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Resumos das Comunicações Orais (C) e dos *Posters* (P)
Abstracts of Oral Communications (C) and Posters (P)
Résumés des Communications Orales (C) et des Posters (P)

C1.
Le risque allergique en milieu hospitalier

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Le personnel hospitalier est confronté dans l'exercice de sa profession à des risques variés: biologiques, chimiques, physiques. Le but de notre travail était d'évaluer la prévalence du risque allergique dans les hôpitaux et les structures sanitaires de huit villes au Maroc. Il s'agissait d'une enquête transversale à l'aide d'un questionnaire anonyme portant sur 2831 personnes (53,8% de femmes, 46,2% d'hommes, 16,6% de médecins, 55,5% de paramédicaux, 14,9% d'agents, 11,3% d'administratifs et 1,7% de biologistes) parmi 3906 de l'effectif existant (taux de réponse: 73,2%) avec une moyenne d'âge de 40,5 ans. La méthode utilisée était le porte à porte. Les prick tests (PT) ont pu être réalisés dans 496 cas avec des extraits allergéniques Stallergènes® (France) vis-à-vis des acariens DP et DF, le pollen des 5 graminées, la blatte germanique et le latex. Les enquêtes s'étaient déroulées de mai à août 2001. L'étude et l'analyse étaient faites sur logiciel Epi-Info 6. La prévalence de l'asthme, de la rhinite, de la conjonctivite, de l'eczéma et de l'urticaire était respectivement de 10,4%, 22,8%, 17,4%, 14% et 13,5%. Les réactions cliniques au latex étaient notées dans 7,1%, au formaldéhyde dans 7,4% et au glutaraldéhyde dans 1%. Le taux de PT positifs au latex était de 5,2%. La prévalence de toutes les affections citées était significativement plus élevée en cas d'antécédents parentaux ou familiaux d'atopie, chez les femmes et chez les biologistes. L'asthme était qualifié de professionnel par le personnel dans 2%. La prévalence de l'asthme, de la rhinite, de la conjonctivite et de l'allergie au latex et formaldéhyde ne variait pas de façon significative selon les villes. Le contact avec le latex entraînait de l'urticaire dans 5,1%, de la rhinite dans 3,9%, de l'eczéma dans 3,1%, de la conjonctivite dans 2,1%, une gêne respiratoire avec sifflements dans 1% et un choc anaphylactique dans 0,1%. Il existe donc un risque allergique non négligeable et il est important d'accorder l'attention voulue à l'identification du risque allergique et son évaluation afin de mettre en œuvre des stratégies de prise en charge et de prévention adaptées à ce risque .

C2.
Nasal obstruction and atopy in Obstructive Sleep Apnoea Syndrome

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Introduction: Nasal obstruction may be a contributing factor in the pathogenesis of Obstructive Sleep Apnoea Syndrome (OSAS) and allergic rhinitis may be associated with sleep disturbance.
Aims: To evaluate the relationship between nasal obstruction, atopy and OSAS.
Patients and methods: 78 consecutive patients (65 men and 13 women), referred for suspected OSAS were included in the study. Mean age was 50.4±12 years and mean body mass index was 31.4±5.3. All patients underwent a sleep study, skin prick tests to 8 common inhalant allergens (Leti, CBF), Epworth sleepiness score, nasal symptom scores (severity of symptoms were rated on a scale that ranged from 0 to 3) and nasal obstruction index – NOI (Mouth Peak Inspiratory Flow-Nasal Peak Inspiratory Flow/Mouth Peak Inspiratory Flow), measured with a inspiratory peak flow meter (In Check, Clement Clark).
Results: OSAS diagnosis (Apnea-Hypopnea Index-AHI- ≥ 5) was confirmed in 80.8% of patients, with a mean AHI of 40.9±26.5. Positive skin prick test response (wheal diameter equal to 3 mm or greater) to at least one allergen was present in 19 % of OSAS patients (91.7% to house dust mites) and all had symptomatic rhinitis; mean nasal symptom score was 2.5±2.5 (0-12), while reduced nasal patency (NOI ≥ 0.5) was present in 54%. There was no correlation between nasal symptom scores, nasal patency (NOI) and OSAS severity (AHI). Atopic patients with OSAS had significantly more severe nasal symptoms (5.3±2.8 vs 1.8± 1.9, $p<0.05$), but nasal patency and AHI were similar to non-atopic apneics (NOI: 0.56±0.15 vs 0.49±0.17 and AHI: 30.5±20.8 vs 43.0±27.4)
Conclusions: The prevalence of allergic rhinitis in this cohort of OSAS was high. Nasal obstruction had no relation with the severity of OSAS. Atopic patients with OSAS have more severe nasal symptoms which can have implications in the long-term tolerance of nasal CPAP.

C3.
How do Primary Care Physicians recognize Obstructive Sleep Apnoea

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Introduction: Obstructive Sleep Apnoea (OSA) is a common disorder. However, primary care physicians often under diagnose this condition and fail to make appropriate referrals.
Objective: To evaluate what percentage of patients referred by primary care physicians for suspected OSA actually show OSA and to characterise the clinical features of these patients.
Setting: Recently created Respiratory Sleep Disorders clinic of a teaching hospital.
Materials and Methods: A retrospective database review of patients referred for suspected OSA by primary care physicians during the year 2001.
Results: From a total of 286 patients, we included 132 patients (46%) referred by 54 primary care physicians. 77.3% were male, middle aged (52,1±12,32 years). In 16,7% patients sleep study was not performed and in 17,4% sleep disordered breathing was excluded. OSA was diagnosed in 65,2% cases, of whom 45,2% were severe (Apnoea/hypopnoea index -AHI ≥ 30) and 41,9% were mild (5>AHI<15). The mean Epworth value of OSA patients was of 12,7 ± 6,3 and the Mean apnoea-hypopnoea index was 34,2 ± 25.2. CPAP was prescribed in 39,4% patients.
Conclusion: Our survey suggests that primary care physicians still have some difficulties in identifying sleep disorders and certainly under diagnose OSA. Further education is necessary to improve detection of sleep disorders in primary care.

C4.
Obstructive sleep apnoea (OSA) in the elderly

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This study was undertaken to assess obstructive sleep apnoea syndrome in elderly patients.

We consecutively studied 100 patients with OSA diagnosed by nocturnal polysomnography. We considered 2 groups: Group A <65 years (N=78) and Group B ≥65 years (N=22). These groups were analysed for sex, BMI, symptoms, associated disorders, respiratory function tests, electocardiography (ECG), apnoea/hypopnoea index (AHI), compliance with CPAP.
Age: A-51.6±8.7/B-70.4±4.5 years; Sex: A-88.5%/ B-77.3% were males; BMI: A-34.9±6.7/B-35.5±6.7 Kg/m^2. Symptoms were similar, including nocturnal polyuria A-2.3±1.8/B-2.5±1.7 times/night; decreased libido A-76.9%/B-68.2%; impotence A-43.5%/B-64.7% jk (p=0.12). The Epworth sleepiness scale A-16.9±3.7/B-13.9±5.2 (p=0.002). Difficulty concentrating A-19.2%/B-40.9% (p=0.03) and altered memory A-37.2%/B-63.6% (p=0.03) were more frequent in older patients. Traffic accidents/near accidents due to sleepiness occurred often in younger patients A-66.7%/B-35.7%(p=0.03).
COPD A-33.3%/B-56.5% (p=0.04); heart failure A-12.8%/B-40.9% (p=0.003) and ischemic heart disease A-12.8%/B-36.4% (p=0.01) had a higher rate in elderly.
Respiratory function tests were abnormal A-50%/B-77.3%(p=0.01). Blood gases were abnormal A-45.2%B-54.5%; only hypoxaemia A-21.9%; B-13.6%; hypercapnia A-23.3%/B-40.9%. ECG cardiac arrhythmia A-12.8%/B-36.3% (p=0.01). IAH A-52.4±27.9/B-40.1±24.9 (p=0.05). All accepted CPAP treatment. Compliance with **CPAP:** days with device usage A-94.2%±8.2/B-89.1%±10.6 with an average hours of use A-6.1±1.5/B-5.9±1.7.
In conclusion older patients had similar clinical presentation and compliance. Because the higher rate of cardiovascular disease they must be treated as well as younger.

Key words: OSA, elderly.

C5.
Obstructive sleep apnoea (OSA) in very obese patients

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The aim of this study was to assess obstructive sleep apnoea syndrome in very obese patients.
From a total of 118 patients with OSA diagnosed by nocturnal polyso mnography, we considered 2 groups: Group A-BMI (body mass index) <30 Kg/m^2 (N=26) and Group B-BMI ≥40 Kg/m^2(N=28). Both groups were analysed for sex, neck circumference, symptoms, asso-ciated disorders, respiratory function tests, electocardiography (ECG), apnoea/hypopnoea index (AHI), compliance with CPAP.
Age: A-58.1±10.7/B-55.4±13.4 years; Sex:A-100%/B-60.7% were males (p<0.01); BMI: A-26.9±1.7/B-44.2±4.0 Kg/m^2; neck circumfe-rence: A-40.7±1.9/B44.6±3.7cm (p<0.01). Symptoms were similar, except for nocturnal polyuria A-64.0%/B-85.7% with A-1.6±1.5/B-2.9±1.9 times/night (p<0.01). The Epworth sleepiness scale A-15.6±3.7/B-17.6±3.4 (p=0.04). Altered memory A-36.0%/B-71.4% (p=0.01) and depression A-24.0%/B-46.4% were more frequent in very obese patients.
Systemic arterial hypertension A-60.0%/B-89.3%(p=0.01); heart fai-lure A-4.0%/B-17.8% (p=0.11) and ischemic heart disease A-12.0%/B-25.0% (p=0.22) had a higher rate in very obese patients.
Respiratory function tests were abnormal A-39.1%/B-71.4% (p=0.04). Blood gases were abnormal A-21.7%/B-60.7% (p=0.02); only hypoxaemia A-8.7%/B-25.0%; hypercapnia A-13.0%/B-35.7%. ECG cardiac arrhythmia A-17.4%/B-29.6%. IAH A-40.1±19.8/B-50.8±28.6 (p=0.12). All accepted CPAP treatment. Compliance with CPAP: days with device usage A-89.3%±15.1/B-92.9%±10.4 with an average hours of use A-6.1±1.4/B-6.1±1.3.
In conclusion very obese patients had a similar clinical presentation and compliance. They had an higher rate of abnormal respiratory function tests and blood gases, as well as of cardiovascular disease.

Key-words: OSA, very obese.

C6.
The efficacy of an education program on nasal continuous positive airway pressure (CPAP) compliance

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Although Nasal Continuous Positive Airway Pressure (CPAP) is the first choice therapy in correcting Sleep Apnoea/Hypopnoea Syndrome (SAHS), non-compliance with CPAP poses a serious limitation to its efficacy.

The aim of this study was to evaluate the efficacy of an education program of CPAP therapy. We studied 61 male patients with the diagnosis of SAHS: Group A – 31 subjects with a mean age of 54.8 years submitted to an inpatient comprehensive education program and Group B (control group) – 30 subjects with a mean age of 53.3 years not submitted to that program.
The mean follow-up period was 3 months. No differences were found in mean education level, body mass index (Group A- 31.7 Kg/cm^2; Group B – 33.1 Kg/cm^2), Epworth sleepiness scale (Group A – 11.4; Group B – 14.1), apnoea/hypopnoea index (Group A – 46.7/h; Group B – 47.9/h).
Despite the high prevalence of adverse effects related to CPAP, its frequency was similar between the groups (Group A – 71%/Group B – 83%).
Group A showed a higher statistically significant compliance to CPAP (Group A – 77% compliant patients with 5.4 h/night; Group B – 47% compliant patients with 4.3h/night).
We concluded that a comprehensive education program is required to ensure optimal patient compliance.

C7.
Experimental model of monocrotaline induced pulmonary hypertension in rats. Morphometric analysis

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Study objectives: to asses the morphologic changes in the medial layer of pulmonary muscular arteries in rats with pulmonary hypertension induced by monocrotaline.
Material and methods: the administration of one dose of subcuta-neous monocrotaline induced diffuse pneumonitis followed by pulmonary hypertension.
The rats were sacrificed by intraperitoneal pentobarbital after 3, 7, 14, 21, 28, 31 days after the monocrotaline injection.
A special microvisa was used for the morphometric analysis to calculate a hupertrophy index.
Results: we included in our study a total of 42 adult Wistar rats (10 controls and 32 injected with monocrotaline). The hypertrophy index of the witness rats was 29.9%, of the none noninjected rats 29.4% and the total hypertrophy index of the monocrotaline injected rats was 50.6% reflecting marked medial hypertrophy.
Conclusions: the results validate our experimental model with the published literature. This is a useful model for further assessment of various therapeutic interventions.

C8.
Elemental deposition in human lungs

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Information on particulate matter deposited along the human respiratory tract and specially at the cell/tissue level can help linking epidemiological, toxicological and pathological studies.
The present work was carried out to evaluate the importance of nuclear microscopy as a tool to the understanding of the origin of pulmonary disorders induced by respirable xenobiotics.
Cryosections of several autopsy samples of trachea, bronchi, lung and associated lymphoid tissue were evaluated by nuclear microscopy techniques with elemental mapping capabilities which are based on accelerated particle beams (Nuclear Microprobe) and synchrotron radiation (Micro-X Ray Fluorescence Spectrometry). Elemental concentrations, e.g., Cr, Mn, Fe, Ni, Cu, Zn, and Pb, were determined for the intracellular milieu at different respiratory tract level and for discrete phagocytic inclusions from five subjects without respiratory diseases and without known occupational exposures to metals. The intracellular concentrations of some elements such as, Cr, Ni and Pb are reported and the elemental distributions discussed. We can conclude that these techniques can be easily applied to the study of several diseases induced by inorganic respiratory aggressors.

