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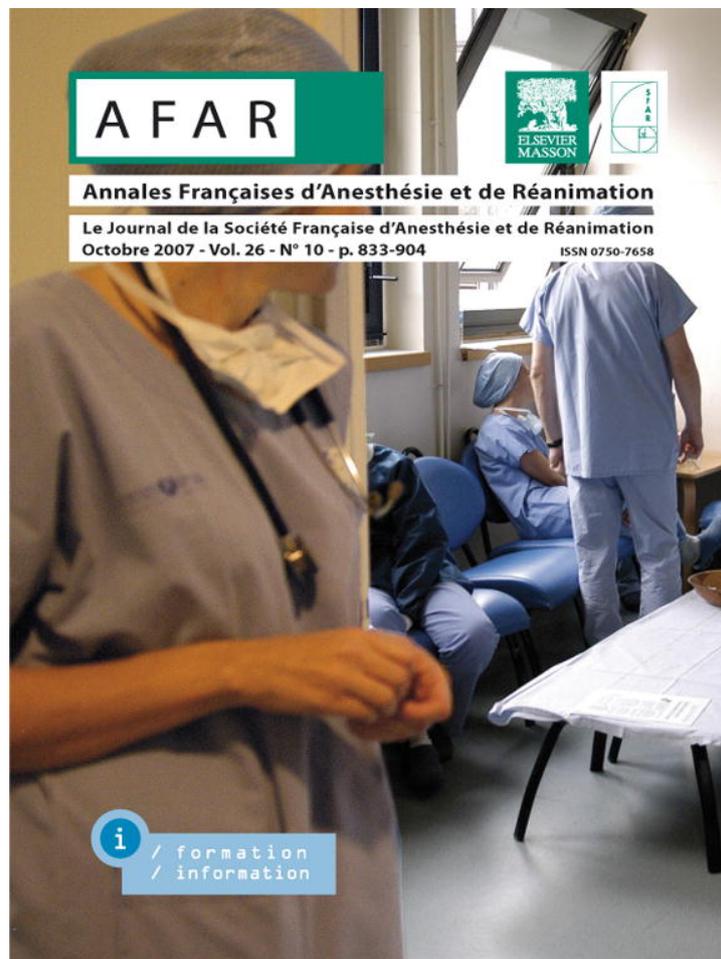
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### **Salmonella non typhi : une cause inhabituelle de la cholécystite aiguë alithiasique chez l'adulte**

#### **Salmonella non typhi: an unusual cause of acute acalculous cholecystitis in adults**

La cholécystite aiguë alithiasique (CAA) est une inflammation aiguë de la vésicule biliaire en l'absence de calculs et qui représente 5 à 10 % des cholécystites aiguës [1]. Elle complique rarement une infection primaire de la vésicule biliaire et encore moins une infection à *Salmonella* [1,2].

Nous rapportons le cas d'une patiente âgée de 41 ans, hospitalisée en réanimation pour prise en charge postopératoire d'une péritonite par perforation de la vésicule biliaire. Dans ses antécédents, on retrouvait un diabète insulino-dépendant, une hypertension artérielle, une chirurgie récente (pontage aortocoronarien) et la notion de prise d'antibiotiques à large spectre.

La patiente a été admise aux urgences dans un tableau d'abdomen aigu avec une histoire de diarrhée, vomissements et douleurs abdominales, une semaine avant son admission. L'examen clinique avait trouvé des signes de sepsis sévère avec une défense abdominale localisée au niveau de l'hypocondre droit. L'imagerie abdominale (échographie + TDM) avait objectivé une cholécystite alithiasique avec épanchement intrapéritonéal.

La patiente a été opérée en urgence. L'exploration abdominale avait mis en évidence une cholécystite avec une péritonite généralisée. Une cholécystectomie avec lavage péritonéal a été réalisée, associée à une antibiothérapie à base de tazocilline et d'amikacine. Les hémocultures étaient négatives. L'étude histologique retrouvait une cholécystite infectieuse avec des masses microbiens. L'étude bactériologique de la pièce de cholécystectomie avait isolé une *Salmonella* spp non typhi (SNT) sensible à l'antibiothérapie instaurée. L'évolution a été rapidement fatale au troisième jour postopératoire dans un tableau de choc septique avec défaillance multiviscérale.

