

Concluzii: Lamboul insular peronier acoperă defecte cu localizare de la picior până la treimea medie a femurului folosind 2 variante: migrare prin “răsturnare” și prin “alinare”. Pentru evitarea complicațiilor postoperatorii este indicată examinarea traseelor vasculare centrale ale gambei, inclusiv vasele perforante peroniale.

POSSIBILITIES AND LIMITS IN MIGRATION OF PERONEAL OSSEOUS FLAP

Introduction: Peroneal osseous flap is well known as a free transfer. But few publications reflect possibilities of its use based on vascular uninterrupted pedicle.

Aim of study: Highlighting all possible variants of peroneal flap’s migration, revealing possible and impossible limits of its use, indications, contraindications in order to obtain expected results.

Material and methods: Peroneal island flaps were used in study on 25 patients for bone defects treatment. In 3 cases transplanted flaps were osteo-fascio-cutaneous, in 1 – fascio-cutaneous. Fibular flap was applied to cover 7 lower limb’s region: distal femoral area – 2 (6.9%) cases, knee joint – 1 (3.4%), leg’s upper third – 1 (3.4%), leg’s medium third – 3 (10.3%), leg’s distal third – 8 (27.6%), talocrural joint – 9 (31.0%) and foot – 5 (16.9%) cases. In order to systematize material we introduced for bone fragment terms „flip” and „align” at skeleton of treated member.

Results: In 2 cases necrosis of cutaneous component of myoosteo-cutaneous flaps occurred, due to absence of a preoperative specification of output’s place of cutaneous perforating vessel from fibular pedicle, and due to absence of vascularization of this area or due to damage of vascular relations between pedicle and cutaneous portion during migration to defect. Cutaneous autografting of flap’s muscular portion has solved these cases. In late postoperative period we determined one „fatigue fracture” of fibular transplant.

Conclusions: The peroneal island flap covers defects localized from foot to thigh’s medium third, using 2 options: migration through „flip” and „alignment”. In order to avoid postoperative complications examination of leg’s central vascular paths is indicated, including perforating peroneal vessels.

RECONSTRUCȚIA SÂNULUI PE UN TERITORIU AFECTAT ACTINIC PRIN UTILIZAREA PLASTIEI CU LAMBOU LATISSIMUS DORSI ȘI A DERMOTENSIEI (CAZ CLINIC)

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Caz clinic: Lucrarea reflectă cazul clinic al unei femei de 33 ani supusă amputației totale de sîn pe motiv oncologic. Postoperator a urmat 3 cure de radioterapie. La 6 luni de la intervenția chirurgicală primară a susținut un examen complex după care a primit acordul medical la refacerea plastică a sînului. La momentul examinării în Clinica de chirurgie plastică prezenta dureri în regiunea cicatricei rămase după amputația sînului. La prima etapă de tratament s-a decis înlăturarea cicatricelor aderente agresiv de hemitorace și plastia defectului rămas cu un lambou insular din latissimus dorsi. Etapa a doua a urmat după obținerea regenerării primei etape – implantarea unui expander tisular cu un volum maximal de 500 ml. Etapa a treia a avut loc după umplerea balonului expandat. Sub surplusul tegumentar în schimbul expanderului am plasat o proteză mamară. Cunoscând că un component al tratamentului a fost iradierea actinică, temerea pentru înlăturarea cicatricei și plastia defectului cu țesuturi locale era argumentată. Astfel motivați am decis să folosim lamboul insular latissimus dorsi din regiunea sănătoasă. Dimensiunile lui maxime au permis expandarea, care a rezultat cu refacerea sînului prin punerea unui implant mamar.

Concluzii: Utilizarea metodelor de chirurgie plastică-reconstructivă și estetică într-o consecutivitate corectă permit refacerea sînului după amputații oncologice, chiar dacă regiunea marcată este tratată actinic.

BREAST RECONSTRUCTION ON ACTINIC AFFECTED TERRITORY BY USING OF THE LATISSIMUS DORSI FLAP PLASTY AND DERMOTENSION (CASE REPORT)

Clinical case: We present a clinical case of 33 years old female, which was subjected to total breast amputation. After surgery she followed 3 cycles of radiation therapy. At 6 months after primary surgery she underwent a comprehensive examination after which has received medical agreement for plastic restoring of the breast. At the moment of the examination she has been complaining on pain in the region of the scar. In the first stage of the treatment it was decided to remove the aggressive adhered on hemithorax scars and to do the plasty of the defect with a free latissimus dorsi flap. The second stage was constituted of implanting a tissue expander. The third stage: under the tissue’s excess instead of expander we have placed a mammary prosthesis. Knowing that one of the treatment factors was actinic radiation, the fear for the removal of the scar and the plasty of the defect with local tissues was substantiated. Thus, we decided to use latissimus dorsi flap from the healthy region. Its maximal dimensions have allowed expanding resulting with restoration of the breast by placing a mammary implant.

Conclusion: Using the methods of plastic-reconstructive and aesthetic surgery in a correct order allows the rebuilding of the breast after oncological amputations, even if the region was exposed to actinic treatment.

VALOAREA DIAGNOSTICĂ A TERMOMETRIZĂRII ȚESUTURILOR TRANSPLANTATE MICROCHIRURGICAL

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