C9.
Functional analysis of TNF-alpha and extended MHC haplotype polymorphism in pulmonary tuberculosis

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There is evidence in natural human disease and experimental infection in mice that host genetic factors influence susceptibility to infection with M. tuberculosis and the progress of the disease. The functional importance of TNF-a in the immune response modulation and its location at the central region (Class III) of the MHC, motivated the inte- rest in the correlation between TNF polymorphism, affecting the induction of its expression, with different MHC alleles and haplotypes. The present work aimed at the evaluation of Major Histocompatibility Complex (MHC) haplotype polymorphism involvement in susceptibi- lity to disease progression after Mycobacterium tuberculosis infection, highlighting the importance of the individual genetic background. Ninety-nine non-multiresistant pulmonary tuberculous patients and 36 infected, non-BCG immunised, t uberculin positive controls, were typed for HLA-A, -B, -Cw, -DRB1, -DQA1, and -DQB1, Properdin factor B (BF), C2, C4A, C4B, TNF-a and LT-a. Monocytes were stimulated for 16 hours with LAM and LPS. TNF-a production was measured in the supernatants. Intracellular detection of TNF-a was performed by flow cytometry. Relative quantification of TNFa mRNA was accomplished by real time PCR. Preliminary data correlate the TNF-a A-308G mutation, important for regulation of gene transcription, with the haplotype HLA-A*01, B*08, DRB1*03, presenting increased levels of TNF-a secretion in monocytes stimulated by LAM, whereas HLA-DRB1*15 presenting haplotypes showed lower levels of TNF-a secretion. These results could support the hypothesis that individuals with HLA-DRB1*15 haplotypes are genetically predisposed to lower production of TNF-a, lower activation of monocyte-macrophages and poorer granulomatogenesis, resulting in increased susceptibility for progression to tuberculous disease after infection with M. tuberculosis.

C10.
Our experience in thoracic trauma. Epidemiology

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Introduction: The initial management of patients with thoracic trauma should be aimed at identifying and appropriately treating potentially life-threatening lesions and lesions that would lead to a reduction in their quality of life. That is why it is necessary to study the clinical epidemiological characteristics of these patients.
Objective: To determine the clinical epidemiological characteristics of thoracic trauma.
Methods: A longitudinal study was designed. Study unit: the population of patients with thoracic trauma that have passed through the Thoracic Surgery Unit of the Gran Canaria University Hospital between October 1995 and December 1999.
Results: A total of 512 patients were treated, of which, 72% (367) of cases were men and 28% (143) women, mean age was 50.9 years (DE = 20), range (13-95 years). Average age for men was 47.7 years (DE = 18.2) and 59.3 years for women (DE =22). The age difference between the sexes was statistically significant; $p < 0.001$. The average hospital stay was 12.1 days (DE = 11.7), range (0 – 103 days). 60.9% of patients presented single traumas, whereas 39.1% presented multiple traumas. The most frequent cause of accidents was casual (45.4%), followed by traffic accidents (38.9%). The average age for traffic accidents was 42.8 years (D = 17.7) and 62.4 years for casual accidents (D = 17.6). Once again, this age difference was statistically significant for $p < 0.001$. Women presented a greater risk of having a casual accident then men; OR = 1.67 (1.2-2.3) for $p < 0.001$; whereas men presented a greater risk of having a traffic accident; OR = 1.65 (1.002 – 2.6) for $p < 0.05$. Concerning the local clinical conditions, 67.3% presented pain and 28.8% dysnea and pain. Of all the patients that presented parietal symptoms (317), 51.7% presented fracture of ribs 1 to 3 and 20%, a fracture of ribs 4 to 6. A total of 159 patients presented pleural symptoms. Of these, 19% presented right pneumo-thorax. Of the 194 patients who received thoracic treatment, the most frequent surgical gesture was pleural draining 66% (28). 44 patients presented respiratory complications, with pneumonia being the most frequent with 29%. General complications were seen in 15.2% and neurological complications in 18% of cases. Mortality was 2.5% (13) and total sequellae 1.9%. The risk of death was greater among patients suffering multiple traumas (OR = 2.1 (1.6 – 2.9)).

Conclusions: The severity of the trauma is greater in patients with multiple traumas and there are differences in the trauma characteristics that vary with the sex and age of the patient. All of this enables us to develop more specific prevention and health promotion measures. Closed and isolated trauma events were more frequent and pleural draining was the most commonly used surgical intervention.

C11.
Primary Spontaneous Pneumothorax: treatment based on aspiration with small catheter versus intercostal tube drainage

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Background: There are several options to treat patients with a primary spontaneous pneumothorax. The objective of this study is to compare the effectiveness of two alternative treatments: simple aspiration (SA) and intercostal tube drainage (ITD).
Patients and methods: We compare a current series of 91 patients treated with SA with a historic series of 216 patients treated by ITD. The SA was performed by emergency physicians, while ITD was done by Thoracic surgeons. Lenght of follow-up ranged from 24 months.
Results: The immediate effectiveness of SA was greater than that of ITD (86.7% vs 76%, $p<0.05$). Recurrence rate was the same (23% vs 17%, NS). Lenght of admission was shorter in SA patients (24h. vs 138h, $p<0.05$). The proportion of success in both proceedings after 24 months of follow-up was the same (63.7% vs 62.9%, NS).
Conclusions: The SA is a therapeutic method as effective as ITD. Its technique is simple, and emergency physicians can perform it correctly. The discomfort, health costs and lenght of admission are greatly reduced with SA.

Key-words: aspiration, spontaneous pneumothorax, thoracic drainage.

C12.
Spontaneous Pneumothorax and Ehlers – Danlos Syndrome: A rare etiology

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Ehlers – Danlos Syndrome (EDS) is a connective tissue disorder cha- racterized by abnormalities of skin, ligaments and internal organs.
Case-report: A 16 years old male was admitted on Nov.2001 with right spontaneous Pneumothorax (PNTX) and complicated empyema. On Dec. 2001 was readmitted with left PNTX with broncho-pleural fistula. It was made thoracoscopy followed by surgery (thoracotomy) with difficult repair because of the extreme lung friability. Pleurodesis with talc and biological glue. Few days later he began with high fever. Physical examination: Chest – left hydropneumothorax; Abdominal keloid (on June 2001 – minimal trauma with spleen fracture. Surgery without splenectomy); joint laxity; Easy bruising.
Laboratory results: Anemia; Inflamatory parameters increased; negative blood and pleural effusion cultures; Chest film and CT scanning-hidropneumothorax.
Therapy: Closed drainage with chest tube; antibiotherapy; transfusional support.
There was a clinical, laboratory and radiographic improvement. Discharged on 21st day. Taking into account: High friability tissues; joint laxity; skin fragility and PNTX, it was made the EDS diagnosis, supported by geneticist opinion and lung biopsy.
It's a rare PNTX etiology with difficult surgery repairs because the extreme tissular friability

C13.
Thoracoscopic surgery for pneumothorax

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Video-assisted thoracic surgery (VATS) is accepted as the surgical treatment of choice for pneumothorax. We report our experience with 101 patients (22 woman and 79 men) age ranging between 14 and 76 years (average 26.5 years) , treated by VATS over a period of 8 years. 88 patients had primary pneumothorax (PP) and 13 patients secondary pneumothorax (SP). Surgical indications included persistent air leak (36), recurrence (48), bullae > 2cm (15) and bilateral involvement
(2). Patients with PP underwent bullectomy and pleurectomy (68), bullectomy and abrasion (7), bullectomy (4) and pleurectomy (9). SP surgical procedures included bullectomy and pleurectomy (2), bullectomy and intrapleural talc (3), pleurectomy (4) and intrapleural talc alone (4). Two patients required thoracotomy. Fo llow up ranging 1 to 96 months, included 3 recurrences (3,4%) in PP and 2 (15,4 %) in SP. We concluded that in PP best results were obtained with bullectomy and pleurectomy. Chemical pleurodesis is efficient and acceptable in SP.

C14.
Video assisted thoracic sympathectomy for treatment of palmar and axilary hyperhidrosis

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Video-assisted thoracic sympathectomy is accepted as the surgical treatment of choice for hyperhidrosis. We report our experience with 50 patients (35 woman and 15 men) age ranging between 14 and 36 years (average 22.8), treated by VATS over a period of 18 months. 48 patients (96%) had palmar and axilary hyperhidrosis and 2 (4%) palmar hyperhidrosis. 49 patients were submitted a bilateral sympathectomy with excision of T_2, T_3 and T_4 sympathetic ganglia and 1 patient unilateral sympathectomy. One patient required thoracotomy (intercostal artery bleeding). The average postoperative hospital stay was 48 hours. Follow up ranged 1-18 months and palmar and axilary hyperhidrosis resolved in all the patients. Compensatory sweating was observed in 23 patients (46%). In conclusion, excision of T_2/T_4 sympathetic ganglia by thoracoscopy is a safe and excelent treatment of palmar and axilary hyperhidrosis.

C15.
Endoscopic cryotherapy in five intraluminal typical bronchial carcinoids

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The Cryotherapy it is a method of destruction base on the effects of local destruction of the extreme cold on the living tissue.
We present our experience in the endoscopic treatment of intraluminal typical carcinoid tumors, using cryotherapy.
Broncho-pulmonary carcinoid tumors constitute around 5% of primary neoplasias of the lung. They are neuroendocrine tumours of relatively low malignancy, mostly arising in main bronchi. They, often, become apparent through coughing, hemoptysis (50% of cases), recurring infection or wheezing…etc. In most cases, diagnosis is carried out endoscopically by way of the typical image displayed by this kind of tumour and then confirmed by biopsy, although said diagnosis must be undertaken with great care due to the possibility of sometimes major and occasionally fatal bleeding. Histologically speaking, two types of carcinoid tumour are described: typical and atypical ones, according to architectural organization, mytosis and necrosis….etc., with the atypical ones being more serious. Surgical treatment continues to be considered the kind offered as a matter of course, with more conservative treatment (such as bronchotomy, Yag-Laser…etc) being reserved for irresolvable cases of typical carcinoid tumours. Nonetheless, ther do exist writers who advocate endoscopic treatusing Yag-Laser with variable results.
We have treated five typical bronchial carcinoid tumours from diffe- rent localizations, accesible by means of bronchoscope and with biopsies displaying typical features of this kind of tumour, with complementary normal blood tests and with thoracic scanner showing the whole wall.
Endoscopic cryotherapy proved completely effective in 4 patients, whithout scanner, histological, endoscopic relapse at **11** years, **9** years, **7** years, **6** years and **4** years, respectively. The 5th case, following cryotherapy prior to diagnostic biopsy and subsequent to various sessions, enabled us to carry out a more conservative pulmonary resection (lower left lobectomy) than that originally envisaged left pneumonectomy. After seven years the results are normal.
Endoscopic therapy anables us to carry out cryodestruction not only of the endoluminal mass but also of the base of implantation on the inside of the bronchial wall practically as far as the cartilaginous lining, the aforementioned without risk of perforation. This justifies the use of said treat-

ment in this kind of tumour (and in other benignant and precancerous lesions and carcinomas in situ). From our experience, 3 carcinoid tumours initially treated using Yag-Laser suffered relapse in the control which we carried out. Treatment using cryotherapy was subsequently undertaken with the aforementioned results.
From our experience in the endoscopic treatment of benignat lesions and those of so-called low malignancy, in addition to other types of lesion (precancerous, carcinoma in situ) we believe that cryotherapy may constitute:

1. The ideal treatment in cases of typical intraluminal carcinoid tumours, on account of its destructive action even on the inside of the bronchial wall without the risk of accident which may arise from endoscopic methods.
2. Essential complementary treatment when another endoscopic technique is initially used (Yag-Laser).
3. Suggestion of cryotherapy prior to diagnostic biopsy in very hypervascularized tumours so as to avoid serious complications.

C16.
Role de la Chirurgie dans le diagnostic des Lymphomes du Médiastin antérieur

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Les Lymphomes du Médiastin antérieur ont une importance croissante et la Chirurgie a un rôle à jouer dans leur diagnostic. De 1968 à Juin 2000, nous avons opéré 421 tumeurs du Médiastin dont 70 Lymphomes (59% des tumeurs malignes du Médiastin antérieur). 67% des malades étaient du sexe féminin et 53% avaient moins de 30 ans. Il s'agissait en 31 cas de Maladie de Hodgkin et en 39 de Lymphomes non Hodgkiniens, dont 12 cas de Lymphomes B sclérosants du Médiastin. Le diagnostic a été établi par biopsie de la masse médiastinale, le plus souvent par médiastinotomie antérieure. En effet, si âge et sexe des malades permettent de suspecter d'un lymphome face à une masse médiastinale antérieure de caractéristiques malignes, la biopsie est évidemment nécessaire pour confirmer le diagnostic et charactériser le type hystologique (Hodgkin, non-Hodgkin, T ou B). La Chirurgie a encore été utilisée face à la persistance d'une tumeur médiastinale de nature indéterminée, après chimiothérapie, ou pour réduire la masse tumorale chez les candidats à une auto-transplantation médullaire.

C17.
La fibrinolyse locale dans le traitement des pleuresies purulentes

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Introduction: Le traitement standard des pleurésies purulentes (PP) comprend, le recours à l'antibiothérapie et au drainage thoracique. Ce dernier devient difficile en présence d'un cloisonnement avec des adhérences. L'utilisation des agents fibrinolytiques en intra pleurale dans ces cas pourrait être une alternative thérapeutique intéressante. Le but était d'évaluer l'apport de la fibrinolyse intra pleurale dans le traitement des PP cloisonnées.
Matériels et méthode: Etude rétrospective incluant les malades hospitalisés au service de réanimation respiratoire de l'Ariana pour PP de 1997 à 2002. Le diagnostic de PP a été retenu devant l'aspect purulent, la cytologie et la bactériologie du liquide pleural. L'indication d'une fibrinolyse intra pleurale a été posée sur les données de l'échographie thoracique (cloisonnement, enkystement). Elle a consisté en l'injection lente (30') d'une solution diluée de 250000 UI de streptokinase dans 250 cc de sérum salé associée à un clampage du drain thoracique durant 04 heures. L'évaluation de l'efficacité du traitement reposait sur des critères cliniques (symptomatologie fonctionnelle respiratoire, apyrexie), biologiques (GB), radiologiques et échographiques à J1, J7 et à la sortie.
Résultats: Durant la période de l'étude, 18 malades ont bénéficié de ce traitement. Il s'agissait de 16 hommes et 2 femmes âgés en moyenne de 35,9±15,9 ans. L'aspect du liquide était purulent dans 89 % des cas. La pleurésie était unilatérale dans la majorité des cas (16 malades). A l'échographie la quantité du liquide était qualifié d'abondante chez 3 malades, de moyenne abondance chez 8 malades et de faible abondance chez les 7 restants. Après traitement local par de la streptokinase, une amélioration clinique a été notée chez tous nos patients, l'évolution radiologique a été favorable à J1, J7 et à la sortie chez respectivement, 56,3% ; 81,3% et 93,8% des patients. L'amélioration échographique a été obtenue respectivement chez 42,9% ; 75% et 90% des malades.
Le recours à la thoracoscopie interventionnelle chez une patiente et à la décortication chirurgicale chez une autre a été nécessaire. Les complications en rapport avec ce traitement étaient rares. On a noté un seul cas d'hémorragie intra pleurale.

