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Background. Apert syndrome (AS) is a dominant autosomal genetic disorder caused by heterogeneous mutation in FGFR2 genes on chromosome 10q26 and belongs to a group of disorders known as craniofacial congenital malformations. AS can promote the premature fusion of bones in the skull, hands, and feet. The incidence of infants born with Apert syndrome is approximately 1 in 50000 to 80000. In this study is emphasized the importance of clinical and genetic approaches in the research on the specific diagnosis in patients with Apert syndrome.
Case report. The clinical particularities of Apert syndrome are determined by craniosynostosis result from the premature fusion of the skull bones. The child present following clinical features: short anterioposterior diameter with high forehead and flat occiput, flat facies, shallow orbits, proptosis, hypertelorism, small nose, maxillary hypoplasia, a cleft palate, low set ears, and cutaneous syndactyly of the fingers and toes. The neuroimaging of the head revealed craniosynostosis of the skull bones. The diagnosis of Apert syndrome was confirmed by clinical manifestations and paraclinical investigations. The treatment of Apert syndrome is directed toward the specific symptoms that are apparent in each individual.
Conclusions. Clinical and genetic approaches during genetic counseling combined with a number of new methods of neonatal diagnosis in patients with Apert syndrome can reduce the frequency of chromosomal abnormalities and congenital malformations.
Key words: Apert syndrome, congenital malformations, craniosynostosis, syndactyly.

DEPARTMENT OF ORTHOPEDICS AND TRAUMATOLOGY

27. RECONSTRUCTION OF THE SCALP DEFECT WITH THE TRAPEZIUS MUSCLE FLAP (CLINICAL CASE)

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Background. Many patients with complex scalp and skull defects can benefit from scalp reconstruction using the trapezoid flap, reducing the morbidity of the donor site. The trapezius flap was first reported by Nakajima and Fujino in 1984. It was originally described as a myocutaneous or muscle flap, and it has also been used as a free flap. The blood that supply the trapezium muscle and the skin is mainly from the superficial and descending branches of the transverse cervical artery as well as the occipital artery.
Case report. This work presents the clinical case of a 65-year-old woman who was diagnosed with cornified pluristrative squoamos cancer with bone destruction and invasion to confluence sinus and left transverse venous sinus, who underwent the occipital extra-intracranial tumor removal. She addresses to our clinic with a massive defect of 10 by 18 cm. After making the operative planning, we decided to solve the case with distal trapezius muscle flap.
Conclusions. The decision of the reconstructive technique should be taken into account with regarding to its consequences on the affected anatomical structures, the personal pathological antecedents and pre-existing lesions at the level of the donor area.
Key words: reconstruction of scalp defect, trapezius muscle, clinical case

28. SURGICAL TREATMENT OF FRACTURES IN PATIENTS WITH POLYTRAUMA, CASE REPORT.

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Background. Polytrauma is a condition defined as the trauma of more than 2-3 anatomic regions, of which 1 with vital risk and it is the leading cause of mortality and morbidity in modern society, in the most cases being affected young, active people capable of working. As a result, spending on treatment will be extremely high for relatives and health institutions. Etiology of polytrauma, the most frequent is associated with car accidents, because motor vehicle accidents often occur at a high velocities causing multiple injuries with the loss of work capacity.
Case report. A 37-year-old woman after a road accident has been hospitalized with multiple trauma. The first aid was rendered at raional hospital in intensive care department, after 4 days she was transferred at the Clinical Hospital of Orthopaedy and Traumatology. After the investigation (computer tomography, x-ray), was established cerebral contusion gr I, subdural hematoma, bone injury: fracture of the right branch of the mandible, comminuted fracture of left distal humeral epimetaphysis AO type C, comminuted fracture of the left distal radial epimetaphysis, fracture of right femoral diaphysis 1/3 medial distal with displacement of fragments and fracture of right proximal fibula with contusion of right fibular nerve. After neurosurgeon consulting, recommendation was, to operate patients no earlier than two weeks after head trauma. The mandible fracture was fixed by the stomatologist with wire in the 7-th day after trauma. The tactic chosen by surgeon-orthoped was pending for stabilization. Because of the subdural hematoma the operation was performed at 14 days after car accident, treatment being performed for all fractures in one step: open reduction with internal fixation (ORIF) of distal left humerus with plates, closed reduction and fixation with K-wires of left distal radial epimetaphysis, ORIF of right femoral diaphysis, right fibular nerve neurolysis.
Conclusions. Decision making in the management of the polytraumatized patient requires the choice of both, time and operative tactics for optimal resolution with low risks in the condition of trauma. In the given case the tactic was successful, stable and with favorable prognosis.
Key words: polytrauma, ORIF, multiple fracture, brain injury.

29. CLINICAL AND PATHOPHYSIOLOGICAL CHARACTERISTICS IN A YOUNG STRESSED PATIENT WITH HYPERTENSION

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Background. Hypertension in young people is secondary, but stress could be an important risk factor.
Case report. A 21 years old patient presented for increased blood pressure in the last two months. He has no medical history, he is non-smoker. Physical exam: normal weight, blood pressure (BP) 160/90 mmHg, 75 bpm, regular. Laboratory tests: mild hypercholesterolemia. Abdominal ultrasound: normal right kidney, left kidney 66/48mm, thin parenchyma. Transthoracic echocardiography, thyroid ultrasonography was in normal limits. Ambulatory blood pressure monitoring showed more than 47% of diurnal values greater than 140 mmHg, with diurnal average blood pressure 137/85 mmHg and nocturnal average blood pressure 115/72 mmHg. Pulse pressure was 42.7 mmHg. Serum TSH, free T4, aldosterone, renin and urinary metanephrines, normetanephrines, 3-methoxytyramine, vanillylmandelic acid was in normal limits. Plasma cortisol was 589 nmol/L. Chest CT in normal limits. Contrast enhanced