

transfer human vascularized fibula (Taylor G.I.) two years later, the same authors describe the first migration of the proximal fibula, for the replacement of the distal femoral defect.

**The purpose of the work:** Presenting a solved case of bone defect, that occurred after ablation of the total knee prosthesis complicated septic in an oncology patient.

**Materials and Methods:** This work presents the clinical case of a woman of 30 years, who was diagnosed in 2009 with osteoclastoma in 1/3 of the distal femur operated in the same year in the Oncology Institute, was removed the tumor and was done total knee joint prosthesis, at the end of 2015 at our clinic addressed with a septic area at pelvic right limb. After performing preoperative planning, I decided to solve in 2 surgery stage. At the first stage we performed ablation of the prosthesis. In another step we made the right knee joint arthrodesis with a vascularized fibular flap. Bone transplantation with a length of 20 cm with a pedicle of 10cm that was migrated through rollover technic, that in his structure entered a muscular sleeve and skin island for future monitoring. At the final, the leg was stabilized in an external extrafocal device. After 4 months later, at a follow-up visit, the patient moves independently, using crutches and moderate support on the foot.

**Conclusions:** Using a composite musculoskeletal cutaneous vascular defect axially allow reconstruction complicated septic at pelvic limb without following the required period.

**Keywords:** fibula, flap, bone, transplantation.

## SECONDARY RECONSTRUCTION OF THE BACK AFTER ONCOLOGICAL EXCISION OF A MASSIVE SQUAMOUS CARCINOMA



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**Introduction:** Plastic surgical techniques can be used to cover defects results from tumor resections, practically at any level of the human body's surface.

**Purpose:** elucidation of a case of plasty with axial vascularized flap of a huge back's defect.

**Material and methods:** the study includes a clinical case of a woman of 56 years, which having a burn at the age of 3 years, now develops a skin squamous keratinized carcinoma of the back. After being treated at the Institute of Oncology and defect's primary closure has failed, she addressed to our department with a huge soft tissues defect of the back. We decided to cover the defect using a LD flap, and we partially extended flap's fascio-cutaneous component on abdomen's antero-intern surface. Secondary surgical debridement was performed in one step with flap's harvesting with dimensions of 30 x 25 cm, donor site being closed in the same stage. After a period of 21 days was determined recovery of the patient.

**Conclusions:** Postoperative defects of oncological patients are a challenge for plastic surgeons and using flaps on a safe vascular pedicle, to ensure an adequate blood supply, represents a solution.

**Keywords:** LD, flap, defect, oncologic.

## EFFICIENCY OF ULTRASOUND PARAMETERS IN DIAGNOSIS POSTTRAUMATIC CARPAL TUNNEL SYNDROME (TCTS)



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**The aim of our study** was retro and prospective analysis of ultrasonographic parameters in the diagnosis of carpal tunnel syndrome. Preoperative median nerve was examined by ultrasonography being taken the following parameters - the length in the transverse plane (T) and thickness in the sagittal plane at the level of proximal entrances (D) of the median nerve in the carpal tunnel, the smallest thickness in the sagittal plane at channel or at the distal outlet (d). Were used the following indices: cross-sectional area of the median nerve (AT norm to 7 mm<sup>2</sup>),  $AT = 3.14 \times T \times D / 4$ , the ratio of  $R = T/D$  (norm up to 3.3), and IGP degree of compression index = 100 (1-d/D) (rule around 10%).

In the Hand Surgery Department of IMSP CHTO in period 2011-2015 we present data of 202 patients with carpal tunnel syndrome. Report male - female is 2.74: 1.

Mean age  $55.6 \pm 11.9$ . In 91 (45.05%) was determined PCTs. At 111 (54.95%) patients with CTS in association with traumatic factor the mean (md) mdAT = 15,06mm<sup>2</sup>, mdTD = 2.12; mdIGP 52.00%. In TCTS mdAT = 13,81mm<sup>2</sup>; mdTD = 2.06; mdIGP = 52.43%.

Following surgery, with amelioration of disease at 6 weeks in the group with CTS were examined by ultrasound to determine mdAT = 14,43mm<sup>2</sup>, mdTD = 2.12; mdIGP = 21.78%; the SCCT lot mdAT = 16,96mm<sup>2</sup>; mdTD = 2.17; mdIGP = 22.82%.

At 3 months at 50 patients, of which 23 with CTS was determined mdAT = 13,52mm<sup>2</sup>, mdTD = 2.01; mdIGP = 13.13%; in group TCTS with 27 patients – mdAT = 14,96mm<sup>2</sup>; mdTD, 2.10; mdIGP, 10.82%.

**Conclusion**

- Problem diagnosis and treatment of these patients until now remains current, despite of successes in the treatment of orthopedic and experience in the treatment of CTS
- In our study, the absolute majority of patients by ultrasound investigation has been determined that IGP is more demonstrative than AT and TD.
- Because the compression is the primary factor in the pathogenesis of CTS, the appreciation of PGI allows the determination of treatment strategy.