Conclusion: L'utilisation de la streptokinase intra pleurale semble être une alternative intéressante dans le traitement des pleurésie purulentes cloisonnées. Elle s'accompagne d'une amélioration clinique et radiologique rapide.

C18.
Kystes hydatiques pulmonaires. 35 ans d'expérience chirurgicale

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Le Kyste Hydatique, longtemps endémique dans le sud du Portugal, est maintenant plus rare. Le but de cette présentation est de revoir notre expérience en Chirurgie du Kyste Hydatique pulmonaire. En 35 ans (1967-2001), nous avons opéré 173 malades pour Kyste Hydatique pulmonaire, dont 94 du sexe masculin. Leur âge variait entre 3 et 76 ans, avec un maximum entre 10 et 19 ans. 45 de nos malades ne présentaient aucun symptôme. La localisation la plus fréquente a été le lobe pulmonaire inférieur droit. Chez 103 malades, il y avait un seul kyste pulmonaire mais chez 48 autres, l'hydatidose pulmonaire était multiple (bilatérale chez 27) et 38 malades avaient une hydatidose hépatique associée. Nous avons réalisé 197 interventions thoraciques, associées chez 16 malades à la chirurgie hépatique. Nous préférons la kystectomie aux autres types d'intervention, réservant les résections pulmonaires aux kystes infectés ou de grandes dimensions. La mortalité a été nulle et les complications peu fréquentes (4%). Les malades avec plus d'un kyste ont été soumis à un traitement médical complémentaire.

C19.
Prevalence of chronic obstructive pulmonary disease in Portugal

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A representative sample of the portuguese population was evaluated, with the aim of establishing and characterizing the prevalence of COPD in Portugal (continental and insular).

Material and Methods: The authors evaluated, between October 2001 and March 2002, 1384 individuals, 35-69 years old (49±9.2), 50.5 % females, randomly selected in bietapic method from all main regions in Portugal. A demographic and respiratory symptoms inquiry was applied, based on ATS questionnaire, previously validated for the portuguese population. This inquiry included the characterization of tobacco, dusts, gases and fumes exposure. A spirometric test was performed. The definition of COPD was that of GOLD initiative (symptoms and airway obstruction – FEV1/FVC < 70% of predicted).

Results: The overall prevalence in the portuguese population was 5.42 % (95% confidence values 4.42-6.42), mainly characterized by 94.7% specificity for cough and sputum > 3 months/year, smoking - 24.5 % actual and 22.3% former, - and an increase with age.

The distribution between GOLD classes of severity, was: 46.7 % in class I, 40.0 % in class IIA, 13.3 % in class IIB, and 0% in class III.

Conclusions: The prevalence of COPD in Portugal is as high as other studies report elsewhere, accounting for an increasing bulge of chronic respiratory pathology.

C20.
Prevalence of modifiable risk factors for exacerbations in chronic obstructive pulmonary disease (COPD)

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We have many guidelines concerning the best way to deal with patients suffering from COPD but only few data about success of preventing the modifiable risk factors related to COPD exacerbations.

We studied the prevalence rates of modifiable risk factors in all patients admitted in a pneumology ward with diagnosis of COPD, during 6 months. Patients unable to answer a questionnaire and with important comorbidity, were excluded.

We included 64 patients (7 females) with 75 admissions, aged (mean±sd) 68±11, 81% with elementary school or less. The median forced expiratory volume in one second was 40%, 66% were in the stage III of Global Initiative for Chronic Obstructive Lung Disease classification and 29% had no functional limitation in performing daily activities at home. From the total, 35% were current smokers, 84% were not in rehabilitation programs and only one was in exercise training. Twenty nine patients (41%) failed the correct inhaler manoeuvres, only 45% received an influenza vaccination and only 14% received pneumococcal vaccine. Patients on long-term oxygen therapy were 43, but 47% used it less than 15 hours/day.
This study suggests unsatisfactory management of COPD patients, in which we found risk factors susceptible to be modified and corrected.

C21.
One-year experience of noninvasive mechanical ventilation (NMV) in a respiratory ward

L MOTA, **C NUNES, C SANTOS, S MELO, F OLIVEIRA**

Use of NMV has rapidly proliferated during the past decade to support patients with acute respiratory failure.
To evaluate our experience, we analysed the admissions with NMV during year 2001. NMV was performed in 154 admissions (28 % of total), and the goals were: to compensate non-acidemic chronic respiratory failure (Group 1: 27%, $PaCO_2$ = 63±11 mmHg), predominantly hypoxemic respiratory failure (Group 2: 18%, PaO_2/FIO_2= 167±29 mmHg/L/min) and acute respiratory acidosis (Group 3: 55%, pH = 7.30±0.04); 53% were already on domiciliary NMV.
After initial improvement, in 20% there were re-exacerbations, mainly in G3 (28%, p=0.01). In 33% there were NMV related complications, the most frequent was mask discomfort (20%) and mostly in G3 (70%, p=0.02). Patients with domiciliary NMV needed significantly higher level of pressure (p< 0.0001).
The final outcome was 92% of success with no differences between groups. Arterial blood gases at discharge were similar in all groups (G1: $PaCO_2$: 54±8 mmHg; G2: PaO_2/FIO_2= 253±67 mmHg/L/min; G3: pH = 7.41±0.03).
We conclude that, in spite the re-exacerbation rate and NMV related complications, NMV can be safely and successfully used in a respiratory ward.

C22.
Noninvasive mechanical ventilation (NMV) in a respiratory ward: monitoring and complications

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Monitoring is an important step for optimal implementation of NVM.
In our ward, the monitoring of these patients includes: a) arterial blood gas (ABG) b) SAPS II c) haemodynamic parameters (RR, BP, HR, axilary temperature); d) level of dyspnea and mental status (MS); e) quantification of bronchial secretions (BS); f) compliance to NMV ;
g) NMV related complications.
In order to evaluate the relationship between some of these factors and the success of NMV, the re-exacerbation rate and related complications we analysed 154 admissions submitted to NMV.
Overall success was 92%. Failure of NMV was significantly related with SAPS II and compliance at admittance, non-improvement of MS, dyspnea, SB and compliance.
Re-exacerbation rate was 20%, and was significantly related with poor compliance, SAPS II and no improvement of MS and dyspnea.
Complications were present in 33 %, were not significantly related with these parameters and the most frequent were: mask discomfort (20%), nose trauma (13%), headache (9%) and eye irritation (5%). The existence of complications was not predictive for failure.
ABG values and RR are known predictive variables for success. From these data it seams that other factors can predict the success NMV and re-exacerbations justifying a larger study.

C23.
Compliance and physiologic effects of Long-term Non Invasive Positive Pressure Ventilation in patients with Amyotrophic Lateral Sclerosis

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Introduction: Non-Invasive Positive Pressure Ventilation (NIPPV) has been shown to improve survival and quality of life in Amyotrophic Lateral Sclerosis (ALS). However ventilatory mode, level of support and objective compliance to this therapy has not been carefully analysed.
Aim: To measure objective compliance and physiologic effects of NIPPV in patients with ALS.
Patients and Methods: From January 1999 until March 2002, we included 19 consecutive patients with ALS who were started on NIPPV. Spirometry, maximal inspiratoy pressure and blood gas analysis were performed at baseline and each 2-3 months after starting NIPPV. NIPPV was applied through a bilevel positive-pressure ventilator in spontaneous mode (*BiPAP Duet Lx, Respironics*) adjusted according to comfort. Electronic recording of compliance (*Encore, Respironics, USA*) was evaluated after 1-2 weeks of treatment and then every 2-3 months.
Results: At baseline, patients had mean FVC 2.0±1.0 L, mean $PaCO_2$ 46,1±6.1 mmHg. Mean IPAP levels were 13.2±2.0 cmH20 and mean EPAP levels 4.1±0.5 cmH20. Eleven patients used NIPPV mainly during the nocturnal period, while 8 could only use it during the day. After 1-2 weeks of treatment mean electronic compliance to NIPPV was 2.9±2.2 hours/day, at 2-3 months was 4.2±4.7 hours/day and at 4-6 months increased significantly to 5.1±4.9/day (p=0.05). PaO_2, $PaCO_2$, FVC and Pimax did not change significantly over time.
Conclusions: Compliance to NIPPV in ALS improves significantly over time. In our experience, NIPPV had no effects on lung function. Electronic compliance may improve control of NIPPV effects in ALS.

C24.
Disability and depression in patients with COPD

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Patients with Chronic Obstructive Pulmonary Disease (COPD) have progressive levels of disability and may have susceptibility for depression. The aim of this study was to investigate the prevalence of depression in COPD patients and analyze its relationship with disability.
We studied 31 COPD male patients with a mean age of 63 years, recruited from an outpatient respiratory clinic. Assessments included pulmonary function tests, blood gas analyze, Mahler dyspnoea scale, 6 minutes walking test and HAD scale for the evaluation of depression.
We found a high prevalence of depression 55% (17 out of 31 patients) and a significant association between dyspnoea and depression. Exercise performance was mainly affected by the severity of airway obstruction and dyspnoea. However, depression did not influence this performance.
We concluded that depression is frequent among COPD patients with high levels of dyspnoea.

C25.
Results of our smoking cessation program in year 2000

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Objectives: This study examined prospectively, the effect of our Smoker Support Consultation program at the Pulmonology Department of the Hospital de Santa Marta. It's a consultation for diagnosis and individualized treatment of tobacco addiction, in which drug treatment is combined, with minimum to specialized psychological support.

Methods : The cessation program was offered to 115 cigarette smo- kers enrolled at baseline. The consultation methodology has been adapted to the recommendations of the Tobaccology Working Group of the Portuguese Pulmonology Society. A phone interview was run at 18 months to assess the abstinence rate of the patients surveyed. The relationship among those who quit smoking and others factors was investigated with a special emphasis regarding the age, gender, level of education, daily consume of cigarettes, degree of motivation, degree of smoking addiction, and number of consultations.
Results: A total of 95 – 52 males and 43 females – of this smoker cohort registered for phone interview, 22 (23%) reported that they had not smoked in the previous 18 months (13 males and 9 females). Conclusions: To be effective, tobacco control requires accomplishment of the smoking cessat ion program. Efficacy was specially related to the frequency of the consultations programmed.

C26.
Smoking cessation in women

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The number of regular females smokers is been increasing all over the world. The aim of this study was to evaluate the smoking cessation in women seeking medical support in a tobacco eviction consultation. **Material and Methods:** Out of 391 volunteers in a smoking cessation programme, 180 women were analysed.
Results: The mean age of individuals observed was 40,3 years old; 29% began smoking before 15 years old, 54% between 15 and 20 and only 17% after 20 years old. The results of Fagerström Test for Nicotine Dependence showed high dependence in 58 % of women. Several methods were used to achieve tobacco eviction: nicotine-replacement products-90, nicotine replacement and bupropion-23, bupropion-5, and non-pharmacological therapy-17. We analysed rates of female smoking cessation and compared with the of men's smokers group. There weren't significant weight differences after smoking cessation. We observed that there were slight great numbers of men than women in the studied population, which might reflect sexual differences in smoking habits in Portuguese population. Women began smoking habits later than men. There weren't founded differences in rates of dependence between the two groups with an average of 60% of individuals having high dependency, which illustrates the need of medical support to modify smoking behaviour.
Nearly all smokers acknowledge that tobacco use is harmful to health but underestimate the magnitude of their own risk. The increasing numbers of female's smoker's alerts for the need of special educational problems for this specific population.

C27.
Bone marrow transplantation (BMT): are pulmonary function testing (PFT) important to detect earlier abnormalities?

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Airflow obstruction secondary to bronchiolitis obliterans is one of most frequent noninfectious posttranspant respiratory complications.
A new obstructive pattern on PFT with reduced flow, hiperinflation and air trapping are common.
We studied 16 patients (10 males – 62,5%) proposed to BMT. They had a mean age of 37±8,48 years.
Only 1 patient was smoker. These patients made PFT with a autobox body plethymograph following the European coal and steel parameters. The PFT were done at 0,3, 6 and 12 months after BMT and vital capacity (VC), forced expiratory forced expiratory flow at 25, 50 and 75% and residual volume were selected. Before BMT, 1 patient had a mild restrictive pattern, 1 had a mild bronchiolar obstruction having the rest patients normal PFT. At 3 months 2 of the 14 patients (14%) with previous PFT developed a mild bronchiolar obstrution also present in PFT at 6 and 12 months after BMT. The other 12 patients had always normal PFT.
Conclusions: None of the patients had respiratory symptoms connected with obstrutction, so PFT are important to detect early abnormalities after BMT. 14% of the patients developed. B. O which is similar to literature data

C28.
Neuroendocrine differentiation in early stage of non-small lung cancer prognostic significance

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Las Palmas de G.C.

Neuroendocrine differentiation in early stage of non-small lung Cancer Prognostic significance. López Rivero L, García Yuste M, Gonzalez Aragoneses F, Quevedo Losada S, De la Torre Bravo M, Pa-niagua JM, Ceballos J, Ramos G, and member of EMETNE-SEPAR. Las Palmas de G.C. Canary Islands.Spain.

