

ml/min, constituting approximately 1000-1200 ml/min. In the splenic vein the volume velocity ranged from - $157 \pm 0,4$ to 366 ± 12 ml/min. A linear increase in blood flow by 70% was observed. Superior mesenteric vein – normal flow volume is 194 ± 25 ml/min. As the pathology progressed, the flow volume also increased from $785 \pm 0,5$ ml/min to 979 ± 138 ml/min.

Conclusion(s). Acceleration of blood flow in the hepatic artery represents informative hemodynamic parameters that secondarily invoke the reduction of elasticity and tone of large veins, the decrease in filling of small and medium caliber arteries of the liver.

Keywords: hepatic, artery, portal, vein, cirrhosis

THE UTILITY OF THE RSS-12 QUESTIONNAIRE IN ASSESSING THE SYMPTOMS OF GASTROESOPHAGICAL REFLUX DISEASE

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Background. Gastroesophageal reflux disease (GERD) has a global prevalence between 10-30%. The RSS-12 questionnaire (Reflux Symptom Score – 12 items) has a sensitivity of 85-90% and specificity of 80-85% for assessing the severity of symptoms of this disease, being a reliable tool for diagnosis and monitoring.

Objective(s). Assessment of the severity and frequency of symptoms in patients with GERD using the RSS-12 questionnaire and analysis of correlations between symptom severity and patient gender.

Materials and methods. The study included 51 GERD patients (36 women–70.6% and 15 men–29.4%) aged between 51 and 76 years, recruited at the Department of Internal Medicine-Semiology during the period 01-05.2025. Evaluation was performed using the RSS-12 questionnaire to quantify symptom severity. Demographic data were collected to analyze correlations.

Results. According to the RSS-12 questionnaire, 39 patients (76.5%) had severe reflux, 6 (11.8%) mild-moderate, and 6 (11.8%) reflux unlikely. The most frequent symptoms were acid regurgitation (88.2%), need to clear the throat (74.5%), dry cough (66.7%), and retrosternal burning (64.7%). Less common symptoms included difficulty breathing (19.6%), sleep disturbances (17.6%), and hoarseness (11.8%). No significant differences were found between the sexes regarding the presence of GERD ($p=0.912$) or the severity of the disease ($p=0.239-0.701$). These results indicate a balanced distribution of GERD severity between women and men in the studied group.

Conclusion(s). The RSS-12 is a practical, noninvasive, and effective tool for identifying GERD, especially those with atypical manifestations. Integrating the RSS-12 into clinical practice may facilitate early diagnosis, treatment adjustment, and allow monitoring of therapeutic response.

Keywords: gastroesophageal reflux disease, RSS-12 questionnaire

COMMUNITY-ACQUIRED PNEUMONIA AND THE NATIONAL CLINICAL PROTOCOL

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Background. Community-acquired pneumonia (CAP) is one of the most frequent causes of hospitalization among all lower respiratory tract diseases. Correct diagnosis, examination,

and proper treatment management according to the National Clinical Protocol (NCP) still represent a challenge for clinicians.

Objective(s). Evaluation of the adherence to the National Clinical Protocol regarding the hospitalization, examination, diagnosis, and treatment criteria for community-acquired pneumonia at the hospital stage.

Materials and methods. The study is a retrospective, descriptive analysis of data from 40 patient records hospitalized in the Pneumology Department of SCM "Sfânta Treime" in the year 2024. The analyzed data included: admission criteria, investigation plan, and empirical antibiotic therapy criteria. The data were processed using SPSS software, version 23.

Results. The average age of the patients was 65 ± 1.5 years, with an equal gender distribution of 50/50%. The hospitalization and examination criteria according to the NCP were respected in 100% of cases. Most patients presented with CAP of moderate severity evolution (75%). The etiological agent was identified in 57.5% of cases, most frequently *Str. Viridans*, *Klebsiella pn.*, *E. coli*, and Group B beta-hemolytic Streptococcus. The most common antibiotic regimens were second/third-generation cephalosporins + macrolides or respiratory fluoroquinolones. The duration of antibiotic therapy was 10.6 days (moderate), 17 days (severe).

Conclusion(s). Currently, maximum adherence to the NCP recommendations regarding hospitalization and examination criteria is observed. Treatment gaps may occur due to the changing bacterial antibiotic resistance patterns that emerged as a result of antibiotic overuse during the post-COVID period.

Keywords: community-acquired pneumonia, National Clinical Protocol

THE EMERGENCY PHYSICIAN'S ROLE IN THE BLUE ZONE OF THE EMERGENCY DEPARTMENT

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Background. The blue zone is part of the triage system in the ED, intended for patients with non-critical, hemodynamically stable conditions, requiring prompt medical evaluation and symptomatic treatment. Emergency physician is essential in the efficient management, to avoid overloading other departments of the ED.

Objective(s). To evaluate the role of the emergency physician in the management of patients triaged in the blue zone, analyzing frequency, typology of pathologies, interventions applied, post-assessment guidance.

Materials and methods. The study was conducted in the ED of the IEM, during 2024, through a prospective analysis of 30141 cases managed in the blue zone. Data were collected on the diagnosis at presentation, investigations performed, initial treatment applied, rate of subsequent surgical interventions and the coordinating role of the emergency physician.

Results. In 2024, the Emergency Department recorded 80,080 visits, with a daily average of 219.7 ± 15.3 patients, of which 37.6% (30,141) were classified in the blue zone (106.6 ± 12.4 /day). Common conditions included sprains/ligament strains (28.5%), contusions (26.1%), superficial wounds (14.6%), dislocations (11.2%), minor dental/OMF issues (11.7%), and simple fractures (7.9%). Interventions included immobilizations (31.7%), symptomatic treatment (78.4%), and minor surgery (4.9%). The presumptive diagnosis was clinical in 71.3%, later confirmed by imaging. The emergency physician ensured triage, clinical evaluation, and coordinated care.

Conclusion(s). The emergency physician in the blue zone has a central role in the decision-