

with 0 glycolide/lactide suture in a horizontal mattress fashion over an oxidized cellulose bolster. On postoperative day 3, the patient reported left flank discomfort and gross hematuria. CT scan revealed multiple pseudoaneurysms and the patient underwent selective arteriography confirming the diagnosis. Percutaneous selective coil angioembolization was successfully performed.

Hemorrhage is the most common complication of partial nephrectomy. However, less commonly, hemorrhage can also occur in the context of a pseudoaneurysm with reported rates of 0.4%-1.4%^{2,3}. Currently, only 25 reported cases are available in the partial nephrectomy literature, with 11 reported after laparoscopic partial nephrectomy and the first one being described in 1973¹.

A pseudoaneurysm during partial nephrectomy procedure is thought to be formed from inadvertent vessel injury or from a suture placed through a vessel during the approximation of the renal parenchyma. After the initial renal injury, hypotension, coagulation and pressure from the surrounding tissue (vascular adventitia, renal parenchyma and Gerota's fascia) results in temporary cessation of the bleeding. Degradation of the clot and surrounding necrotic tissue results in recanalization between the intravascular and extravascular space and, subsequently, the formation of a pseudoaneurysm. With restoration of normal blood flow, this pseudoaneurysm can grow and eventually become unstable with erosion into the surrounding pelviciceal system or the surrounding perinephric tissue⁴. Angiography has been shown to be the gold standard for the diagnosis of renal artery pseudoaneurysm. However, if the patient is hemodynamically stable, non-invasive tests such as contrast medium-enhanced CT and magnetic resonance angiography should be performed. Percutaneous selective coil angioembolization is a safe and efficient technique for the management of the patients with this delayed form of hemorrhage, providing excellent results with maximal renal preservation.

In our opinion, post-partial nephrectomy rates of pseudoaneurysm should be well analyzed by large series studies, since the rarity of this serious and insidious complication is debated.

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Long-term safety and efficiency of endovascular repair in an adolescent patient with post-traumatic aortic pseudoaneurysm

Dear Editor,

The injury pattern in blunt paediatric chest trauma is different from that encountered in adults and traumatic rupture of the thoracic aorta (TRA) is rare in young people.

The newest approach in the treatment of thoracic aortic injuries is thoracic endovascular aortic repair (TEVAR), but the majority of surgeons agree that TEVAR involves uncertainty and risks and that certain guidelines should be followed¹.

The application of TEVAR in young patients presents even more challenges and concerns which are associated with the young age of the patient and could lead to a poor outcome². There are only few reports of TEVAR in pediatric traumatic aortic injury³ and all of them conclude that although short-term recovery and follow-up are encouraging for endovascular stenting in the pediatric population, further long-term follow-up is required.

Such long-term data for the TEVAR approach in children are currently lacking and therefore TEVAR is considered a bridging procedure and not a definitive treatment, in this population.

A 16 year old Greek boy with no previous medical history, was admitted to our hospital with serious multiple trauma, fractures of the lower extremities and ischemic manifestations on the right lower extremity, after a high-speed motor vehicle collision. The patient demonstrated distress in breathing. A Glasgow Coma Scale (GCS) of ten (10) was measured.

Physical examination revealed neither differences in upper extremity pulses nor the presence of pseudocoarctation syndrome. A plain chest radiography was initially performed on a supine position. It revealed mediastinal widening and loss of the aortic knob which are signs of aortic injury. Contrast-enhanced CT was performed on the brain, chest and abdomen of the patient. Mediastinal hematoma, extravagation of the contrast medium and pseudoaneurysm formation, without clear visualization of the exact position of the pseudoaneurysm, were observed. Aortography was then performed to evaluate the exact position of the pseudoaneurysm.

The patient was urgently treated and endovascular stenting was placed. He was followed up every six months initially and every year thereafter. Four years later, chest radiography demonstrated the excellent positioning of the endovascular

stent and thoracic CT with intravenous contrast enhancement revealed no mediastinal hematoma or extravagation of contrast medium to the mediastinum.

The case currently presented is, to the best of our knowledge, the first report of long-term data for the TEVAR approach in children. Although TEVAR is a challenge in this group of patients and is associated with many serious complications, our case shows that in some instances, TEVAR application in the pediatric population is promising in terms of long-term safety and efficiency.

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Treatment with risperidone and venlafaxine of a patient with double-coded diagnosis of body dysmorphic disorder and delusional disorder somatic type

Dear Editor,

DSM-IV classifies body dysmorphic disorder (BDD) under the somatoform disorders and its delusional variant as delusional disorder somatic type (DDST)¹. The differential diagnosis is difficult, especially in cases with delusions of dysmorphobia, the subset of DDST which seems nosologically closest to BDD. DSM-IV, recognizing the diagnostic confusion in these definitions, allows these two variants to be double-coded, and delusional patients may be assigned both diagnoses¹. The pharmacotherapy of these disorders has not been extensively studied. Proposals include antidepressants², antipsychotics³ or a combination of both². We present a patient with a double-coded diagnosis, treated with risperidone and venlafaxine.

A 26-year-old male was referred to our consultation-liaison unit by the dermatology department. The last six months he was preoccupied with beliefs that the skin of his arms became ill-structured, as evidenced by the appearance of 'abnormal skin folding'. He had already consulted dermatologists and plastic surgeons and had undergone minor cosmetic laser treatment for deformity correction.

Besides the aforementioned beliefs, he presented low mood. Due to his preoccupation with the perceived defects, he was withdrawn and abandoned his job. No other psychiatric symptoms were present. He had no prior psychiatric or substance abuse history, or family history of mental disorders. Physical examination and laboratory tests including MRI were normal.

A diagnosis of BDD and additionally of DDST was made, since his beliefs were held with delusional intensity. Pimozide, which was initially administered, was switched to risperidone (2mg/day, gradually increased to 4mg/day), due to extrapyramidal side effects. Simultaneously, due to deterioration in his mood, venlafaxine was introduced, 37.5mg/day, gradually increased to 150mg/day. No side effects developed. Four weeks later the symptoms improved significantly. Six months later he was free of symptoms.

Our patient fulfilled DSM-IV criteria for both BDD and DDST. It was suggested that, rather being distinct, the two disorders may constitute one entity¹. Pimozide, which was suggested as the treatment of choice for DDST³, caused intolerable side effects. Therefore, risperidone was administered, which has been reported as effective in the treatment of this disorder³. Venlafaxine, which was primarily administered for our patient's low mood, was also reported as effective in the treatment of BDD⁴. Additionally, the effectiveness of an antipsychotic-antidepressant combination in the treatment of DDST is established².

This case indicates that combination of risperidone and venlafaxine is effective in the treatment of BDD with somatic delusions. Patients may first seek advice by dermatologists and plastic surgeons, who should be aware of this condition and promptly request psychiatric consultation, for proper treatment and to avoid unnecessary, inefficient or even harmful interventions.

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