Objetive: The present study examines the relationship between neuroendocrine differentiation and the clinical behaviour of non-small lung cance r(NSCLC) in stage I. Methods:Retrospective study in 80 patients with stage I(Ia 17, Ib 63) teated surgically.68 men and 12 women. Age 40 to 79 years, mean 63. Tumors comprising 46 squamous-cell carcinomas, 32 adenocarcinomas, and 2 adenosquamous carcinomas, were analyzed inmuno-histochemically with antibodies to chomogranin-A (CGA), synaptophysin (SYN) and P53. Histology, tumor size, pleural afecct ation, local recurrence, metastasis, and survival were the clinical variables considered. Expression, grade of expression and intensivity were study for CGA, SYN and P53 in each of the tumors. Inivariant statistical analysis were performed. A value of $p<0.005$ was considered as significant.

Results: Segmentary resection 7, lobectomy 57, pneumonectomy 16. Tumor size 5 to 90 mm, mean 38. Pleural invasion 16. Local recurrence 10, metastasis 31. Positivity for CGA in 8, SYN in 32,P53 in 43, CGA and SYN in 6, CGA SYN and P53 in 5. There was no significant statistical difference in survival from tumor size, histology, pleural invasion, local recurrence and metastasis. There was no statistical correlation between this variables and positivity of the neuroendocrine markers except for tumor size with P53 ($p=0.034$). Metastatic recurrence was higher in patients with CGA, SNP or both positive: 48% versus 33%. A difference in survival at 3 and 5 years was found 52% and 39%, versus 64% and 51% ($p=0.06$) between both.

Conclusion: neuroendocrine differentiation may be a prognostic significance in patients with early stage of NSCLC treated surgically.

C29.
The bronchopulmonary carcicnoïd tumors

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The bronchopulmonary carcinoïd tumors belong to the group of the pulmonary neuroendocrin's tumors wich its own origin's the kultchitzki cell. This is a retrospective study of 40 cases diagnosed an treated in our service during the period of 1987 to 2000. The results were: 23 woman, 17 man, the mean age is 39 year old with an extrems of 15 and 70 years. First symptoms were: haemoptisy (62%); dyspnea (50%) chest pain (20%) pleurisy (10%). The chest x Ray showed: a round opacity (50%); A ventilatory trouble (40%); pleurisy (10%). The bronchoscopy found: lesions were situated in the right (29 cases) intermediary trunk (15 cases). The biopsies were positive in 28 cases the others diagnosis was put by the pathological exam of the operatory pieces; 38 patients were treated surgically: (10 pneumonectomy; 18 lobectomy; 9 biolobectomy, 1 explo-ratrice thoracotamy 2 patients were transferred to radio– chemotherapy service the servical varied between 6 to 62 for 34 months of mean.

C30.
Clinical features and outcome of pulmonary carcinoids – 16 years review

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Objectives: Recognize the profile of patients with pulmonary carcinoids admitted to our unit. Evaluate outcome.

Methods: Retrospective analysis of clinicopathologic data and outcome of patients from a central hospital in the last 16 years (from 1985 to 2001).
Results: We found 2567 cases of lung tumours from 1985 to 2001. The pulmonary carcinoids were 0,86% (n=22): typical (n=10) and atypical (n=12). The ratio of female to male was 1,2/1 with a mean age of 51,3±15,5 years. Cough was the most frequent clinical presentation (41%) (n=9) followed by pleuritic pain, hemoptysis and dyspeia (27% each). Concerning radiology 55% of cases (n=12) had a mass. In the typical group they were central (with right predominance) in 80% (n=4) and in the atypical group they were peripherical (with left predominance) in 60% (n=5). Bronchial obstruction was present in 41% of cases (n=9). Diagnosis was made using bronchoscopy in 36% of patients and thoracotomy in 59%. We found 14% of patients (n=3) that were staged as III-B or IV. Carcinoid syndrome occurred in only 1 case who presented hapatic metastases on recurrence. The treatment was surgery in 82% of cases (n=18). Five patients died and the survival rate was 23,1±27,2 months. Thirteen are alive (with a minimum and maximum folow up time of 6 and 92 months) and 4 were lost for follow up.
Conclusions: Pulmonary carcinoid is a rare tumour with a reasonable prognosis and the treatment of choice is surgery

C31.
Radiotherapie mediastinale dans le syndrome cave superieur d'origine cancereuse. A propos de 23 observations

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Introduction: Le syndrome cave supérieure d'origine cancéreuse (SCSOC) est relativement fréquent et constitue une urgence thérapeutique.
But du Travail: évaluer l'efficacité thérapeutique immédiate de la radiothérapie dans le SCSOC.
Malades et Methodes: C'est une étude rétrospective menée a propos de 23 observations de SCSOC colligées entre Janvier1988 et Décembre 2001 au centre d'oncologie IBN ROCHD de CASABLANCA. L'age moyen a été de 37 ans avec des extrêmes de 22 et 53 ans. Le sexe ratio a été de 7. Douze patients avaient une intoxication tabagique. La dyspnée a été majeure (mettant en jeu le pronostic vital) dans tous les cas motivant la consultation aux urgences. Sur le plan histolo gique, les carcinomes ont représenté 65 % et Les lymphomes 22%.
Resultats: La radiothérapie a été délivrée en urgence par un telecobalt après échec d'une corticothérapie à fortes doses. Trois patients ont été irradiés sous ventilation artificielle. La radiothérapie a été délivrée en 2 «Flashs» a J1 et J3. La dose par séance a varié de 4 gray a 6.5 gray. La corticothérapie a été maintenue dans tous les cas. Vingt patients étaient sous oxygénothérapie a la sonde. Une amélioration spectaculaire de l'état respiratoire est survenue dans 9 cas après 24 heures, dans 6 cas après 48 heures et dans 7 cas après 72 heures.
Chez un seul patient, la réponse a été médiocre: il s'agissait d'un mélanome malin irradiée sous ventilation artificielle. Il n'a pas eu de complications immédiate liée a la radiothérapie.
Conclusion: La radiothérapie reste la principale arme thérapeutique efficace et d'action rapide. Il convient de l'indiquer et de la réaliser précocement dans les SCSOC avec dyspnée menaçant le pronostic vital.

C32.
Gemcitabine and cisplatin (GD) as first line chemotherapy in patients with non-small-cell lung cancer (NSCLC)

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Purpose: The aim of this study is to present the results of a consecutive series of patients (pts) with locally advanced/metastatic NSCLC, treated with GD, in the clinical practice.
Patients and Methods: Fifty eight chemotherapy naïve patients with NSCLC were treated with gemcitabine (1000mg/m^2 day1 and day 8), and cisplatin (100mg/m^2 day 1) every 3 weeks. G-CSF support was given according to clinical judgment. Three (5,17%) pts had stade IIIA, twenty (44,5%) had stage IIIB and 35 (60,3%) had stage IV disease. Most of the patients (88%) had a WHO performance status of 0/1; the predominant histologic type was adenocarcinoma (32 pts). All patients were included in the analysis (intent-to-treat).
Results: Twenty-two pts (44,0%) (CI 95% 25.5 – 62,6%) achieved a partial response to treatment. The median overall survival was 56.2 weeks. The 1-year survival rate was 55,0% (IC 95% 29.0 – 74.1%). A total of 217 courses of therapy were given (median 3 cycles/patient). Grade 3 or 4 neutropenia occurred in 5.2% of administered courses. Other acute side effects were relatively mild.
Conclusions: GD regime seems to be useful in the management of NSCLC in the current clinical practice.

C33.
A clinical review of military tuberculosis

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In order to determine the clinical, radiographic and laboratory characteristics, diagnostic methods and mortality rate, in patients with Miliary tuberculosis (TB), a retrospective study was carried. From April 1999 to November 2001, 450 patients were admitted in a TB Unit of a central hospital and the records of 23(5.1%) patients with miliary TB were analyzed. The mean age was 37.7±13 years, 17(73.9%) were male, 18(78.3%) were co-infected with HIV1 and 14(60.9%) were intravenous drug addicts. The main clinical findings were fever (69.5%), weight loss (78.2%), anorexia (65.2%), cough (73.9%), hepatomegaly (34.8%) anemia (87%), leukopenia (47.8%), limphopenia (73.9%), thrombocytopenia (39.1%), hyponatremia (68.2%) and hypoalbuminemia (64.7%). On chest x-rays were found 17(73.9%) cases with miliary infiltrates. In the remaining six cases, the diagnosis was made by high resolution CT scan. Acid fast bacilli were demonstrated in 73.9%(17/23), and positive culture for Mycobacterium tuberculosis 82.6%(19/23) of the tested specimens (predominantly sputum and blood). Multi-drug resistance TB was found in three (13%) patients, all of them HIV1 co-infected. Adverse reactions were found in 8(34.8%) cases. Mortality rate was 17.4%. HIV1 co-infection prevalence and intravenous drug addicts incidence is high in miliary TB patients on this review. Blood cultures should be done whenever the diagnosis of miliary TB is suspected.

C34.
Tuberculosis in the elderly – experience of a pneumological centre

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Aims: A analyzed clinical and epidemiological features, therapy as well as side effects, drug resistance patterns, and clinical evolution.

Material and Methods: The authors reviewed data concerning patients over 65 years of age, with confirmed tuberculosis (TB) diagnosis hospitalized between April 1999 and March 2002. AA analyzed epidemiological data,clinical presentation, concomitant diseases, previous TB treatment, therapeutical regimen, adverse effects, and drug resistance patterns.

Results: 43 patients were included, representing 9.41% of the total 457 TB cases hospitalized during this period. Median age was 72.63 years (69.8% men, 30.2% women). 48.8% were smokers. According to WHO classification 58.1% were new cases. Pulmonary Tuberculosis was present in 86%, 16.3% had extra-pulmonary forms. Among concomitant diseases the most frequent were COPD(27.9%), Diabetes (18.6%), HTA(18.6%) and silicosis(11.6%). One HIV positive patient was detected. At admission, sputum direct microscopy was positive in 74.4%. 18.6% presented side effects. Only 1 drug resistance (2.3%) was found.86 % had good evolution, 6 patients died (14%).

Conclusions: This group represent a low percentage among all TB patients treated. High prevalence of associated diseases, namely chronical respiratory pathology. High mortality rate. Low incidence of drug resistance and adverse effects.

C35.
La tuberculose chez les hemodialysés chroniques

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Introduction: La tuberculose est une complication infectieuse dont la prévalence ne cesse d'augmenter chez les patients immunodéprimés en particulier chez les hémodialysés chroniques (HDC).

Materiel et Methodes: Nous rapportons 24 cas d'atteinte tuberculeuse parmi 170 hémodialysés chroniques entre 1990 et 2001. Nous analysons l'ậ ge, le sexe, la durée d'hémodialyse, les moyens de diagnostic de la tuberculose et les différentes localisations de la tuberculose ainsi que le traitement et l'évolution.

Resultat: Parmi 170 HDC il y a 24 cas de tuberculose, soit une prévalence de 14%. L'age moyen des patients au moment du diagnostic est de 36 ans (20-69 ans) avec légère prédominance masculine. L'atteinte tuberculeuse est découverte après une durée moyenne d'hémodialyse de 12 mois (2 mois – 4 ans). Il s'agit d'une localisation pulmonaire dans 4 cas, pleurale dans 5 cas, endobronchique dans 1 cas, péricardique dans 5 cas, péri-

tonéale dans 3 cas, hépatique dans 2 cas, ganglionnaire dans 2 cas, méningée dans 1 cas et oesophagienne dans 1 cas. Les signes généraux sont les principaux signes d'appels. Tous nos patients ont été traités par une association de tri à quadri-thérapie antibacillaire pour une durée moyenne de 11 mois (7-12 mois). Parmi ces patients, deux sont décédés au bout des 3 premiers mois de traitement, pour les autres patients aucune récidive n'est observée après guérison.

Conclusion: La prévalence de la tuberculose est élevée dans la population des HDC surtout au cours des deux premières années d'hémodialyse, elle pose un problème diagnostique par la fréquence des localisations extra pulmonaires et l'absence de preuve bactériologique; et un problème thérapeutique par la nécessitée d'adapter les doses des drogues antibacillaires. Il faut y penser devant toute fièvre inexpliquée surtout dans un pays d'endémie tuberculeuse, afin de démarrer précocement le traitement antibacillaire.

C36.
Antituberculous drug-induced hepatotoxicity risk factors in patients presenting both HIV infection and tuberculosis

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Introduction: Most antituberculous drugs are prone to cause liver injury. An increased incidence of antituberculous drugs side effects is found in patients presenting both HIV infection and tuberculosis, conducting to closer clinical and laboratorial surveillance and monitoring.

Objective: Determine the incidence of antituberculous drug-induced hepatotoxicity (transaminases greater than threefold normal and/or γ-GT greater than 250 U/L) in patients presenting both HIV infection and tuberculosis and identify its predictive factors.

Materials and Methods: Retrospective study based on data from 205 HIV infected patients under antituberculous drugs in an Ambulatory Respiratory Diseases Medical Unit since 1995 till 2000.

Results: The majority of patients were male (74,6%), mean age of 33±8,3 years. Hepatitis B and C were present in 22,4% cases and in 30,7% cases, respectively. Alcohol abuse was seen in 20% patients and 71,7% took illegal drugs. Hepatotoxicity development was verified, during antituberculous treatment, in 20,5% patients. This injury appeared, on average, after 3 months of therapy initiation and in 55% cases caused drug suspension. Age, sex and antiretroviral therapy were not associated with hepatotoxicity. Hepatitis C and alcohol abuse were more frequent in hepatotoxicity patients group, also not reaching a statistical significance. Hepatitis B infection and illegal drugs abuse were significantly associated with the development of hepatotoxicity.

Conclusions: Liver injury is a common antituberculous drugs side effect in patients presenting HIV infection. Hepatitis B infection and illegal drugs abuse in HIV infected patients were significantly associated with the development of liver injury during antituberculous drugs therapy.

