GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GEORGIAN MEDICAL NEWS
Published since 1994. Distributed in NIS, EU and USA.

WEBSITE
www.geomednews.com
К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра в три сантиметра. Используемый компьютерный шрифт для текста на русском и английском языках - *Times New Roman* (Кириллица), для текста на грузинском языке следует использовать *AcadNusx*. Размер шрифта - 12. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применяющие методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста в *tif формате*.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.


В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.
REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or computer-printed on a single side of standard typing paper, with the left margin of 3 centimeters width, and 1.5 spacing between the lines, typeface - Times New Roman (Cyrillic), print size - 12 (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles. Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author’s name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in tiff format. Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.


In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title “References”. All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author’s original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.
1. სტატიის ფოტომასიურ და გრაფიკული წარწერის ადგილი პოზიციონირება:

• ტიპოლოგიური ფოტომასიური და გრაფიკული სახელი (თარობის ან ფორმატი)
• ზეგანის სახელი
• სტატიათა გამოკვეთილი მოთხოვნა
• ტიპოლოგიური ხაზი

2. სტატიის მოთხოვნა აქტიური ვარდის ლოგით რუსულ და ინგლისურ დემონსტრაცია.

3. სტატიაზე გათვალისწინებული ფაქტები:

- სტატია შეუძლებელიათა ცნობით
- მნიშვნელოვანია ფოტოგრაფიული ილუსტრაციები
- სტატიის გამოკვეთილი მოთხოვნა
- სტატიობის კომპიუტრული ფორმატი

4. სტატიის სახელი გათვალისწინებულია პირობები:

- დახვრჩილ მოხერხების მხარე
- სტატიის გამოკვეთილი მოთხოვნა
- სტატიის უმაღლესი რეჰერსალი

5. სტატიის გამოცემის არჩევით კონტექსტი

6. სტატიის გამოცემის არჩევითი მნიშვნელობა

7. სტატიის გამოცემის არჩევითი მნიშვნელობა

8. სტატიის გამოცემის არჩევითი მნიშვნელობა

9. სტატიის გამოცემის არჩევითი მნიშვნელობა

10. სტატიის გამოცემის არჩევითი მნიშვნელობა

11. სტატიის გამოცემის არჩევითი მნიშვნელობა

12. სტატიის გამოცემის არჩევითი მნიშვნელობა
SAFETY AND EFFICACY OF THYMIC PEPTIDES IN THE TREATMENT OF HOSPITALIZED COVID-19 PATIENTS IN HONDURAS.

Melnychenko MH, Kvashnina AA, Sytnikova VA.
PROGNOSTIC MODEL OF POSTOPERATIVE ADHESIVE INTESTINAL OBSTRUCTION RISK IN CHILDREN.

Musayev SA.
EVALUATION OF THE QUALITY OF LIFE AFTER REVASCULARIZATION AND RECONSTRUCTIVE OPERATIONS ON MITRAL VALVE IN PATIENTS WITH CORONARY HEART DISEASE.
INTRAMUSCULAR MYXOMA OF THE BUTTOCK- A CASE REPORT

Alexander Schuh¹, Philipp Koehl², Stefan Sesselmann³, Tarun Goyal⁴, Achim Benditz⁵.

¹Hospital of trauma surgery, Department of musculoskeletal research, Marktredwitz Hospital, 95615 Marktredwitz, Germany.
²Hospital of trauma surgery, Marktredwitz Hospital, 95615 Marktredwitz, Germany.
³Institute for Medical Engineering, OTH Technical University of Applied Sciences Amberg-Weiden, 92637 Weiden, Germany.
⁴Department of Orthopaedics, All India Institute of Medical Sciences, Bathinda, Bathinda, Panjab, India.
⁵Hospital of trauma surgery, Department of orthopedics. Marktredwitz Hospital, 95615 Marktredwitz, Germany.

Abstract.

Intramuscular myxoma (IM) is a benign, soft tissue neoplasm of mesenchymal origin. IM is rare, with an incidence of between 0.1 and 0.13 in every 100,000 individuals. Onset is usually between the fourth and seventh decades of life, predominantly in women (70%). The thigh is the common site of involvement seen in 51% patients, followed by upper arm (9%), calf (7%), and rarely in buttocks. We present the case of a 63-year-old female patient with a 6-month history of a growing IM of the right buttock. Due to rapid tumor growth resection of the tumor was indicated to obtain histopathological examination and to rule out malignancy. Marginal surgical removal was performed. Histopathological examination brought the diagnosis of a big intramuscular myxoma. There is no recurrence at latest follow-up.

Key words. Intramuscular, myxoma, buttock, diagnosis, treatment.

Introduction.

