

## White phosphorus burn. Case report

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White phosphorus burn is a special subtype of chemical burns, rarely encountered and is very limited in literature. Case Presentation On January 11, 2009, an 18-year-old male was transferred to the Emergency room (ER), due to exposure to military attack with White Phosphorus shell, with multiple scattered patches of full thickness burn, surrounded by sloughed tissue, involving 30% of his body surface area, distributed in both upper and lower limbs and right shoulder, a clinical diagnosis of white phosphorus burn was made. Airway was secured, without signs of inhalation burns; resuscitation fluid was initiated, irrigation with diluted sodium bicarbonate solution and wet dressing were done. In the Burn Unit, White smoke was noticed coming up from the wounds which became deeper, with extensive necrotic tissue, apparent localized injuries weren't correlated with underlying severe deep destruction. In the operation room, debridement and excision for dead tissues and removing phosphorus particles was accomplished, transferred to ICU for monitoring of vital signs, electrolyte disturbance and ECG changes where he was managed accordingly. After 8 days of hospitalization, the patient was relatively well, and discharged without manifestations of systemic complication of white phosphorus burn. White phosphorus is transparent combustible substance, associated with extensive full thickness burn injury with delayed wound healing. In our case, the management include irrigation by diluted sodium bicarbonate solution at ER, whereas, only water have been proved to prevent deaths , early excision and massive debridement of particles was accomplished, electrolyte disturbance was noticed as a complication.

## Microsurgical Treatment of the Sacular Supratentorial Aneurysmes

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The purpose of the study is to compare the results of minimally invasive keyhole craniotomy and standard larger craniotomies in the surgical treatment of patients with intracranial aneurysms.

In the past 5 years 105 patients were operated by two experienced neurosurgical teams. The first group of 30 patients with 32 aneurysms were operated through a small keyhole craniotomy, using the eyebrow keyhole approach in particular. The remaining 75 patients with 82 aneurysms were operated using a standard craniotomy that included pterional/frontotemporal, frontoparietal parasagittal and retrosigmoid suboccipital craniotomies. All operations were performed in the standard microsurgical technique using intraoperative evoked potential monitoring and endoscopic assistance in selected cases. Results: Most supratentorial aneurysms and basilar tip aneurysms were successfully operated through an eyebrow keyhole craniotomy. Distal MCA aneurysms as well as aneurysms on the MCA with a long M1 segment were operated through a temporal keyhole, and aneurysms of the distal PCA (P2-P3) segment subtemporally. The frontoparietal parasagittal keyhole approach was used only for pericallosal artery aneurysms. Infratentorial aneurysms of the VA/PICA complex were operated via a retrosigmoid approach. On comparing the surgery results in patients with a keyhole craniotomy and those with standard standard craniotomy, similar outcomes were found for both groups, with excellent or very good outcomes (GOS 5 and 4) in 23 (76.66%) patients from the keyhole craniotomy group, and in 51 (68%) patients from the standard craniotomy group.