P1.
A Behcet's disease revealed by bilateral chylothorax and a pericardic effusion

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Chylothorax is the occurrence of chylus (lymph) in the pleura due to damage or obstruction of the thoracic duct-it is rarely bilateral. The main aetiology could stay unknown. A 42 year old man was hospita- lized for: a dyspnea, increasing progressively since 2 months, inferior member's oedema, superior veno cava syndrom and a cutaneous signs such as: month's aphtosis – pseudofolliculitis in the back. The chest Roentgram showed a bilateral pleurisy and superior mediastinal widening; the pleural ponction brought a lacteous liquid, Rivalta+(TG = 6g/l; cholesterol 0,7g/l). An echocardiography objectived a small pericardic effusion without hemodynamic retentissement with the nature lacterous has not been confirmed. The TDM showed a superior veino cava syndrom thrombosis. In front of this Radio clinical context: the diagnosis of Behcet's disease was hold. The patient's ontcome under oral corticotherapy, colchicines and platelets anti aggregates after 6 weeks was very succeful (disappearence of all clinical and radiological signs). Though this observation we underline the interest to raise up the behcet's disease as a cause of the chylothorax even if it is rare, but the out come under treatment is satisfying.

Ref: G. Hilledal: Chylothorax and pseudo chylathorax

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P2.
Anévrysmes artériels pulmonaires multiples thrombosés en dehors de la maladie de Behcet

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Les anévrysmes artériels pulmonaires associés ou non à des thromboses sont des manifestations exclusives de la maladie de Behcet. Le syndrome de Hughes-Stovin est une entité nosologique, vraisemblablement apparentée à la maladie de Behcet, associe des anévrysmes artériels pulmonaires à des thromboses veineuses, des anévrysmes isolés des gros troncs artériels pulmonaires avec vascularite sont souvent considérés comme des formes frustes de syndrome de Behcet.
Nous rapportons l'observation d'un patient porteur d'anévrysmes artériels pulmonaires avec thromboses en dehors d'une maladie de Behcet.
Il s'agit d'un homme âgé de 43 ans admis pour des hémoptysies de moyenne abondance avec dyspnée stade IV. La radiographie du thorax a mis en évidence des opacités arrondies hilaires bilatérales avec signe de recouvrement et cardiomégalie importante. La tomodensitometrie thoracique: multiples anévrysmes artériels pulmonaires thrombosés avec signes de cœur pulmonaire chronique. L'échographie cardiaque a conclu à des cavités droites éctasiques avec HTAP maligne. La gazométrie: hypoxémie avec hypocapnie. Il s'agit d'un cœur pulmonaire chronique en rapport avec une altération du lit vasculaire pulmonaire par des anévrysmes artériels pulmonaires avec thromboses. L'interrogatoire ne retrouve pas d'aphtose récidivante, les tests pathérgiques sont négatifs, l'examen ophtalmologique avec angiographie rétinienne sont normaux. Les anévrysmes artériels pulmonaires en dehors de la maladie de Behcet sont exceptionnels, de rares observations ont été rapportées et qui seraient des formes frustes de maladie de Behcet ou du syndrome de Hughes-Stovin

P3.
A propos d'une cause rare du syndrome cave supérieur: L'hyperhomocystèinèmie

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Introduction: L'homocystéine est un acide aminé soufré et l'hyperhomocystéinémie résulte d'un dysfonctionnement métabolique du à un déficit enzymatique inné ou à un déficit acquis de cofacteurs enzymatiques. Sur le plan clinique, les hyperhomocystéinémies se traduisent par des manifestations vasculaires, ophtalmologiques, neurologiques et osseuses. Les hyperhomocystéinémies suscitent actuellement un intérêt grandissant car elles tendent à être individualisées comme facteur de risque vasculaire indépendant. Le but de ce travail est de faire une mise au point concernant les connaissances actuelles sur les hyperhomocystéinémies et de rapporter un cas personnel.
Observation: Patient de 22 ans, aux A.T.C.D familiaux de thrombose veineuse (mère, oncle, tante), hospitalisé au service de pneumologie de L'H.M.I.M.V en septembre 1992 pour un syndrome cave supérieur révélé par une dyspnée évoluant depuis six mois. En dehors du syndrome cave supérieur, l'examen clinique de ce jeune patient pesant 70Kg pour une taille de 172 cm, normotendu, apyrétique, est pauvre. Il n'existe pas d'éléments cliniques en faveur de maladie de Behcet ou de vascularites. Les examens ophtalmologique et neurologique sont normaux et il n'existe pas d'anomalies morphotypiques. La radiographie pulmonaire note un discret élargissement médiastinal supérieur avec réaction pleurale droite. La cavographie objective une thrombose cave supérieure et le scanner thoracique élimine l'existence d'un processus tumoral. Le bilan biologique note un syndrome inflammatoire avec une VS à 120 mm à la première heure et une anémie macrocytaire (Hb à 10g/dl, VGM à 100µ). Le taux des globules blancs et des plaquettes est normal. Le myelogramme note une megablastose, le taux plasmatique de la vitamine B12 est diminué et le facteur intrinsèque est normal.
Le bilan immunologique est sans particularité, les fonctions rénale et hépatique sont conservées. Au total, l'existence d'une thrombose veineuse inexpliquée associée à une anémie megaloblastique chez un jeune patient de 22 ans aux A.T.C.D familiaux de thrombose veineuse, fait évoquer une maladie héréditaire et thrombogène: l'hyperhomocystéinémie. En effet, le taux plasmatique de l'homocystéine est à 140 mmol/l pour une valeur normale inférieure à 14 mmol/l.

Le patient est mis sous vitamine B12 et AVK. Après un recul de huit ans, l'évolution est marquée par une stabilisation clinique du syndrome cave supérieur et une correction de l'anémie megaloblastique.

Discussion: L'hyperhomocystéinémie est définie par un taux plasmatique d'homocystéine supérieur à 14 mmol/l. Elle reconnaît plusieurs mécanismes physiopathologiques.

La clinique est dominée par l'athérosclérose précoce et les thromboses artérielles et/ou veineuses .

Le diagnostic positif est biologique. Le dosage de l'homocystéine doit se faire chez: Sujet jeune, Sans facteurs de risque vasculaire, Présentant une maladie thrombo embolique. Le traitement est peu codifié.

P4.
Bullous degeneration in a heroin addict

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Several substances besides tobacco are inhaled for recreational purposes, including heroin. Its abuse has been rising, thereby increasing concern about pulmonary complications.

Multiple large lung bullae have been described in tobacco smokers and bullous degeneration is a known complication of intravenous drug abuse. To our knowledge, the case we report is the first one suggesting a similar role for inhaled heroin.

A 33-year-old man who worked as a hotel reception clerk presented with a large bulla in right lung apex, incidentally found on chest ra- diography. He had a tobacco smoking history of 20 pack years and had been inhaling heroin 3 or 4 times a day for 10 years. α_1-antitrypsin level was normal and HIV, HBV, HCV serologies were negative. A computer tomography scan of the thorax confirmed bullous degeneration, mostly in the upper and middle lobe of the right lung. The large bulla in the right upper lobe was resected by video-assisted thoracic surgery.

Although we are unable to implicate inhaled heroin definitively as an etiological agent, the young age and the relatively low tobacco exposure in this case does raise the possibility of at least an additive role for this illicit substance in the development of bullae.

Key-words: bullous degeneration, heroin, drug abuse.

P5.
Pneumopathie de cracheurs de feu chez les toxicomanes. Résumé d'un cas clinique

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Les cas de pneumopathies de cracheur de feu chez l'adulte sont rarement décrits. Comme le toxicomane pratique, de plus en plus, les spectacles de cracheur de feu dans les rues, afin de gagner de l'argent, nous profitons à travers un cas clinique de pneumopathie de cracheur de feu chez une jeune toxicomane pour éclairer la conduite à tenir et la revue de la littérature.

Il s'agit d'une patiente de 24 ans toxicomane, sans ATCD particulier qui se présente au service des urgences de l'hôpital de la Croix Rousse à LYON après un spectacle de cracheur de feu avec douleurs thoraciques, fièvre, toux, expectorations, nausée et vomissement et syndromes inflammatoires majeurs biologiques et les signes radiologiques d'une pneumopathie multiabcédée. Le tableau nécessitent deux semaines d'antibiothérapie (Augmentin et Ciflox) ainsi que la Corticothérapie simultanée. Une nette amélioration clinique est observée après deux semaines et la résolution radiologique après deux mois.

Les pneumopathies des cracheurs de feu sont des pneumopathies d'inhalation d'hydrocarbure (pneumopathie chimique) divisées en deux grandes catégories: les hydrocarbures volatiles de faible viscosité comme le pétrole et le kerdane, provoquant des aspect pseudo infectieux avec fièvre, dyspnée et douleur thoracique et les hydrocarbures non volatiles de forte viscosité (paraffine) donnent un aspect pseudo tumorale avec les même signes cliniques. Elles se soient chacune sous antibiothérapie et corticothérapie (pour éviter les séquelles respiratoires) en quelques semaines mais les complications (surinfections avec du Pseudomonas aeroginosa et abcès locale, fistule bronchopleurale et Pneumothorax spontanée…) ne sont pas rares et parfois même fatales. Un suivi correct est donc nécessaire.

P6.
Acute eosinophilic pneumonia with ARDS, a clinical case

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The authors present a clinical case of a healthy young patient with 17 years old, non-smoker, and denied drug abuse. Five days before, starts fever with dysuria, and was medicated with nitrofurantoine with no result. Progressively develops acute respiratory failure, with ARDS (PaO_2/FiO_2 < 100), that dictates the need of mechanical ventilation.
Throughout the stay in the ICU, all the microbiological (traqueobronchial aspirate, BALL, blood, urine and stool cultures), and serological research where negatives. He had peripheral eosinophilia, elevated IgE, with eosinophilic (39%) and neutrophilic (15%) alveolitis.
He was medicated with metilprednisolone, and 48 hours after, he began clinical and radiological improvement.
The laboratorial finds and the clinical response made possible the diagnosis of Acute Eosinophilic Pneumonia (AEP).
The aim of the presenting case is the rarity of the clinical entity, and the need to consider AEP on the differential diagnosis of acute interstitial pneumonia, particulary in the critical ill patient.

P7.
Lipoproteinose alveolaire. A propos d'un cas

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La lipoprotéinose alvéolaire (LPA) est une affection pulmonaire chronique caractérisée par l'accumulation dans les alvéoles d'un matériel acellulaire, lipoprotéinacé. Elle est rare, d'étiologie inconnue
Nous rapportons une observation de lipoprotéinose alvéolaire chez une femme de 28 ans, sans antécédents ni exposition professionnelle particulière, hospitalisée pour exploration d'un syndrome interstitiel de découverte fortuite. L'aspect du LBA est trouble. La négativité du bilan étiologique a conduit à la pratique d'une biopsie pulmonaire qui montre des lésions typiques de LPA associées à une fibrose pulmonaire. La patiente étant asymptomatique sur le plan respiratoire, le bilan fonctionnel respiratoire peu perturbé, aucun traitement, en particulier le lavage broncho-alvéolaire thérapeutique n'a été encore envisagé.

P8.
Bonchiolite oblitérante avec pneumonie organisee.
A propos de trois cas

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Nous rapportons trois cas de BOOP diagnostiqués chez trois patientes, dont l'âge moyen est de 49 ans, durant une période allant de mai à août 2001. Le tableau clinique est fait d'une toux sèche, de douleurs thoraciques, et de fièvre chez deux patientes uniquement. La radiographie du thorax montre des images nodulaires pulmonaires chez une patiente, des opacités alvéolaires chez les trois malades n'ayant pas régressé sous antibiothérapie à large spectre. Le diagnostic de BOOP a été évoqué devant l'évolution radiologique, de l'aspect tomodensitométrique chez les trois patientes et confirmé par la biopsie pulmonaire chirurgicale chez une seule patiente. Le diagnostic étiologique basé sur l'anamnèse et le bilan biologique nous permet de retenir deux cas de BOOP idiopathiques et un cas de BOOP présumé secondaire à une maladie de Crohn. L'évolution a été favorable spontanément dans un cas et sous corticoïde dans deux cas malgré une rechute à la suite d'un arrêt volontaire du traitement corticoïde.

P9.
Difficult asthma – a report of four cases

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Asthma control can be difficult to manage in some patients, profoundly affecting their quality of life. Sometimes is difficult to identify the condition responsible for this. Gastroesophageal dysfunction, hyperthyroidism, psychological factors as panic disorders and psychosocial stress are some of the factors to be considered. In some situations no aggravating factor is found and patients may have brittle asthma. Authors report four cases of asthma difficult to manage.

Case 1: 48 years-old female, atopic asthma since childhood, pulmonary tuberculosis when she was 9. In the last 2 years worsening of a moderate persistent asthma with admissions in the emergency room several times. Submitted to invasive ventilation in one occasion. Patient complained of anxiety and racing pulse. Evaluation of thyroid function was done and hyperthyroidism was found. The condition was treated and asthma control improved gradually.

Case 2: 44 years-old female, asthma since childhood, afterwards no symptoms until her first pregnancy. Worsening asthma since her forties with frequently hospital admissions for status asthmaticus. Panic disorder was found. She was referred for psychiatric evaluation and was included in a education program to improve self-management.

Case 3: 62 years-old-female, arterial hypertension, obesity. She was referred for difficult asthma. She complained of abdominal fullness. Gastric endoscopy and a 24-hour esophageal pH monitoring was performed and gastroesophageal reflux was found. Treatment was initiated with dramatic improvement.

Case 4:26 years-old-female, asthma since childhood, several hospital admissions for status asthmaticus with need of invasive ventilation. She has a type 2 brittle asthma. Her condition has improved with a better self-management of her asthma.

In difficult asthma effective treatment depends on identification of exacerbating factors. Most international guidelines contain recommendations for patients to receive advice in self-management. A good communication between patient and health professional is an important point to obtain an effective asthma control.