The term myxoma was introduced in 1863 by Virchow to describe a mesenchymal tumour, which histologically resembles the umbilical cord, with no other differentiation [1-18]. In 1948 Stout outlined the diagnostic criteria and defined myxoma as “a true neoplasm composed of a paucity of stellate cells in a loose myxoid stroma of reticulin and collagen fibres” [2, 4, 9, 11, 13,]. Myxomas that arise from the skeletal muscle are termed intramuscular myxomas and were described by Erzinger and Weiss in 1965 [11]. Intramuscular myxoma (IM) is a benign, soft tissue neoplasm of mesenchymal origin. It typically involves large muscle groups in the thigh, buttocks, shoulder, and upper arm. IMs typically appear as painless, ovoid, slow-growing masses [1, 5, 6, 8, 11]. IM is characterized by bland spindle-shaped cells embedded in hypo vascular, abundantly myxoid stroma [17]. IM is rare, with an incidence of between 0.1 and 0.13 in every 100,000 individuals. Onset is usually between the fourth and seventh decades of life, predominantly in women (70%) [4, 5, 8, 9, 14]. The thigh is the common site of involvement seen in 51% patients, followed by upper arm (9%), calf (7%), and rarely in buttocks [2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 17,18]. Rarely, IM can be observed with monostotic or polyostotic fibrous dysplasia of bone, a condition known as the Mazabraud’s syndrome [1, 4, 5, 8, 10, 11, 16]. We present the case of a 63-year-old female patient with a 6-month history of a growing IM of the right buttock.

Case report.

A 63-year-old woman was referred to our orthopaedic department with a 6-month history of growing right buttock mass. Physical examination showed swelling of the right buttock, but no local tenderness. Laboratory findings were within normal limits. Plain radiographs of the right hip in two planes showed no soft tissue calcification or bony lesions. MRI of the pelvis showed a well-circumscribed, ovoid, intramuscular soft tissue mass in the right gluteus maximus. T2-weighted MRI of the pelvis coronal and axial demonstrated spectated and hyperintense tumor measuring 11 cm in its greatest dimension (Figure 1 and 2). A thin rim of higher signal intensity approaching that of fat was seen around the mass on T1-weighted images.

Due to rapid tumor growth resection of the tumor was indicated to obtain histopathological examination and to rule out malignancy. Marginal surgical removal was planned, and the mass was completely excised under general anesthesia. The tumor appeared to be an encapsulated gelatinous mass, encased within the muscle. It was easily separated from the muscle (Figures 3).

On gross examination, the resected tumor was seen to consist of solid, pseudo cystic mucoid tissue measuring 11.5 x 8.5 x 6.5 cm (255 g). Serial sectioning showed a predominantly myxoid neoplasm with benign-appearing spindle cells. No nuclear
Myxoma is described as a benign, poorly vascular tumor composed of fibroblasts and abundant myxoid stroma. Myxoma generally occurs as an isolated lesion from the surrounding healthy tissue. It can be located within heart, bone, skin, subcutaneous tissue, intestines, pharynx, and muscles. Myxomas that arise from the skeletal muscle are termed Intramuscular myxoma (IM) and were described by Erzinger and Weiss in 1965 [3]. IM frequently involves the muscles of proximal extremities. It mostly occurs between the fifth and seventh decades of life and is more prevalent in women [1, 8]. The thigh is the common site of involvement seen in 51% patients, followed by upper arm (9%), calf (7%), and rarely in buttocks [2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 17, 18].

While usually asymptomatic, the most common clinical sign is a slow growing intramuscular mass that can be painful in less than 20% of patients [5, 8, 11, 12]. IM of the gluteal region can present sciatica like symptoms [5, 7]. There is often a trauma history in the past [11]. Recently IM of the gluteus maximus muscle has been reported after continuous intramuscular injections [11].

Differential diagnoses according to imaging findings include benign soft tissue masses (lipoma, haemangioma, desmoid tumour, myxoid schwannoma, neurofibroma), cystic lesions (high water content may mimic a ganglion cyst, synovial cyst, bursa or haematoma) or malignant neoplasms (myxoid liposarcoma, fibrosarcoma, malignant fibrous histiocytoma, rhabdomyosarcoma, synovial sarcoma, or extra skeletal chondrosarcoma [1, 2, 8, 14, 16]. Radiological and clinical diagnosis is difficult [1]. It can be challenging to differentiate between IM and myxoid sarcoma preoperatively [2, 14, 15, 17].

The typical IM is a well-defined ovoid lesion with fluidlike signal intensity, a peritumoral fat rind visible on T1- weighted MR images, and an increased signal in the adjacent muscle on T2-weighted or fluid-sensitive MR sequences [2,11]. The tumor usually appears homogeneous, but heterogeneous presentation due to fibrous septa is reported as well [9]. Intramuscular myxoma is shown as a homogeneous low-attenuating mass on CT [10]. FDG PET reveals an increased uptake of FDG in IM [10, 17]. Histologically, IM are composed of a small number of spindle or stellate cells (fibroblasts) in a prominent myxoid matrix (mucus) characterized by hypocellularity, poor vascularization, and no mitotic figures. On gross examination, myxomas are commonly described as gray/white, well circumscribed, lobulated, and gelatinous. On microscopic examination, however, atrophic muscle fibers can often be seen infiltrating the boundaries of the cut section. Immunohistochemistry shows vimentin as strongly positive in the myxoma stromal cells and desmin, S-100 protein, and endothelial markers as negative [8, 10, 11].

Treatment of myxomas is generally marginal surgical excision, although wide margins are recommended by some authors [5, 8, 10, 14]. No instances of recurrence, metastasis, or malignant degeneration of intramuscular myxomas have been reported in several series of patients with solitary lesion [8, 12]. Myxoma may recur if it is not excised completely or if it is a cellular variant of IM [1].

Conclusion.
IM is infrequent and difficult to diagnose. Simple excision with a small margin of surrounding tissue is sufficient for its treatment, regular follow-up with MRI scan is recommended.

REFERENCES
10. Nishio J, Naito M. FDG PET/CT, and MR imaging of...


