patients undergoing haemodialysis may cause large transcompartmental shifts of potassium. Potassium transfer across the dialysis membrane may be inadequate to compensate for such shifts, and life-threatening hypokalemia may occur.

References

Case Report

Ovarian enlargement associated with massive oedema
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Abstract
Massive ovarian oedema is a rare entity described as accumulation of oedema fluid within the ovarian stroma, separating normal follicular structures. Our case was a 27-year-old woman who presented with a large solid pelvic mass after recurrent episodes of self-limited abdominal pain. On physical examination, she had left abdominal tenderness with minimal rebound and guarding. With a diagnosis of malignant ovarian tumor, an exploratory laparotomy was done and a twisted ovarian mass was found which was excised completely. Histopathological evaluation of the mass revealed massive oedema of the ovary. Massive ovarian oedema should be suspected in women at the fertile age range with solid enlargement of the ovary.

Introduction
Massive oedema of the ovary is a rare entity affecting young women.1-2 Due to its neoplastic appearance, most patients are over-treated with resultant loss of fertility and hormonal function.1 The etiology of this entity is still obscure. It has been suggested that massive edema of the ovary results from interference with the venous and lymphatic flow due to torsion of the mesovarium. Although the right ovary is most commonly affected, bilateral affections have also been reported.1 Clinicians should also remember that ovarian oedema may occur along with carcinoma.3 This case report underlines the fact that massive ovarian oedema should be suspected in women with solid enlargement of the ovary.

Case Report
The patient was a 27-year-old woman who presented with a large solid pelvic mass after recurrent episodes of self-limited abdominal pain. Her vital signs were stable. On physical examination, she had left abdominal tenderness with minimal rebound and guarding. She had appropriate developmental features for age without signs of virilization and there were no remarkable abdominal findings. Sonography showed an enlarged left ovary of 8 x 6.5 cm with hypoecogenic foci at its periphery, and a small
amount of pelvic fluid occupying the space of Douglas. Biochemical analysis of tumour markers alpha-fetoprotein, bHCG, and CA 125 were normal. With a diagnosis of malignant ovarian tumor, an exploratory laparotomy was done and a twisted ovarian mass was found which was excised completely, the uterus and right ovary appeared normal. The left ovary appeared as a solid, grayish mass, measuring 8 x 6.5 cm (Figure 1), and complete torsion of the adnexa was noted. No other pathology was observed. Pelvic fluid was sent for cytology and detorsion and oophorectomy was performed. Postoperative course was uneventfull. Histopathological examination revealed expanded, oedematous ovarian cortex with increased subcapsular density, dilated blood vessels, and massive oedema (Figure 2). The omentum pelvic fluid cytology was normal. The final diagnosis was massive ovarian oedema.