P10.
Le tabagisme passif et l'asthme

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L'augmentation de la prévalence de l'asthme ces dernières décennies (100-300%) est avant tout attribué à l'environnement domestique (allergènes et tabagisme passif[1]. Il est admis que l'exposition au tabagisme passif soit un facteur de risque (Causal) pour l'asthme chez les nouveau-nés et les enfants génétiquement prédisposés; Mais chez l'adulte le fait que le tabagisme passif soit un facteur de risque pour l'asthme est sujet de controverse, cependant il est admit que ce tabagisme passif potentialise d'autres allergènes (rôle adjuvant) et qu'il soit facteur déclenchant des crises[1]. D'autre part les asthmatiques exposés a la fumée des autres visitent plus souvent le département des urgences, et accusent un déclin plus rapide du VEMS, et donc est plus coûteux.. Mais par quel mécanisme, et quel sont les composants de la fumée du tabac qui inaugure ces processus à l 'échelle moléculaire? Cela n'est pas encore clairement élucidé, mais plusieurs mécanismes sont accusés: recrutement des cellules inflammatoires, libération de L'ECP, augmentions de la ration CD4 /CD8 avec un profil sécrétoire Thelper2, médiateur neurogenes et stress oxydant responsable d'œdème et d'hyper-reactivité bronchique[2]. C'est dire l'intérêt à planifier des mesures pour limiter l'exposition au tabagisme passif, d'autant plus que selon les statistiques de l'OMS 50% des enfants dans le monde seraient exposés à la fumée des autres. Mots clés: Asthme, tabagisme passive, inflammation bronchique.

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P11.
Tobacco and schizophrenia

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Objective : Previous studies of smoking habits of schizophrenia patients have found rates as high as 88%. Our purpose is to study smoking behaviour of tobacco consumption in patients with schizophrenia and compare them with the smoking habits of a general population sample.
Methods : 89 patient, with schizophrenia were invited to complete a questionnaire on smoking habits.
Results: All of them returned the questionaires. The rate among the patients was 4 (846%) smokers (23(56%) males and 17 (44%) females) and 49 not smokers (24 males and 25 females). In our comunity the rate of smoking between general population is 37% (42% of males and 33% between females).
Conclusions:

1. Tobacco date is higher between scizophrenia patients than general population.
2. Males rate is twelve poins above female rate.

P12.
Tobacco in children befor 12 years of age

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Objective : Previous studies of smoking habits in some areas of Barcelona (Osuna). Spain demonstrated that the rate of tobacco habits is at early ages (9±1.8 years) Also other studies gave about the same rate. Our purpose is to study smoking behaviour of tobacco consumption in children below 12 years in our community.
Methods : 200 primary students were meet, and a questionnaire was complemented asking about if he/she smoke, beginning, quantity, and influence to begin smoking.
Results: 18 (9%) childs, 10 boys and 8 girls smoke±daily between 2 a 10 cigarettes, 34 (17%) smoked occasionally and 158 (78%) never smoke. The age of beginig to smoke was between 7 and 12 years. They were influenced by friends, teachers and fathers.
Conclusions:

1. There are an important number of child who begin the smoke habit very early.
2. Fathers, teachers and friends conduce childs to begin tobacco habits.

P13.
Le tabagisme chez le personnel d'un centre hospitalier et universitaire d'Alger

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La recherche scientifique possède actuellement la preuve absolue que le tabagisme est le facteur étiologique prédominant des maladies pulmonaires obstructives chroniques et de la plupart des cancers des voies aériennes supérieures et des bronches.
L'étude du tabagisme chez le personnel de santé a plusieurs intérêts:

- connaissance de la morbidité individuelle;
- rôle clef que tient le personnel de santé dans la lutte anti-tabac.

Le centre Hospitalo Universitaire de Bab El Oued, un des plus grands centres d'Alger, comprend 33 services spécialisés et 7 unités techniques et administratives; le personnel de santé est chiffré à 2300 répartis en 92 médecins universitaires, 522 médecins hospitaliers et 1670 para-médicaux.
En Avril 2001 nous avons réalisé une enquête prospective portant sur le tabagisme du personnel de santé du CHU. Le sondage a été mené sur un questionnaire OMS rempli par des médecins enquêteurs. Le taux de réponses générales est de 71% (80% pour les médecins et 68% pour le personnel para-médical).
L'étude du tabagisme en fonction de l'âge et du sexe a montré que quelque soit le sexe la catégorie d'âge la plus touchée est celle des 30 - 39 ans.
Le tabagisme est plus fréquent chez les hommes que chez les femmes probablement en raison de l'interdit social du tabagisme chez la femme en Algérie.
La catégorie professionnelle la plus touchée est celle des para-médicaux (27% de fumeurs pour 12% chez les médecins hospitaliers et 15% chez les médecins universitaires).
En ce qui concerne le rôle du médecin dans l'éducation sanitaire, 48% des médecins disent fumer devant les malades et 49% dans les lieux publiques; seuls 59% recherchent systématiquement le tabagisme chez leurs consultants, 41% ne le recherchent que s'il y a une maladie liée au tabac.
48% des médecins interdisent aux consultants de fumer dans la salle d'attente.
En cas de maladie, 78% des médecins fumeurs demandent au patient d'arrêter de fumer et 21% de diminuer le tabagisme, et 83% et 15% des médecins non fumeurs.

P14.
Unsuspected foreign body aspiration. Two cases identified wit rigid bronchoscopy

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Foreign body aspiration may occur at any age (mostly in children) causing airway obstruction. Its removal with bronchial endoscopy (usually rigid bronchoscopy) often produces a cure. Most cases are easily recognized and witnessed.
A delayed therapy for an unsuspected episode may contribute to prolonged pneumonitis, obstructive pneumonia, lung abscess and bronchiectasis.
We describe two cases of unsuspected foreign body aspiration incidentally identified with rigid bronchoscopy, one in a 5-year-old child and the other in a 65-year-old man. Cough productive of purulent sputum and bronchiectasis of unknown etiology with six months evolution motivated the endoscopic procedure in the child. The adult underwent the rigid bronchoscopy in the setting of an obstructive pneumonia associated with suspected endobronchic neoplasm. A 5-mm bone fragment was visualized and extracted from the child's left main bronchus. A chicken vertebra, nailed in the adult's right main bronchus, was removed. In both cases bony foreign bodies were masked due to granulation tissue and exuberant inflammation signs. Rigid bronchoscopy performed ten days after endoscopic foreign body removal revealed an optimal evolution in both situations, also treated with oral corticosteroids and antibiotics.

Key-words: foreign body aspiration, rigid bronchoscopy, bronchial endoscopy

P15.
Clinical, diagnostical and therapeutic considerations in what concern pleural empyema at patients hospitalized in "Marius Nasta" Institute of Pneumology, in 1999-2000

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The aim of the study: the evaluation of the medical and surgical treatment in solving the pleural empyemas according to their evolution status.
We present our clinic's experience for 2 years (1999-2000) in treating 208 patients that have been diagnosed with pleural empyema.
Results: from the 208 patients, 75% (156) have been hospitalised in the thoracic surgery department having pleural empyema, the rest of 25% (52 patients) have been hospitalised in the medical department.
We found that the free pleural empyema were predominant (57%) compared to the loculated ones (43%). Concerning the ethiology, more than half of cases (55%) were parapneumonic empyema followed by post-surgical (15%), tumoral (8%), post-traumatic (7%) and post-tuberculosis (6%); in 9% of the cases the ethiology of the empyema couldn't be precised.
The ethiologic agents met in the pleural empyema have been: Streptoccocus pneumoniae (13%), Pseudomonas aeruginosa (3%) and Stafilococci (3%) and other undetermined positive gram cocci (21%). In 60% of the cases the ethiologic agent could not be précised, but we have to mention that this category included the anaerobic germs. The surgical treatment was the pleural decortication (41%) or pleural drainage associated with local lavage in 59% of the cases.
The average number of the hospitalisation days in the thoracic surgery was 20,4 days, compared with 30,6 days in the medical departments.

P16.
Probleme de prise en charge therapeutique d'une hydatidos multiple bi-polaire: pulmonaire et hepatique

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Nous rapportons le cas d'une patiente âgée de 44 ans épileptique depuis l'âge de 16 ans, présentant une insuffisance surrenalienne depuis 3 ans, opérée en 1995 pour lithiase vésiculaire et kyste hydatique du foie, hospitalisée pour prise en charge d'une hydatidose pulmonaire multiple. L'auscultation pleuropulmonaire retrouve quelques râles crépitants aux 2 bases. Téléthorax : aspect en lâcher de ballon aux 2 champs pulmonaires. La recherche d'autres localisations secondaires de l'hydatidose, retrouve un volumineux kyste hydatique du foie. Cette hydatidose multiple est fréquemment observée dans les zones d'endémie. Il peut s'agir soit d'une infestation primitive itérative, soit d'une hydatidose secondaire à la rupture d'un kyste hydatique pulmonaire pré existant, avec greffe secondaire des vésicules filles qui vont se vesiculer, ou bien aussi secondaire à une rupture plus ou moins brutale, dans la veine cave d'un kyste hydatique du foie. Le traitement du kyste hydatique est essentiellement chirurgical, mais devant cet aspect d'hydatidose multiple, la chirurgie ne peut être proposée du fait des difficultés techniques, mais aussi chez notre patiente d'une contre indication fonctionnelle respiratoire. Un traitement médical par drogues antiparasitaires larvicides, dérivés du bendozole (Albendozole) a été proposé chez cette patiente. Des résultats intéressants dans quelques cas particuliers ont été rapportés concernant ce produit. On conclue, en insistant sur la nécessité de mettre en œuvre les mesures simples de prévention, qui sont bien connues et qui peuvent agir efficacement, permettant d'éviter cette pathologie, qui pose ainsi souvent de sérieux problèmes thérapeutiques.

P17.
Etude comparative des donnees du lavage broncho-alveolaire au cours de la sarcoidose et de la tuberculose pulmonaire

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Introduction: La sarcoïdose thoracique et la tuberculose pulmonaire s'accompagnent dune hypercellularité avec lymphocytose au niveau du lavage bronchoalvéolaire (LBA). Peu de travaux ont comparé l'étude des sous populations lymphocytaires alvéolaires au cours de ces deux pathologies. Les auteurs se proposent de rapporter les particularités propres à chacune de ces deux pathologies à partir des données du LBA.
Mathériel et Méthodes: 32 sujets présentant une tuberculose pulmonaire confirmée et 29 sujets présentant une sarcoïdose pulmonaire ont bénéficié d'un LBA avant tout traitement. Pour 1a tuberculose, il s'agissait de 25 hommes et 7 femmes, d'âge moyen 33±12 ans et pour 1a sarcoïdose, il s'agissait de 15 hommes et 14 femmes d'âge moyen 40±15 ans. Les sous-typages; lymphocytaires ont été réalisés par la méthode de cytométrie du flux.
Résultats: Il n'existe pas de différence significative entre la sarcoïdose et la tuberculose pour la cellularité globale, respectivement de 446 ± 232.10^3 /ml et de 553 ± 346.10^3/ml, et la proportion des lymphocytes respectivement de 29±19,2 % et de 22±17 %, ainsi que les différents autre: éléments cellulaires. La sarcoïdose présente un rapport CD4/CD8 significativement plus élevé que la tuberculose respectiv ement 4,5±7,6 et 2,8±1,5 ($p < 0.05$).
Discussion et Conclusion: Si le profil cytologique dans le LBA au cours de la tuberculose et de la sarcoïdose semble superposable, l'étude des sous populations lymphocytaires montre une réponse lymphocytaire surtout de type CD4+ dans la sarcoïdose. L'étude cytologique du LBA permet d'apporter des informations supplémentaires contributives au diagnostic différentiel entre ces deux maladies

P18.
A study of ventilatory prediction in resection for tuberculosis and pulmonary infections

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The goal: the comparative evaluation of the ventilatory function in the pulmonary resection for tuberculosis (TB) and pulmonary suppurations.
Method: the retrospective study has been made on two groups of patients during 1999-2000. The first group has included 33 sick persons that have been ill for 1-5 years, with MDR-TB. They suffered partial resections in 24 of the cases and pneumonectomies in 9 of the cases on a lung destroyed from the tuberculosis point of view.
The second group has included 51 sick persons 45 of them have suffered lobectomies and 6 of them have suffered pneumonectomias. The ventilatory function has been analysed before and after the operation, after one and six months on the basis of the FVC and FEV1 parameters and of the prediction formulas emitted by Juhl and Frost.
Conclusions: the functional depreciation improves in time so that the investigations right after the operation does not represent a functional damage after the resection. The appreciation of the functional impact over the ventilatory function has to be analysed at least 6 month after the operation.

P19.
Details analyses of TB-mortality – Romania 2000

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Methods: In order to compute TB mortality in Romania, we watched data available both at the National Institute of Statistics (death notification forms) and at the National TB Register. Ratios to the inhabitants 1st July 2000 were computed.
Results: the 2130 deaths notified in Romania in 2000 correspond to a mortality rate of $9.5^0/_{0000}$. In males, TB mortality was $16.2^0/_{0000}$, (1776 cases representing 83.4% of all TB deaths) ranging between 1.9 and $50.1^0/_{0000}$ by district, and $3.1^0/_{0000}$ in females (354 cases) ranging between 0.3 and $8.5^0/_{0000}$ by district. A number of 2075 deaths were re-gistered in respiratory TB. By district of death, mortality rate varied between $1.2^0/_{0000}$ (CV) and $29^0/_{0000}$ (DB). There were some differences between the mortality by district of death and mortality by district of residence.
The differences were explained by people's mortality raised by unemployment rate. By reported level of scholarship 63.2% deaths were registered in person with elementary, 24.9% with medium and 0.9% with high educational level.
Conclusions: the significant differences in mortality within districts suggest that besides the differences in TB incidence and prevalence between districts, significant differences establishing cause of death. In order to solve the later source of differences cause of death in each form are to be validated by district TB specialist using TB register.

