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ABLATIA PRIN RADIOFRECVENTA IN DETERMINARILE PRIMARE SI SECUNDARE DIN NEOPLASMELE COLO-RECTALE

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Ablatia prin radiofrecventa constituie o solutie terapeutica recenta in chirurgia determinarilor primare sau secundare din neoplasmele colo-rectale. Realizata prin abord deschis, laparo-endoscopic sau percutan, metoda asigura un control acceptabil asupra procesului tumoral, cu riscuri reduse comparativ cu chirurgia de exereza, cu conditia respectarii stricte a indicatiilor.Obiective. Evaluam aceasta procedura terapeutica, aplicata pentru indicatia clasica din metastazele hepatice, cat si pentru tumorile rectale joase sau recidive pelvine dupa cancer rectal operat, prin prisma experientei acumulate pe parcursul a 4 ani, focusand complicatiile perioperatorii si rata de recidiva locala si evolutia la distanta. Metoda. In perioada decembrie 2006 – martie 2010 au fost tratati prin radiofrecventa 64 pacienti, 46 cu metastaze hepatice secundare CRC, iar 18 cu cancer rectal inferior sau recidive pelvine; procedura s-a realizat in majoritatea cazurilor sub control echografic intraoperator, prin abord chirurgical clasic in 59 cazuri, iar in 5 cazuri prin abord laparoscopic. Evolutia pacientilor a fost monitorizata imagistic prin CT postoperator la 30 zile, ulterior din 3 in 3 luni, urmarirea markerilor tumorali (CEA, CA19.9.) si control endoscopic .Rezultate. Complicatii perioperatorii s-au inregistrat la 6 pacienti si au constat in sindroame febrile, citolize hepatice. Nu s-au inregistrat complicatii de tipul hemoragiilor, fistulelor sau peritonitelor; si nici mortalitate perioperatorie imputabila metodei. Recidive locale inregistrate, la un interval de 6-25 luni, la 12 pacienţiConcluzii. Experienta initiala arata ca radioablatia in chirurgia determinarilor primare sau secundare din neoplasmele colo-rectale este o procedura relativ sigura, grefata de morbiditate redusa si rata scazuta de recidiva locala; urmeaza ca studii de urmarire pe perioade mai intinse sa confirme valoarea metodei.

RADIOFREQUENCY ABLATION IN PRIMARY COLO-RECTAL CANCER AND LIVER METASTASIS

Radiofrequency ablation represent a therapeutic option for primary colo-rectal cancer and liver metastasis, performed by open surgery, laparoscopic approach or percutaneous, provide a reasonable local tumor control, involved low risks comparative resection surgery.Objectives. We analyzed this procedure, for classic indication in hepatic metastatic tumors, as well as in low rectal tumors and pelvic recurrences after rectal surgery based on four years experience, focused on perioperative complications, recurrence rate and long distant evolution. Method. Between December 2006 and March 2010, 64 patients underwent RFA; 46 cases had metastatic lesions from colo-rectal cancer and 18 cases had low rectal cancer or pelvic recuurrence. RFA was performed in 59 patients via open surgery and laparoscopic approach in 5 patients. Postoperative course was followed with CT scan at 1 month, and then at 3 month interval, in correlation with tumor markers level (CEA, CA19.9.) and endoscopic control .Results. Perioperative complications occurred in 6 cases, consist of prolonged fever, severe hepatic cytolysis, without other complications such, biliary tract injury, hemorrhage,and peritonitis; no mortality caused by RFA procedure. 12 cases had local recurrence, at 6 and 25 month after post RFA procedure. Concluzii. Initial experience shows that RFA is a safe procedure for treatment of primary colo-rectal cancer and liver metastasis, with low rate of morbidity and local recurrence, indicated for patients with unresecable lesions or high risks for surgical resection.

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RUPTURA SPONTANA DE SPLINA MALARICA (PLASMODIUM FALCIPARUM) TRATATA CONSERVATOR

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IntroducereRuptura spontana a splinei malarice (Plasmodium Falciparum) este o complicatie rara fiind frecvent asociata cu malaria cauzata de Plasmodium Vivax. Material si metodeLucrarea prezinta cazul unui pacient de 30 de ani internat de urgenta prin transfer de la Spitalul Clinic de Boli Infectioase cu diagnosticul ruptura spontana de splina patologica (malarica), hemoperitoneu mare tratat nonoperator (angioembolizare splenica proximala).RezultateEvolutie favorabila cu recuperare completa.Concluzii Ruptura splinei malarice poate fi tratata nonoperator cu succes iar prezervarea acesteia trebuie sa fie obiectivul tratamentului.Pentru stabilirea precoce a diagnosticului este necesar un indice ridicat de suspiciune pentru evitarea unor consecinte catastrofale.Cuvinte cheie: malaria, ruptura spontana splenica, tratament nonoperator, angioembolizare.