Discussion

Massive oedema of ovary is a rare non-tumoral entity. It is considered a rare entity and most physicians are not aware of its existence.1-5 Kalstone et al first described it as a “massive, solid enlargement of the ovary associated with interstitial oedema”.4 Predominantly massive oedema is seen in patients, with an average age of 20 years.2,5 It has been described during pregnancy and post partum period. The clinical presentation of cases reported it as an incidental finding during surgery4, presentation with recurrent intermittent abdominal pain, abdominal tenderness, rebound and guarding or a pelvic mass.2,3 Menstrual irregularities were common and some had hormone secretion related signs (hirsutism, clitoromegaly, voice deepening, precocious puberty) resulting from stromal cell compression due to stromal oedema.1 In earlier publications, plain abdominal radiographs were performed at best, showing displacement of bowel loops by a soft tissue mass.2 Ultrasound findings were considered non-specific. MRI in one case identified multiple small, cystic areas thought to be ovarian follicles and areas that suggested the presence of haemorrhage within the mass.2 Macroscopically, the same description of a smooth, enlarged, grayish ovary, with glistening surface and rubbery consistency was given in most reports.1,6 The etiology of massive oedema of ovary is uncertain. The most appealing pathogenetic theories include oedema due to partial recurrent torsion with outflow obstruction and a proliferative condition related to ovarian fibromatosis.2 Studies suggest that partial torsion or kinking of the mesovarium with obstruction to the venous and lymphatic drainage were etiologic factors.5 There are many studies which are in accordance with this assumption, because most show venous and lymphatic obstruction4, but not with arterial blood flow. Treatment of massive ovarian oedema is controversial. It is a benign entity, usually affecting young patients in need of fertility preservation and retention of hormonal activity with conservative approaches.3,7,8 On the other hand, sometimes massive ovarian oedema, mimics a malignant tumour in its appearance, and these cases are subjected to extensive surgery.4,6 Güvenal et al reported the case of a 20-year-old woman with unilateral massive ovarian edema with findings on ultrasound of an enlarged polycystic ovary and arterial and venous blood flow in the pedicle, observed with colour and pulsed wave Doppler examination.7 Due to the non-neoplastic nature of the disease, some authors retrospectively suggested a more conservative approach with frozen section of the involved ovary after detorsion and treatment according to the result.1 Detorsion has already been shown to be safe either in women undergoing fertility treatment or in young girls, both with torsion of the ovaries.8 Intraoperative pathological diagnosis was through frozen section. Torsion was treated by detorsion, at times laparoscopically, and the oedematous ovary or ovaries were left in situ with or without suspension.9 After extensive review of the literature, Giest et al reported that most cases were over-treated., as was ours. Also stated that this entity should be suspected in women at the fertile age range with solid enlargement of the ovary and definite treatment should be undertaken only after confirmed pathological diagnosis.6

Cheng et al reported that with de-torsion, wedge resection, and plication of the ovary, the patient was successfully relieved of the abdominal pain and experienced no recurrence in the follow-up period.10

In conclusion, it is observed that the massive oedema of the ovary is not a well recognized entity and therefore, more extensive treatment than is necessary is undertaken too often, as was the case in our patient. This entity should be considered in young women presenting with an ovarian mass, especially when there is a history of recurrent
abdominal pain. Conservative treatment should be the rule where fertility preservation is mandatory.

References

Case Report

Left main coronary artery dissection during percutaneous coronary intervention in patient with chronic total occlusion

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Abstract
Catheter induced left main coronary artery dissection is a rare but well recognized life threatening complication of coronary angiography and angioplasty. We present a case of left main coronary artery dissection induced with a guide catheter while dealing with chronic total occlusion(CTO)and bailout stenting of left main and Left anterior descending(LAD) artery.

Introduction
Left main coronary artery(LMCA) dissection is rare but can pose life threatening complication during Percutaneous coronary intervention (PCI). LMCA dissection can occur spontaneously, as a complication of aortic root dissection or can be iatrogenic. LMCA dissection is the threat for vessel closure. It can be precipitated by the manipulation of interventional hardware in the LMCA ostium. The conventional management of LMCA dissection is coronary artery bypass grafting (CABG) but bailout stenting has also been shown to be life saving in cases of acute LMCA occlusion.

We present a case of guide catheter induced LMCA dissection dealing with CTO that resulted in symptoms and ECG changes with subsequent successful stent implantation of Left main (LM) and then Left anterior descending artery (LAD).

Case Report
The case of a 45 year old male with hypertension, diabetes mellitus and a 5-month history of exertional angina Functional class II-III, on Beta blockers, aspirin, clopidogrel, angiotensin receptor blockers and lipid lowering drugs is presented. Resting 12-lead electrocardiogram was within normal limits. Stress thallium at 4METS showed 2-mm ST-segment depression in all leads with reversible ischemia at apex, anterior wall and septum.

Coronary angiography showed totally occluded proximal segment with distal LAD filling via collateral from Left circumflex (LCx) and Right coronary artery (RCA)(Fig 1a). The decision was made to proceed with an intervention of the LAD.7Fr. left Judkins guide catheter (JL3.5) (Cordis) was used to cannulate the LMCA.PT2 guide wire (Boston scientific) was used to cross the lesion which at the exit of the lesion was unable to advance for which 1.5x10mm balloon monorail (Easyway 2, Cordynamic) was taken to support the wire for advancement. Over the wire (OTW) balloon was not...