P20.
Severity elements of tuberculosis evolution in Bucharest – Romania

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The incidence of tuberculosis in Romania has increased continuously since 1985. In Bucharest, he incidence of tuberculosis has also increased: $84.0^0/_{0000}$ in 1990 and $154.1^0/_{0000}$ in 2001, being situated permanently at a level superior to the incidence by the whole country. This is also due to the fact that a floating population – very difficult to be assessed and supervised epidemiologically – is added to the stable population of about 2 million inhabitants. The incidence of tuberculosis differs substantially among the 6 sectors of Bucharest: $118.3^0/_{0000}$ in the 1st Sector and $202.5^0/_{0000}$ in the 5th Sector. The last sector has a numerous community of gypsies who are confronted with precarious socio-economic conditions and a high degree of promiscuity. The population of 30-59 years is the most affected one (between $145.1^0/_{0000}$ – $191.9^0/_{0000}$). The weight of patients with relapses has increased from 7.7% in 1990 to 11.9% in 2001. The maximum prevalence of patients eliminating bacilli increased in Bucharest from $89.2^0/_{0000}$ in 1990 to $114.7^0/_{0000}$ in 2001, thus getting greatest ten population's risk of contamination. As a result, the infection prevalence was 5.6% and the infection incidence 1.1% in the children of 1-5 years in 1999. The TB incidence in children as also increased from $24.5^0/_{0000}$ in 1990 to $60.8^0/_{0000}$ in 2001 and it varies between $24.6^0/_{0000}$ and $86.1^0/_{0000}$ in the town sectors. The mortality due to the TB increases from $7.4^0/_{0000}$ in 1990 to $13.6^0/_{0000}$ in 1995, but decreases to $10.2^0/_{0000}$ in 2000. The rate of success in the treatment of the pulmonary tuberculosis (M+) increased from 78.0% in 1998 to 82.0% in 2000. Tuberculosis remains in Bucharest a priority problem. Out of the total amount of money paid for medical leave days in 1999, 4.4% were due to a single disease: tuberculosis.

P21.
Assesment of the results of the chemotherapy administrated to the patients with pulmonary tuberculosis in Bucharest (Romania) in 2000

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The incidence of tuberculosis in Bucharest during 1995-2000 was maintained at values between $122.0^0/_{0000}$ and $139.9^0/_{0000}$, above the values by country. The National Program of Tuberculosis Control emphasises especially the correct treatment of all the patients recorded with tuberculosis, practising the strict supervised administration of the physicians. In what regards with pulmonary tuberculosis, with bK+ at the microscopic examination, the success rate (healing and concluded treatments) was 76% in 1997, 78% in 1998, 81.9% 1999 and 83.0% in 2000. The rate of success was 83.0% in those with positive micros- copic examination and 84.7% in those positive only by culture and 86.2% in that M-C-. The rate of success in the patients with a pulmonary M+relapses was lower, reaching only 63.4% in 2000. The rate of failure was 14.2% in the patients with relapse and 6.2% in the new patients with pulmonary M+tuberculosis. The rate of abandon was 6.3% in the new patients with pulmonary M+tuberculosis and 11.5% in those with relapses. The strict monitoring of the first treatment was the medical key in fighting the tuberculosis. All the forces are acting in this direction.

P22.
Actualities in AIDS and pulmonary tuberculosis at adults in Romania, Features

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The first case of AIDS appeared in Romania in 1985. The total number of AIDS cases registered at the adults between 1985 - 2001.06.01 was 1334 (with a significant increase in the last 3 years) but this did not influence yet the TB epidemic. After 1985 it was also noticed an alarming increase of the pulmonary tuberculosis (TB) cases in our country (the global incidence of tuberculosis in 1986 was 56.4%00 and in 2001 it was 124.1%00). The way in which HIV infection spreads in Romania is predominantly heterosexual (63% of cases). The incidence of HIV infection at the TB patients is 0.47% and 0.01% in the general population. Out of a total number of 442 AIDS adult patients registered in Bucharest between 1985 - 2001, researches have been started in 322 pacients out of whom 76 (23,6%) have had TB. 80% from them, where from an urban area; only 2,5 % had a high education. Clinical forms: caseous cavitary TB was present in 25% of cases, 20% of cases were with infiltrative nodular excavates, 33% with infiltrative forms and 22% was miliary TB. Disseminated TB was present at 44,7% of cases, with a serious evolution. Smear confirmation was present in 43,4% of patients. The immunitary profile was done by finding the value of CD4 at 49 patients with AIDS and TB. The treatment for TB was well tolerate in 89% of cases. Intradermoreaction to 2 U PPD was positive in 21% of cases. In 59% of cases we have discovered various risk factors for the appearance of a TB. TB is the most important pulmonary disease associated with AIDS in Romania and it is predictable that the two diseases being reciprocally influencing as they are both growing in incidence

P23.
La tuberculose multifocale chez une patiente immunocompètente

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Introduction: Les atteintes diffuses ou multifocales de la tuberculose représentent 9 à 10% des atteintes extra-pulmonaires. Les patients immunodéprimés, notamment ceux infectés par le VIH sont particulièrement exposés et la mortalité reste élevée.
La particularité de notre observation est la survenue chez une patiente d'une tuberculose à plusieurs atteintes, alors qu'aucun terrain débilité n'a été individualisé.
Observation: Nous rapportons le cas d'une patiente de 43 ans, sans antécédents particuliers, hospitalisée pour un syndrome bronchique traînant avec grave altération de l'état général.
L'examen clinique de cette patiente cachectique (poids de 46 Kg pour une taille de 165 cm) notait une pâleur cutaneo-muqueuse, des lésions cutanées sous forme de gommes disséminées. Il existait un syndrome d'épanchement liquidien basal droit à l'examen thoracique, une ascite avec splénomégalie à l'examen abdominal et des adénopathies sus claviculaire et axillaire gauches. Des douleurs sont provoquées à la pression du rachis dorsal.
L'imagerie thoracique (radiographie standard et scanner) confirmait la pleurésie droite et montrait l'existence d'adénopathies médiastinales.
L'imagerie du rachis (scanner et IRM) concluait à une spondylodiscite T11-T12, la radiographie de la jambe droite objectivait une ostéite de la tête du péroné et l'échographie abdominale retrouvait une ascite, une splénomégalie et des adénopathies.
Les recherches de BK sont négatives à l'examen direct et aux cultures aussi bien dans le liquide de tubage gastrique que dans le liquide pleural.
L'étude anatomopathologique des différentes biopsies réalisées (peau, ganglion, plèvre) montrait la présence d'un granulome épithélio-gigantocellulaire avec nécrose caséeuse.
Le diagnostic de tuberculose multifocale était retenu et la recherche d'un terrain immunodéprimé restait négative.
L'évolution, sous traitement antibacillaire bien conduit, était marquée par l'apparition d'une encéphalopathie hépatique conduisant au décès de la patiente.

Conclusion: L'intérêt de cette observation est de rapporter une atteinte *multifocale* de la tuberculose en dehors d'une immunodépression et de discuter ses aspects épidemiologiques, thérapeutiques, évolutifs et physiopathologiques.

P24.
Lung tuberculosis diagnostics in pulmonologic hospitals: are there any problems?

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Purpose of this research was to compare lung tuberculosis (TB) and pneumonia's clinic symptoms and the reasons of mistakes in TB differential diagnosis, done by doctors in pulmonologic hospitals.
Methods: 122 clinical records of TB patients, hospitalized as pneumonia patients and 35 records of acute pneumonia patients were analyzed. RESULTS. 86,1% of ÒÂ patients had complains on cough (in 63,9% with sputum), 76,2% – on weakness, and 81,1% – on high temperature. Objective examination showed only in 3,3% of patients blanting of pulmonary sound, and in 22,1% crepitations in lungs. Ave-rage ESR was 32,4 mm/h, leukocytosis – 6,6*109/l. In pneumonia group similar complaints (cough in 98%, including 80% with sputum, weakness 68%, high temperature 74%) were followed by more informative objective status – 46% of patients had blanting of pulmonary sound, and 57% of patients had crepitations in lungs. Average ESR was 27,5 mm/h, leukocytosis – 6,7*109/l. Chest X-ray was done to all of patients in average period of 2,7 days after hospitalization and smear microscopy in 83,6% of patients. BK were found only in 25,4% patients. TB was diagnosed in average period of 12,4 days after hosp italization. CONCLUSION. Quickest chest radiography and smear microscopy is needed for differential diagnosis of lung TB and pneumonia.

P25.
Primary tuberculosis of the Breast

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Despite generalized BCG vaccination, and the introduction of Dots. Dots+Strategies tuberculosis remains a public health issue in Morocco. Breast localizations are exceptional and constitutes a diagnostic and therapeutic challenge.
Case report: a 47 year old women widowed since 1990 has presented a year ago a nodule of the right breast wich has increased progressively of volume. The mammary echography and the mammography realized suspected a neoplasic origin. It's the biopsy of the nodule that has confirmed the diagnosis. The out come after 6 months of antituberculosis drug therapy was favorable (2 months: INH+PZA+RiF – 4 Months: INH+Rif).
Conclusion: tuberculosis is rarely localized in the breast the main differential diagnosis is breast cancer. Pathology examination is required for diagnosis. Anti tuberculosis antibiotic therapy may be associated with surgery in cases of extension or failure of the medical therapy.
Ref: 1-Zouhal A. Outifa M et Al. A rare cauise of a pseudoneoplastic mass of the breast: breast tuberculosis: Rev med int 1996 174(2) p: 173-5. 2-Perkinjo, Stanley w. tuberculosis mastitis: clest 1990 98: 1505-9.

P26.
La tuberculose cerebrale: a propos de 3 observations et une revue de la litterature

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Nous étudions les aspects épidémiologiques, cliniques et radiologiques de la tuberculose cérébrale à travers ces 3 cas personnels colligés aux services de pneumologie et de neurologie de l'hôpital de Kairouan avec une revue de la litterature.
Nous ressortons que la tuberculose cérébrale est une entité rare qui accompagne souvent la tuberculose miliaire mais qui peut aussi accompagner d'autres localisations. Elle peut être révélatrice ou survient au cours de l'évolution d'une tuberculose déjà sous traitement.

Le diagnostic repose sur la clinique la bactériologie et surtout l'imagerie grace aux progrès de la tomodensitométrie et l'imagerie par résonnance nucléaire.
Le traitement est toujours le même, d'une durée plus prolongée, mais faut-il ajouter une corticothérapie?

P27.
Coexistence of lung TB and bronchogenic carcinoma

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Among 134 patients with diagnosed lung carcinoma in the Institute during 2001, there were two cases of simultaneous lung TB. Case 1#: S.G., male, aged 64, with many years cigarette smoking habit, was admitted to our Institute with a 10 day long history of following symptoms: temperature up to 39 C and headache. Objective findings: sedimentation rate was 75/, ARB were detected in sputum by fluorescent microscopy; chest X ray showed fibrous line shadows in the right upper lobe, infiltrative not well defined shadow bellow them and enlargement of right hilus; fiberbronchoscopy examination obtained histologic confirmation for squamous cell carcinoma (in the right upper lobe bronchus). Treatment: curative resection in combination with antituberculotic drug therapy. Case 2#:V.J., male, aged 52, with many years cigarette smoking habit, was admitted to our Institute with a two months long history of previous antituberculotic drug treatment in the Hospital of Jasenovo (reason: persistent haemoptysis and worsening of findings on chest X ray). Objective findings: sedimentation rate was 26/; chest X ray showed tiny fibrous shadows in the right upper lobe, infiltrative not well defined shadow in the left hilus; fiberbronchoscopy examination obtained histologic confirmation for squamous cell carcinoma (in the left main bronchus). Treatment: radiotherapy suggested by oncologist, in combination with continuing faze of antituberculotic drug therapy. A possibility of coexistence of TB and lung cancer should be carefully investigated, particularly in patients proceeding radio/chemotherapy.

P28.
Spontaneous pneumothoraces caused by metastazing malignancy

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Spontaneous pneumothorax is still a rare complication of pulmonary metastases. Malignancy originating from the lung or another era in the body and despite its rarity, is an important etiology of spontaneous pneumothorax. Its incidence is reported to be less than 0.05%. These cases of pneumothorax are thought to be caused by tumor necrosis and /or bronchiolar distension. Any agent which causes tumor necrosis and cavitation would increase the risk of pneumothorax.
From 1995 till 2001, Three patients ranging in age from 27 to 70 years old with secondary spontaneous pneumothoraces were treated at our unit. The pneumothorax was bilateral in two patients and associated with lower limb osteosarcomas while in the third patient the pneumothorax was associated with lung metastases and limb's melanomas. In one patient the pneumothorax was the presenting symptom of the disease.All cases were successfully treated using videoassisted thoracoscopy without any mortality or morbidity.
Conclusions: Textbooks and review discussing the etiology of pneumothorax frequently neglect to mention metastatic neoplasms. It is important to include metastatic neoplasms in the differential diagnosis of spontaneous pneumothorax.

P29.
Syndrome de Pancoast et Tobias. Revelateur d'un carcinome a petites cellules (a propos d'un cas)

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Le syndrome de poncoast et tobias et caractérisé par des douleurs cervico brachial, un syndrome de Claude Bernard-Horner, (ptôsis myosis enophtalmie) et une lyse costale et/ou vértèbrale. Associé à une opacité de l'apex à la radiographie pulmonaire.
Son étiologie est le plus souvent maligne représentée par les cancers épidermoides dans 40%, les autres causes néoplasique représentent 40%. Les carcinomes à petites cellules sont rarement rapportés par la littérature (1%).
Nous rapportons un cas de carcinome à petite cellule révélé par le SD de Pancoast et Tobias .
Il s'agit de patient âgé de 65 ans, hospitalisé au service de pneumologie pour douleurs thoracique haute droite évoluant
Dans un contexte d'altération de l'état générale pendant 8 mois.
L'examen clinique retrouve un patient en mauvais état général (INDICE DE KARNOFSKY à 70), une matité de l'hémithorax droit. La radiographie pulmonaire note une opacité apicale droite avec lyse costale, la fibroscopie bronchique est normale. Le bilan biologique note une hypercalcémie. L'étude anatomopatologique révèle un carcinome à petite cellule.
Le bilan d'extension montrait des métastases osseuses et cérébrale. Vu l'age du patient, métastases cérébrale, le patient a été confié à sa famille avec un traitement symptomatique .
A propos de cette observation, nous proposons de rappeler les étiologies du SD de PANCOAST ET TOBIAS. Ainsi que la modalité diagnostics et thérapeutique.