La CAA est une complication rare de la fièvre typhoïde. Elle a été décrite surtout chez l'enfant, rarement rapportée chez l'adulte [1,2]. En plus de *S. typhi*, d'autres souches de

SNT (*S. typhimurium*, *S. enteridis*, *S. virchow*) ont été incriminées. McCarron et Love [3] ont rapporté trois cas (5,8 %) de CAA dans une cohorte de 52 patients traités pour entérocolites à SNT. Cette complication a été surtout décrite chez des patients immunodéprimés (sida), où des infections par cytomégalovirus (CMV) et cryptosporidium étaient associées [4]. Les principaux facteurs de risque rapportés sont l'âge (les deux extrêmes), les maladies chroniques telles que le diabète, les maladies lymphoprolifératives, la transplantation d'organe et le traitement immunosuppresseur [5]. L'infection de la vésicule biliaire peut se faire soit par bactériémie, soit par invasion directe des voies biliaires. Le traitement conservateur avec l'usage d'antibiotiques dans la cholécystite alithiasique due à *Salmonella* est recommandé [6].

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### **Intralingual tracheal intubation!**

#### **Intubation trachéale intralinguale**

*Keywords:* Intralingual; Tracheal intubation

*Mots clés :* Intubation trachéale ; Intralinguale

There is no doubt that airway management is among a few skills, which an anesthesiologist is defined with. In the past,

airway management in emergency departments (ED) was limited to orotracheal intubation in the cardiac-arrest patients [1]. Nowadays this trend is changing and most of the critically ill patients with traumatic injury to the airway or head and Glasgow Coma Scale (GCS) below 7 are intubated in ED or pre-hospital setting. We would like to report a strange intubation, which had past undetected through our hospital ED. A 35-year-old-male, suffering multiple traumas following car accident, had been taken to the emergency department of a local hospital where his trachea had been intubated due to low GCS (<7) by a general practitioner. Later, he had been transported to our hospital's ED to be admitted in neurosurgical intensive care unit. We received patient intubated (low pressure tracheal tube  $N=8$ ), breathing spontaneously, GCS = 5, bilateral raccoon sign and a neck collar with stable vital signs.

Inspecting the patient, we noticed that the tracheal tube (TT) had past through his tongue. We thought that the TT had been misplaced, but airflow could be seen through it. We connected it to a capnograph, which showed  $ETCO_2$  of 30 mmHg in close inspection we noticed that TT had past through the tongue and correctly placed in trachea. We replaced the intralingual tracheal tube with an orotracheal one. Tongue inspection revealed a transverse cut with intact rims probably caused by patient teeth during trauma and the tracheal tube had been inserted through the cut into the trachea (Fig. 1).

The incidence, we unheard of so far, stresses the challenging circumstances of tracheal intubation in emergency settings. Trauma patients whether in ED or prehospital environment, all are almost no fasted, hypoxic or combative and their intubation would always be expected to be difficult and are deemed to be high-risk in anesthesia practice. Since impending airway obstruction leaves us little time to evaluate and prepare the patient. Rapid sequence intubation (RSI) is the recommended procedure in these settings. The person who has the

greatest experience for acute airway management should perform airway management in emergency setting and all physicians with responsibilities in acute care medicine are expected to complete some courses in anesthesia training and have practical skills in different techniques of airway management. Even in the hands of anesthesia trained emergency physicians, CL grades (Cormack & Lehane laryngeal view), compared to elective cases in operation room, will shift to grades III and IV and failed intubation will be higher [2]. Examining the factors influencing emergency intubation in the prehospital setting showed that meeting the criteria needed for an optimal/best attempt at laryngoscopy (as Helm has put it) will result in high success rate especially in the first ETI attempts [3]. We strongly believe that the safety of airway management in any emergency setting will be enhanced greatly by strong cooperation between departments of anesthesia and emergency medicine [4]. Finally, trained emergency medical personnel and standardization of acute airway management as stressed by Combes and al. reduces intubation failures and associated complications [5,6].

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Fig. 1. Tracheal tube, which had passed through the tongue.

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