Small Cell Mammary Neuroendocrine Carcinoma – Case Presentation

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Neuroendocrine carcinomas are very rare and develop from the neuroendocrine cells which are present in the whole body. The carcinomas usually appear in the bronchopulmonary or the gastro-intestinal tract, but these can also occur in the mammary glands. There have been reported only about 50 cases of this type of cance in the medical literature. The diagnosis is set on the presence of neuroendocrine markers present in the tumor cells (ex. Neuron Specific Enolase – NSE). Female patient aged 40, presents to the hospital for further investigation after the appearance of a mass at the level of the left breast. The clinical exam showed the presence of a painless tumoral mass with a diameter of 2cm. The anatomopathological and the imunohistochemical exams revealed the presence of a small cell neuroendocrine carcinoma. The CT exam (thorax, abdomen, pelvis with constrast substance) exposed nodular hyperactive nodules at the level of the left mammary gland, left axillar adenopathy without other pathological changes. The final diagnosis was primary mammary neuroendocrine carcinoma with resection recommendation. The patient's tumor and the lymph nodes from the first axillary station were excised and metastases were revealed in 3 of the 6 examined lymph nodes. The patient had cytostatic treatment to avoid recidive. The patient continues the cytostatic and radiotherapy but the prognosis is reserved due to metastases present in the axillary lymph nodes. The precocious discovery and the quick onset of treatment are vital for the increase in survival chances of patients.

Nonoperative Management of Blunt Splenic Injury in Associated Abdominal Trauma

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The aim of the study was to assess the results and evaluate the efficiency of nonoperative management (NOM) in polytrauma patients with blunt splenic injury (BSI). Material and methods: A prospective study on 30 patients, 2008-2009 with BSI; the m:f/ 19:11; mean age=39.97±20,35, RTS=7,66±0,5, ISS=6±8,95. The hemoperitoneum was first established by USG(100%). Its volume and extent of parenchimatous organ injury was subsequently quantified at CT(90%), the laparoscopy was performed in 6(20%) cases for assessing USG sensitivity and determined ascites in 2 cases of politrauma patients with splenic lesions established at CT, and exaggerate volume of free liquid. Results: Isolated BSI in 5(16,7%) patients, in 21(71%)–associated with thoracic trauma, in 9(30%)–with head trauma and in other 9(30%)–with musculoskeletal trauma. 7(23,3%) patients presented hemodynamic instability: 6 politrauma patients with BSI: IInd degree–4 and IIIrd degree–2 cases with unstable pelvic fractures, and one patient with isolated BSI; they were all hemodynamically stabilized, but the last resulted in failure of NOM in the first 4h. In 3 politrauma patients with cerebral contusion and GCS- 12p NOM succeeded, splenic lesions being of IInd (n=2) and IIIrd (n=1) degree, despite of determining intraabdominal free liquid and hemodynamic instability in 2 cases. The severity of BSI was determined from IInd degree to IVth degree according to AAST, IInd degree–16(53,3%), IIIrd degree–13(43,3%), IVth degree–1(3,4%), simultaneously being diagnosed 3 cases of minor liver contusions (Ist degree–2 patients, IInd degree–1 patient). The mean value of hemoperitoneum determined by CT for IIIrd degree lesions was 766,67±208,17ml, while for IInd

degree was 271,43±146,79ml (p<0,001). The volume of blood transfusions for patients with BSI associated with lesions of the musculoskeletal system was 933±208,79ml, but for IIIrd degree BSI without pelvic fractures–282,3±82,5ml; IInd degree BSI did not require blood transfusions (p<0,01). Failure of NOM was reported in 3(19%) cases: in 2–isolated BSI of IIIrd degree, 1 case associated with head trauma with hemoperitoneum mean value of 1400±200ml. Conclusions: NOM can be successful both in isolated and associated BSI of I–III degree. USG is the screening method for determining hemoperitoneum, but CT defines the degree and volume of hemoperitoneum, and it can serve as a relative prognostic criterion of failure. Lack of awareness is not a criterion to avoid NOM, laparoscopy in these conditions reflects the success of this option. Decreased haematocrit and the need for blood transfusions in patients with BSI and musculoskeletal trauma is not a failure index in case of stable and responsive to infusion therapy hemodynamics.

Do We Need a Specialization of Recovery Room According to Patient's Surgical Profile?

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For economic, fast recovery and processes optimization reasons, patient's postoperative route is divided, according to illness severity, in 3 levels of care: recovery room (RR), intermediate care service (ICS) and intensive care unit (ICU). Although the existence of RR in Moldova is referred only formally, no hospital in the country has, in fact, such a unit. Consequently, patients are awaked in operating room or in the ICU – both locations are not suitable for this purpose. For these reasons, we decided to analyze postoperative evolution of general surgery and orthopedic surgery patient's profiles, with the intention to: 1) identify specific patterns of recovery from anesthesia, 2) argue the necessity of opening more specialized recovery rooms, 3) stratify the patients flow to correspondent care levels, according to they postoperative state severity. The general surgery (n=103) and orthopedic (n=103) patient's postoperative profiles were analyzed for 3 consecutive months of 2009. There were compared: time profiles of patient's admission and discharge; recovery duration and stabilization of homeostasis in post-operative period; the proportion of patients of mild severity, moderate to severe state in general surgery vs orthopedic surgery groups. Were used statistical tests: t-Student, Chi2 with Yates correction, Kaplan-Meyer curve. A $p<0.05$ was considered statistically significant. Groups were comparable according to age, body mass, ASA score. The interventions spectrum of general surgery profile included: endoscopic cholecystectomy (32%), colectomy (23%), inguinal hernia repair (17%), hysterectomy (12%), and other interventions (16%); for the orthopedic profile: hip joint replacement (59%), lower limb osteosynthesis (32%), upper limb osteosynthesis (6%), and other interventions (3%), respectively. The timing of discharge from surgical block depending on daily working hours and week-days' hours were identical for both groups. Surgical vs orthopedic patients were eligible for the route "RR" in 63% vs 20% (Chi2=36, $p<0.0001$) of cases, for the route "ICS" – 31% vs 71% (Chi2=5.7, $p<0.001$), and for the route "ICU" – 4% vs 9% (Chi2=1.8, $p=0.17$). Surgical patients were progressive discharged on the evening of the same operation day, these of the orthopedic group – massive, in the next morning. Conclusions: 1) For both studied patient's profiles (surgical and orthopedic), it is reasoned the stratification of post operative's route in RR, ICS and ICU flows; 2) It is argued the need of supplementary specialization of RR for general surgical and orthopedic patient' profile; 3) Concomitant diseases determined recovery duration for surgical profile patients, and size of intervention – for the orthopedic profile, respectively.