P30.
Liposarcomes mediastinaux: a propos de 3 cas

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Les liposarcomes (LPS) sont des tumeurs malignes mésenchymateuses rares à différenciation adipocytaire. La localisation médiastinale est peu fréquente (2% des tumeurs de cette région). Leur symptomatologie clinique est non spécifique et leur diagnostic n'est assuré que par l'examen histologique. Les données récentes de la cytogénétique et la biologie moléculaire ont jeté un jour nouveau sur la biologie des liposarcomes, leurs potentiels évolutifs leurs interrelations et leur classification. Les auteurs rapportent 3 cas de liposarcomes du médiastin (2 cas de LPS myxoïde et à cellules rondes et un cas de LPS myxoïde pur). Ils soulignent le rôle de l'examen anatomopathologique dans le diagnostic et dans l'établissement du pronostic. Celui-ci est lié à la précocité d'une exérèse chirurgicale complète et large mais aussi au type histologique de ces tumeurs.

P31.
Une cause rare des tumeurs du médiastin postérieur: l'hématopoïèse extra-médullaire

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Introduction: L'hématopoïèse extra-médullaire (HEM) est une réponse physiologique à une production inadéquate ou à une destruction excessive des cellules sanguines. Elle se rencontre essentiellement au cours des bêta thalassémies ou des myélofibroses et intéresse préférentiellement la rate et le foie; la localisation médiastinale est rare.
Cas clinique: A la suite d'une visite de médecine, on découvre chez un homme de 44 ans une opacité paravertèbrale gauche sur une radiographie standard.
Ce patient fumeur de 10 paquets année, sans antécédents est asymptomatique. L'examen clinique est sans anomalies et le scanner thoracique notait l'existence de deux formations polypoides siégeant dans les gouttières paravertèbrales, bien limitées, de densité tissulaire, sans érosion osseuse, sans extension canalaire et se rehaussant après injection de produit de contraste.
L'échographie abdominale ne montrait pas d'hépatomégalie ni de splénomégalique et le bilan biologique était normale notamment l'hémogramme montrait une hémoglobine à 14,7 g/dl.
On décide alors de réaliser une thoracotomie par le 7ème espace intercostale gauche, l'exérèse est incomplète vue un saignement important et l'examen microscopique concluait à une hématopoïèse extra-médullaire.
Il n'existait pas de myélofibrose sur la biopsie osteo-médullaire ni sur le myélogramme et l'electrophorèse de l'hémoglobine était normale.
Il s'agissait donc de la mise en évidence d'un foyer d'HEM médiastinal sans myélofibrose associée. Il n'existait pas d'autres foyers ectopiques visibles.

Discussion: L'HEM de localisation médiastinale est rare, son diagnostic doit être évoqué devant toute masse médiastinale postérieure associée à une myélofibrose ou à une hémoglobinopathie.
L'I.R.M et la scintigraphie au TC99 permettent d'approcher le diagnostic.
Le traitement diffère selon son étiologie et son caractère compressif ou non.
Conclusion: notre cas illustre bien que l'HEM médiastinale doit être évoquée même en l'absence d'hémopathie.

P32.
Ganglioneurome du mediastin. A propos d'une observation

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Les tumeurs neurogénes médiastinales représentent 15 à 35% des tumeurs du médiastin postérieur, elles ont comme particularité majeure d'être asymptomatique et presque toujours bénignes chez l'adulte. Le gonglioneurome médiastinal est une tumeur neurogéne bénigne, rare chez l'adulte, bien différenciée, développée à partir de neurones du système sympathique, végétatif principalement.
Les auteurs rapportent l'observation d'un gonglioneurome médiastinal de découverte fortuite chez une jeune patiente âgée de 16 ans; victime d'une noyade. La radiographie thoracique montrait une opacité médiastino pulmonaire paravertebrale droite, de topographie postérieure.
La TDM thoracique montre une opacité dense; homogène, apicale droite mesurant (67x64x59) mm, cette masse de siége para trachéal, refoule les vaisseaux du cœur en avant. La fibroscopie bronchique est normale. La ponction transpariétale scannoguidée était non concluante.
Une thoracotomie a été décidée et une tumorectomie a été réalisée. Les suites opérations étaient simples ; aux une nette amélioration radiologique de la pièce opératoire.
L'examen anatomopathologique de la pièce opératoire a permis d'établir le diagnostic de gonglioneurome sans signes de malignité.
A travers notre cas, colligé dans le service de pneumologie de l'hôpital moulay youssef; CHU Rabat. A la lumière d'une revue de la littérature, nous discuterons les caractéristiques épidémiologiques, diagnostiques et thérapeutiques de cette variété de tumeurs. Tout en précisant les difficulté et l'intérêt de l'analyse histologique de cette tumeur.

P33.
Les metastases broncho-pulmonaires

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Nous rapportons le cas clinique d'un patient de 25 ans, sans antécédents pathologiques notables présentant depuis une année des douleurs thoraciques postéro-basales gauches rebelles au traitement antalgique associé à des crachats muco-purulents sans hémoptysie. L'évolution est marquée par une altération de l'état général avec un amaigrissement et fièvre non chiffré. A l'examen clinique, on se trouve devant un patient en mauvais état général fébrile à 39°. Un syndrome de condensation pulmonaire postéro basal gauche ainsi que de douleur exquise sont retrouvés à ce niveau. Le reste de l'examen est sans particularités notamment l'examen cutané. La radio thoracique de face objective une opacité retrocardiaque basale gauche. Plusieurs diagnostics ont été soulevés notamment: une pneumopathie à germes banaux ou à BK, et une néoplasie primitive ou secondaire. Devant la non amélioration radiologique ou clinique sous traitement antibiotique à large spectre et la négativation du bilan phtysiologique une bronchoscopie est réalisée qui n'a montré qu'un aspect inflammatoire de 1er degré de la lobaire inférieure gauche avec des signes de compression extrinsèques. Un complément scannographique objective une énorme coulée tumorale hétérogène de l'espace médiastinale postérieure avec lyse costale entrant en contact avec les organes du médiastin postérieur et présence d'adénopathies médiastinales et coeliomésenteriques. Le diagnostic d'une métastase bronchopulmonaire d'un mélanome malin est posé grâce à une ponction biopsie scanno-guidée. La recherche d'une localisation primitive: cutanée, ophtalmologique ou digestive est revenue non concluante. Le patient est adressé au service de radio-chimiothérapie pour prise en charge. A travers cette observation et selon les données de la littérature une mise au point sera faite sur les métastases bronchopulmonaires des mélanomes malins et sur les difficultés diagnostics, vu leur rareté et lorsque le primitif n'est pas évident, est sa résistance à toute thérapeutique radio-chimio-thérapeutique et les essais de nouvelles approches telles l'aerosolothérapie d'IL2 ou l'immunothérapie à base de vaccin autologue.

P34.
L'hamartochondrome pulmonaire: a propos de 4 cas

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Les tumeurs bénignes du poumon sont rares, l'hamatochondrome pulmonaire présente près de la moitié de ces tumeurs.
Nous rapportons 4 observations d'hamatochondrome pulmonaire. Il s'agit d'hommes âgés en moyenne de 47,5±7,76; 3 patients étaient tabagiques. Les circonstances de découverte étaient fortuites chez 2 patients et une douleur thoracique chez les deux autres.
L'aspect radiologique était celui d'une opacité arrondie bien limitée intra-parenchymateuse.
La fibroscopie bronchique était normale chez 3 patients et avait mis en évidence un bourgeon endo-bronchique dont la biopsie est revenue négative, chez un patient. La tomodensitométrie thoracique a mis en évidence une opacité de densité tissulaire ne prenant pas le produit de contraste, des calcifications en Popcorn ont été présentes chez un seul malade.
Le traitement a consisté en une tumorectomie sous thoracotomie chez 2 patients, une tumorectomie vidéo-assistée chez un patient et une lobectomie chez un autre. L'évolution était bénigne dans tous les cas.

P35.
Rhabdomyosarcome pulmonaire primitif: a propos d' un cas

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Le rhabdomyosarcome (RMS) pulmonaire primitif est une tumeur très rare, une quinzaine de cas ont été rapportés dans la littérature.
Il existe deux types de localisation: intra-parenchymateuse et endobronchique.
Nous rapportons une observation d'un RMS pulmonaire primitif dans sa forme endobronchique chez un sujet de 66 ans qui s'est présenté pour une dyspnée, toux productive et altération de l'état général évoluant depuis 1 mois.
L'examen physique a trouvé une polypnée à 30 c/mn et des crépitants à droite.
La radiographie du thorax a montré une opacité para cardiaque droite. A la fibroscopie bronchique il existe une formation tumorale pédiculée mobile prenant naissance au niveau de la lobaire moyenne. Les biopsies per-endoscopiques ne sont pas concluantes. Le patient a été opéré à J3 d'hospitalisation, il a subi une pneumonectomie et décède dans les suites opératoires dans un tableau d'insuffisance respiratoire aigue.
L'examen anatomo-pathologique de la pièce opératoire a conclu à un RMS pulmonaire. Le RMS primitif pulmonaire est rare, son diagnostic positif nécessite l'élimination préalable d'une métastase d'un RMS d'un autre site, d'un contingent épithélial associé ou d'un carcinosarcome. Les formes endobronchiques seraient de meilleur pronostic que les formes intra parenchymateuses. Le traitement de choix est la chirurgie.

P36.
Quel est votre diagnostic?

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Les auteurs rapportent l'observation d'une jeune patiente de 20 ans, sans antécédents notables, hospitalisée au service pour une toux sèche traînante.
L'examen clinique trouve un syndrome de condensation basal droit, les aires ganglionnaire sont libres et il n'existe pas d'hépatosplénomégalie.
La radiographie pulmonaire objective un syndrome alvéolaire intéressant le lobe moyen et le lobe inférieur droit. Le scanner thoracique élimine l'existence d'adénopathies médiastinales.
Le bilan biologique retient uniquement un syndrome inflammatoire, les recherches de BK sont négatives et la fibroscopie est normale.

Quels sont vos hypothèses diagnostiques ?
Résultats: L'étude anatomopathologique de la biopsie pulmonaire réalisée sous thoracotomie droite conclut à une maladie de Hodgkin de type scléro-nodulaire.
Le bilan à la recherche de localisations secondaires est resté négatif (Biopsie osteo-médullaire, scanner abdominal, taux de LDH).
Mots-clés: Lymphome hodgkinien pulmonaire primitif, difficultés diagnostiques, traitement.

P37.
Approche morphologique et clinique de la tuberculose extra-pulmonaire dans la wilaya de Skikda

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Il sagit d'une etude rétrospéctive etalée sur la période (Janvier 1990 – Décembre 2001).
52 cas de tuberculoses extra-pulmonaires ont été répertoriés au service d'anatomie et de cytologie pathologiques de Skikda représentant ainsi 2% de l'ensemble de la pathlogie médico-chirurgicale recrutée.
93% des localisations sont ganglionnaires, dont 97% touchent les chaines lymphatiques cervicales.
Le diagnostic clinique peut être mis a tort sur le compte d'une lesion maligne primitive ou secondaire redressé ultérieurment par l'étude histopathologique qui révele dans la majorité des cas une lesion caséeuse, caséo-folliculaire ou caséo-fibreuse.
Le traitement de la Tuberculose ganglionnaires est avant tout medical, toutefois la chirurgie garde une place non négligeable.

P38.
Profil des rhinites allergiques dans la wilaya de Skikda. Étude transversale d'une année

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Il s'agit de résultats préliminaires d'une étude transversale s'étalant de janvier 2001 – decembre 2001 dont l'objectif est de définir le profil épidemiologique des patients atteints de rhinite allérgique. Ont été exclues de notre étude toutes les lésions post-traumatiques.
La pertinence des résultats recueillis est de taille d'autant plus que Skikda est considérée comme un pôle industriel générateur d'une pollution atmosphérique assez importante.
309 cas de rhinites allérgiques ont été étiquetés (51%).
Le diagnostic positif est aisé devant une symptomatologie révélatrice riche et polymorphe dominée par la triade classique: rhinorrée, eternuements en salve et obstruction nasale (retrouvée chez 62% de nos malades), parfois associée à une polypose naso-sinusienne et/ou un asthme.
Le traitement de la rhinite allérgique et médical, toutefois le recours à la chirurgie est de mise dans la polypose naso-sinusienne.

P39.
Étude anatomoclinique rétrospective des TCFM au niveau de la wilaya de Skikda

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Dans cette étude, les auteurs tentent de situer les tumeurs cervico-faciales malignes (TCFM) par rapport à la pathologie médico-chirurgicale générale et les tumeurs cervico-faciales (TCF) en particulier.
Il s'agit d'une étude rétrospéctive couvrant la période de Janvier 1998 jusqu'à Septembre 2001.

43 cas de cancer de la région cervico-faciale ont été recensés au niveau de la wilaya de Skikda, le diagnostic est le plus souvent porté sur biopsie exérese.
Les TCFM se présentent comme des tuméfactions de la région latéro-cervicale (70%).
On note une concordance anatomo-clinique satisfaisante de l'ordre de 79% des cas. Les types histologiques restent dominés par les carcinomes.

P40.
Evaluation de la prise en charge de 102 cas de tuberculose pulmonaire à bacilles multirésistants au CHU Mustapha – Résultats thérapeutiques

N HAMMACHE, H FILALI, S. NAFTI

102 cas de tuberculose pulmonaire à bacilles multirésistants ont été pris en charge et traités entre 1996 et 2001 au CHU Mustapha à Alger. Il s'agit de patients jeunes de moins de 40 ans et qui ont reçus 2 à 3 cures de chimiothérapie de «ler ligne». Ces patients ont reçu un régime comportant 5 drogues en phase d'attaque d'une durée de 03 mais puis 4 drogues en phase d'entretien de 21 mois (3 KEOZC/21 EOZC).
Les 102 malades ont terminé leur traitement et on retrouve les résultats suivants :

- Guérison confirmée bactériologiquement: 55 cas(53,90%)
- Echecs: 13 cas (11,90%)
- Rechutes: 8 cas (7,84%)
- Déces : 19 cas (18,6%)
- Perdus de vue: 15 cas (14,70%)

Enfin on retrouve 10 familles de tuberculeux à bacilles multirésistants totalisant 29 cas.