Smart et al. in 1986. In our case study we report the case of a 65-year-old woman who had typical reflux symptoms with heartburn and regurgitation for about seven years. During the year before her admission to our clinic her reflux symptoms resolved and dysphagia developed. Endoscopy revealed esophageal dilatation with erosive esophagitis, narrowed cardia and hiatal hernia. Biopsies from the distal esophagus showed chronic esophagitis and Barrett's metaplasia. Barium swallow showed dilated esophageal body with decreased peristalsis, nonrelaxing sphincter and retention of barium. Manometry and 24-hour pH monitoring was performed. The LES pressure was 34.5 mmHg with 11.9% relaxation. 24-hour pH-metry showed acid reflux, with multiple sharp dips characteristic of typical gastroesophageal reflux, with total DeMeester score of 94.6. Using pH 3 as a discriminatory threshold for GERD the reflux score was 64.2. Achalasia and concomitant GERD was diagnosed and the patient underwent laparoscopic surgery. The hiatal hernia was reconstructed and a Heller’s myotomy with a 360 degree Nissen fundoplication was performed. At the 3-year follow-up the patient was symptom free. In summary, based on our experience and the review of the literature we believe that there is a cause-and-effect relationship between gastroesophageal reflux and the development of achalasia. We believe that the development of achalasia in patients with GERD can be a protective reaction of the esophagus against reflux. In these cases the treatment of choice should be different from that of pure achalasia patients: a laparoscopic Heller’s myotomy completed with a 360 degree Nissen fundoplication should be the recommended surgical treatment to minimize the possibility of postoperative reflux disease.

Results and conclusions: Examination findings included the following: bilateral bradykinesia and tremor of the upper limbs. The remaining neurological examination was negative. The neuropsychiatric assessment revealed significant levels of anxiety. Although the patient exhibited a normal global cognitive profile, reaching normative scores on the screening tests, abnormalities were detected for the performance on conceptualizing and response-inhibition tasks. The MRI showed no alterations in the brain parenchyma signal. The patient showed no response-inhibition abilities as measured by the GO/NOGO task and action-monitoring deficits (error awareness). Moreover, fMRI acquisition revealed absent task-sensitive recruitment of cingulo-frontal regions for the contrast NOGO vs GO.

Take-home message: In our experience, MRI response-inhibition task may be useful in PD for better characterizing the clinical profile evaluating treatment options. A frontostriatal – cingulofrontal dysfunction may reflect impairment in metacognitive-executive abilities (such as response-inhibition, action monitoring and error awareness). Interestingly, impaired response-inhibition is an example of the motor/behavioral aspect of impulse control. Its assessment is supposed to be particularly useful in the PD post-diagnostic phase, to better identify individuals at risk of developing ICDs with dopaminergic medication. Theoretical models will be more effective if they integrate fMRI and neuropsychological data according to a neurocognitive approach to Parkinson’s disease and ICDs.

http://dx.doi.org/10.1016/j.nhccr.2017.06.155

Partial Priapisim: A rare presentation of sickle cell anemia

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Introduction: Partial segmental thrombosis of the corpus cavernosum (PSTCC); known as partial priapism; is an uncommon urological condition which predominantly affects young men in which the proximal part of one corpus cavernosum is thrombosed. Many risk factors are described in the literature, the exact etiology of penile thrombosis and its pathogenesis remains unclear. Several treatment options are available ranging from conservative medical treatment with NSAIDs, antibiotics, analgesics, low molecular weight heparin, acetylsalicylic acid and antibiotics, surgical or to a follow-up observation without treatment. In this study we presented a sickle cell patient who presented with pain and perineal swelling and diagnosed with PSTCC using MRI and was treated conservatively.

Case description: A 23-year-old male, known case of sickle cell anemia, presented to casualty with a 1-day history of perineal pain of a sudden onset, increasing in severity, no aggravating or relieving factors. It was associated with perineal swelling, decrease in urine output and vomiting, not associated with urethral discharge, erectile dysfunction, trauma, sexual contact, fever, abdominal pain, lower urinary tract symp-toms, change in bowel habits, or bleeding per rectum. He had a past history of left pyeloplasty in childhood. He was a smoker, non-alcohol consumer with a family history of liver malignancy. Examination revealed a stable vitals, abdomen was soft and non-tender, genitalium examination findings confirmed the absence of priapism. There was a normal circumcised penis, normal bilateral testis and epididymis, separated perineal mass slightly hard in consistency, fixed and tender at the proximal part of the penis. Digital rectal examination was unremarkable. The complete blood count showed mild leukocytosis, electrolytes, coagulation profile, urine analysis and urine culture were unremarkable. MRI perineal and penis showed the right intratunical corpus cavernosum with altered...