SPONTANEOUS SPLENIC RUPTURE DUE TO PLASMODIUM FALCIPARUM-NONOPERATIVE MANAGEMENT

Introduction Spontaneous rupture of malarial spleen due to Plasmodium Falciparum is uncommon. It is most frequently associated with Plasmodium Vivax malaria. Material and methodsWe report the case of a 30-years old male transferred to our hospital from Clinical Hospital of Infectious and Tropical Diseases. He was admitted with the diagnosis of spontaneous splenic rupture and large haemoperitoneum. Because the hemodynamic stability we decided a nonoperative management and performed a proximal splenic angioembolization.ResultsThe evolution was uneventful and the patient was discharged on day 14th.ConcluziiRupture of the pathologic spleen do heal and attempt at splenic salvage should be the aim in management. A high index of suspicion of splenic rupture is imperative because delay in diagnosis may lead to catastrophic consequences.Keywords: malaria, spontaneous splenic rupture, nonoperative management, angioembolization.

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RUPTURA SPLENICA POSTCOLONOSCOPIE - ROLUL TRATAMENTULUI NONOPERATOR

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Introducere: Ruptura splenica dupa colonoscopie reprezinta o complicatie rara dar potential fatala. Primul caz a fost publicat in anul 1974 de catre Wherry si Zehner. Incidenta acestei complicatii este de 0.00005-0.017 % cu o mortalitate de 7.4 %. In mod frecvent (64.4%) tratamentul optim este reprezentat de splenectomie.Metoda: Este relatat un caz de ruptura splenica postcolonoscopie la un barbat de 65 ani, care s-a prezentat la camera de garda la 4 zile dupa efectuarea unei colonoscopii de screening, colonoscopie fara incidente. Pacientul a prezentat durere abdominala moderata debutata la 4 ore dupa colonoscopie; in evolutie durerea a devenit intensa, generalizata. A negat orice fel de traumatism abdominal. CT abdomino-pelvina cu substanta de contrast iv a evidentiat o ruptura splenica polara inferioara grad II, hematom subcapsular fisurat, hematom perisplenic si hemoperitoneu mic, fara semne de sangerare activa. Stabilitatea hemodinamica si gradul rupturii splenice a mandatat tratamentul nonoperator cu rezultate favorabile.Concluzii: Pana in anul 2009 au fost publcate 67 de cazuri de rupturi splenice secundare colonoscopiei; este posibil ca aceasta sa fie al 68-lea caz raportat. Diagnosticul este frecvent intarziat. Principalele mecanisme de producere sunt reprezentate de tractiunea excesiva asupra ligamentului spleno-colic sau sindromul aderential supramezocolic prezent.Diagnosticul de ruptura splenica postcolonoscopie trebuie avut in vedere la orice pacient care, dupa o procedura de endoscopie digestiva inferioara prezinta dureri abdominale asociate cu scaderea valorilor hemoglobinei in absenta hematocheziei. Echipa medicala (medicina de urgenta, gastroenterologie, chirurgie) trebuie sa aiba in vedere aceasta complicatie potential fatala.Cuvinte cheie: colonoscopie, ruptura splenica, tratament nonoperator.

SPLENIC RUPTURE AFTER COLONOSCOPY TREATED BY NONOPERATIVE MANAGEMENT

Background: Splenic injury is a rare and potentially fatal complication of colonoscopy. It was first reported in 1974 by Wherry and Zehner. The incidence of this complication is around 0.00005-0.017 with a mortality rate about 7.4 %. Frequently, the usual treatment is represented by splenectomy. Method: We report a case of splenic rupture following splenectomy. A 65-years-old Caucasian male was presented to the emergency department 4 days after an uncomplicated screening colonoscopy. He reported poorly abdominal pain that started 4 hours after the procedure; in evolution the pain had become more severe. He denied any abdominal trauma. Clinical abdominal examination revealed diffuse rebound tenderness; a rectal examination was normal. Computed tomography of the abdomen and pelvis with intravenous contrast media revealed a grade 2 splenic rupture (OIS-AAST) lower pole, a ruptured subcapsular hematoma, perisplenic hematoma and small haemoperitoneum without active bleeding. Because of hemodynamic stability and his grade 2 splenic rupture a nonoperative approach was elected with good outcome. Conclusion: Until 2009, 67 cases of splenic rupture following colonoscopy were published; it is possible our case to be the 68th. The diagnosis is frequently delayed. Excessive traction on the splenocolic attachment or on preexisting adhesions represent the essential mechanism of injury. The diagnosis of splenic rupture should be considered in any patient presenting abdominal pain after a colonoscopic procedure and declining hemoglobin levels in the absence of hematochezia. In many cases the surgical treatment is the modality of choice. The medical staff (primary care physicians, gastroenterologists, surgeons) need to be aware of this potentially life threatening complication.Keywords: colonoscopy, splenic injury, nonoperative management.