

## Ovarian Cancer in Children and Adolescents

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Ovarian cancer represents a small proportion of the tumors in children and adolescents, about 3-4% of solid tumors in this age group. Little accurate information is available regarding the true incidence of ovarian tumors in children and adolescents in Romania. The objective of this study was to evaluate the particularities of ovarian cancer in children and adolescents, to analyze the survival and late effects. This historical prospective study is based on the data from the medical records of 32 patients – children and adolescents - with ovarian cancer who were treated between 1990- 2008 in Institute of Oncology Bucharest, Romania. The highest incidence was for the age group of 10-14 years (17 cases), followed by the 15-19 years old group (14 cases). The histological types were: dysgerminoma (12 cases), undifferentiated carcinoma (4 cases), differentiated carcinoma (5 cases), endodermal sinus tumor (5 cases), mixed tumors (6 cases). Stages at the time of diagnosis were as following: stage I-5 cases, stage II- 10 cases, stage III- 16 cases (50% of patients) and stage IV-1 case. The primary tumor was unilateral in the majority of cases: 23 patients (72%) and bilateral for 9 patients. The treatment was multimodal. Initial management was surgical for all patients: unilateral oophorectomy in 15 cases, bilateral oophorectomy in 8 cases and bilateral oophorectomy + hysterectomy in 7 cases. In 1 case the purpose of the surgical intervention was citoreduction, in 3 cases- palliative surgery and in 4 cases second-look surgery (positive in 2 cases). All patients received chemotherapy following specific protocols. Radiotherapy was used in 12 cases (pelvic and abdominal RT in 8 cases and only pelvic RT in 4 cases) and hormonal substitution used in 3 cases. All cases were followed-up at least 1 year after the end of the treatment. Clinical observation: In the cured cases the procreation was conserved (2 patients with normal pregnancy, normal accouchement and healthy child). The most frequent metastases: peritoneum, lungs, liver. Mortality: 10% (1 case-stage I with incomplete treatment, 1 case stage II, 1 case stage IV). Conclusions: 1. ovarian tumors in children and adolescents are rare, the highest incidence being at pubertal age. 2. the most frequent histological type was germ-cell tumors. They are curable if early diagnosed. 3. Survival rate in stage III was very good with modern multimodal treatment.

## Acute Gynecological Abdomen in Children

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Acute abdomen is acutely emerging pathological processes in the abdominal cavity of different etiology and clinical course. Among the reasons causing the acute abdomen in children is the torsion ovarian formations in about 15%. Causes of acute abdomen in gynaecology can be divided into 3 groups: acute intra-bleeding (ectopic pregnancy, ovarian apoplexy - poor circulation in the internal reproductive organs (the torsion stem tumors and tumor formations ovarian torsion and / or necrosis of myoma node); acute inflammatory diseases of internal genital organs with involvement in the process of the peritoneum. The aim of the work was to demonstrate the frequency of gynecological diseases in girls occurring in the clinic of an acute abdomen. In the National Center of Pediatric Surgery [N. Georgiou" from 2004 to 2009 were operated on 126 children with pathology of the internal female genital organs, hospitalized with clinical acute abdomen. Among them are marked 59 (47%) children with apoplexy of the ovary, 52 (41%) with ovarian cysts, 21 (16,6%) with a uterin

tube chists and only 2 (1.6%) with parovarian cyst. Also, among the children with ovarian cysts in 14 (27%) is recorded torsion, in 2 (3,8%) - necrosis in 3 (5.8%) - rupture and in one (1.9%) - infecting. It is also important to note that there were encountered combinations of gynecological pathologies, such as ovarian apoplexy with cyst of the uterin tube 6 (4.5%), paraovarian cyst torsion on the right ovary with the right ovary cyst 1 (0.7%), ovarian cyst with a cyst in the uterine tube 2 (1,5%) cases. But it also noted the combination of gynecological pathology with secondary appendicitis in 27 (21,4%) children and in one case (0, 8%) with gangrenous appendicitis. The distribution by age as follows: 6-10 years - 6 (5%) children, 11-13 years old - 15 (12%) children, ages 14 - 17 - 105 (83%) children. The most common gynecological pathology causing acute abdominal clinic in our hospital was ovarian cyst, and the age of most of the patients was from 14 to 17 years, while children 6 to 10 years with gynecological pathology clinic that simulates an acute abdomen is largely an inflammatory and does not require surgical treatment. In view of the anatomic-topographic and anatomic and physiological features of a child's body, high mobility of neoplasms in female internal genital organs in girls clinic usually simulates acute appendicitis. Ovarian Neoplasms and the leasure of the right ovary occur in puberty more often confirming the theory of genetic determination of an earlier and higher functional activity of the right ovary.

## Treatment of Donor Wounds with a Free Transplant Grafts in Children

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The biggest advantage of the medium thickness free grafts transplantation is that large areas of skin can be transplanted without any damage (functional or cosmetic) to the donor site wounds. However, for the implementation of this basic advantage in practice, is a smooth donor wound healing, which is most successful ensured by an appropriate treatment and by leaving the wound open. In the Children's Republican Hospital "Em.Cotaga" in Burns Department, during the 2009 have been hospitalized 626 patients. 114 patients of those operated, with diagnosis autodermoplasty with split grafts. The excision of the flap was carried out under general anesthesia. Before the excision, donor site was treated with antiseptic solution. Subcutaneously sa-line solution was injected till the formation of "citric peel". After this, the excision of the graft was performed. At the end of the operation to the surface of donor wound was covered with Kollahit, non-woven wound coverings based on collagen-chitosan complex. Coverage Kollahit is placed on the wound so that it stood for the wound for 5-10 mm, is pressed to the bottom of the wound, and then is imposed a gauze and fixed with gauze bandage. Donor site wound is immobilized. Bandages should be changed in two days after surgery. From the wound surface only the wet areas are removed and are replaced with new pieces of cover of the same size. The crust formed is closely welded to the bottom of the wound, forming a solid and yet flexible protective coating. Cover stucked to the wound are left on the wound until its complete epithelialization. Wound surface of the donor site wound epithelialization begins primarily from the edges. The development of the process of epithelialization is shown by the delamination of crust edges, which is observed in 6-8 days after the surgery. The lifted crust edges should be cut every day, so that they could not accidentally be caught on the patient's clothes, and lift the adhered parts, which may cause bleeding and even lead to the occurrence of the infection. 10-14 days after the operation, the epithelialization ends, the crust is definitively decaled; the place of the donor site is shown only by the bright spot on the skin. The Kollahit coatings stimulate regeneration of damaged tissues in the wound: stimulate marginal and island epithelization and provide conditions to epithelial cells migration, providing the conditions for scar free healing. A very valuable asset of Kollahit is its: soft spongy structure, high capacity to absorb wound fluid content, the ability to provide normal moisture in the wound. This allows an easy and painless bandage change. Due to the high plasticity,