombosis with partial recanalization of the superior vena cava and thrombosis in the right brachiocephalic vein. An extensive laboratory evaluation for thrombophilia was negative. Papulopustules developing at venipuncture sites were considered as an equivalent to a positive pathergy test. The therapeutic approach involved the administration of glucocorticoids, anticoagulant therapy and cyclophosphamide.

This case report confirms the rare but documented appearance of obstruction of the superior vena cava in patients with ABD. Venous thrombosis occurs in 7% to 34% of patients with ABD. Its mechanism remains largely unknown, but it is suggested to be more closely related to vasculitis than to clotting disorders. Male gender and a positive pathergy test are associated with higher risk of venous thrombosis<sup>3</sup>. Some authors support the use of corticosteroids in all cases of deep venous thrombosis. In cases of thrombosis of the vena cava or cerebral venous sinuses, an additional immunosuppressive agent should be administered<sup>4</sup>. Nevertheless, thrombosis in the dural sinuses, vena cava and Budd-Chiari syndrome carry a poor prognosis.

To our knowledge, stenosis of the right brachiocephalic vein has not yet been described in patients with ABD, and it was attributed to multiple venous thromboses with partial recanalization of the right brachiocephalic vein. A case of complete thrombosis of the supraazygos superior vena cava, brachiocephalic veins and right internal jugular vein in a patient with ABD has only recently been reported<sup>5</sup>. It seems likely that unusual deep venous thrombosis will be detected more often in disorders of hypercoagulation with the use of modern imaging techniques.

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## Acute vulvar edema a rare consequence of preeclampsia may characterize the severity of the disease

Dear Editor

Preeclampsia is a disease unique to human pregnancy characterized by new-onset hypertension and proteinuria after the 20<sup>th</sup> week of gestation. It affects 6-8% of all pregnancies and is one of the leading causes of maternal and fetal morbidity and mortality worldwide. Voluminous vulvar edema in association with preeclampsia is a rare sign during pregnancy. In our case a primigravida women with acute appearance of massive vulvar edema in ongoing twin pregnancy with severe preeclampsia further developed an acute renal failure. Vulvar edema during pregnancy may characterize the severity of the disease. Because of poorly controlled blood pressure of our patient, deteriorated renal function the following 9 hours from her admission and the non-reassuring recordings of the fetal heart rates a caesarean section (CS) was decided. Because of prematurity, neonates were transferred in the Neonatal Intensive Care Unit (NICU), while mother was transferred to the Intensive Care Unit because of severely deteriorated renal function and of the uncontrolled blood pressure. Forty-eight hours later biochemical blood tests, physical findings improved dramatically, while the vulvar edema almost disappeared. The first infant died 10 days after birth because of intraventricular hemorrhage while the second one remained in NICU for 60 days and was discharged when her body weight was 2880 grams.

Preeclampsia ranges from mild disease to a severe form that endangers the life of both mother and the fetus. Severe edema in preeclamptic patients is very rare. The current evidence encloses only five cases related to this issue<sup>1-4</sup>. Preeclampsia associated with acute renal failure presents in 5-10% of severe cases of preeclampsia with a predicted mortality rate of 10%<sup>5</sup>. Recovery is usually complete if the acute phase passes without further complications.

Persistent hypertension despite anti-hypertensive therapy, progressive deterioration in renal function and non-