estimează că studierea profilului molecular/genetic al tumorilor colorectale va dicta în viitor deciziile terapeutice de urmat.Cuvinte cheie: cancerul colorectal, markeri moleculari, factori de prognostic

PROGNOSTIC FACTORS IN COLORECTAL CANCER EVOLUTION

Background. This paper tries to evaluate prognostic value of various pre and post-operative colorectal cancer markers. Material and methods. In the study conducted in our clinic over a period of five years we tried to emphasize the biological factors of prognostic value in colorectal cancer, and to demonstrate the important role of these factors in predicting survival, but also of early relapse or, in some cases, resistance to chemotherapy. Most important component of these factors remains molecular tumor markers. Results. Of the markers of tumor load increased preoperative serum levels of carcinoembryonic antigen (CEA) means increased risk of neoplastic recurrence and reducing survival expectancy. Aneuploidy tumor cells would have the same importance. Conclusions. Although for their study modern and expensive techniques are necessary, molecular tumor markers have an increasingly role appreciated by researchers both in estimating the risk of relapse and neoplastic dissemination and the response rate to adjuvant treatment. It is estimated that the study of molecular/genetic profile of colorectal tumors in the future will dictate therapeutic decisions ahead.

D84

FALS ABDOMEN ACUT CU IMPLICATII MEDICO-LEGALE

Ghiur M., Ghiur Luminița, Zbuchea A.

Spit. CF 2

Bolnvul A.M. de 26 de ani se interneaza in garda pentru dureri abdominale, greturi urmate de varsaturi, stare subfebrila. Analizele de urgenta consemneaza doar o leucocitoza de 8000. Se pune diagnosticul de apendicita acuta si se practica in urgenta apendicectomie. Intraoperator, aspectul morfopatologic al apendicelui nu justifica simptomatologia bolnavului (fig. 1).Postoperator, starea generala se agraveaza brutal, instalandu-se un sindrom de ocluzie intestinala. Considerandu-se o complcatie postoperatorie, se reintervine in a 4-a zi de evolutie nefavorabila. Intraoperator nu se constata decat un ileus dinamic si ingrosarea apreciabila a mezenterului. S-a practicat ileostomie de degajare (fig. 2).Evolutie postoperatorie nefavorabila. Se instaleaza acelasi sindrom de ocluzie intestinala. Starea bolnavului devine critica. Transfer la Cinica de chirurgie Spitalul Floreasca.Dupa o reevaluare clinica si paraclinica se practica o noua reinterventie chirurgicala pentru acelasi sindrom de ocluzie intestinala, cand se constata un mezenter mult ingrosat, de 8-10 cm, si staza in circulatia portala (fig. 3). Evolutia postoperatorie este grava cu deces in a 5-a zi prin stop cardio-respirator..Cazul este trimis direct la Institutul de Medicina Legala pentru malpraxis intr-o operatie de apendicectomie.Dupa 60 de zile, concluzia IML: Sindrom Budd-Chiari prin ingestie de alcool metilic, producand o endoflebita ocluziva pe venele suprahepatice cu bloc posthepatic ce a dezvoltat o forma maligna de hipertensiune portala cu evolutie letala.

FALSE ACUTE ABDOMEN WITH MEDICAL - LEGAL IMPLICATIONS

The patient A.M., 26 years old, is urgently hospitalized for abdominal pains, nausea followed by eructation, subfebrile temperature. The emergency analyses show only a leukocytosis of 8000. It is diagnosed as acute appendices and it is practiced an appendicectomy. During surgery, the morpho-pathological aspect of the appendix does not justify the symptomatology of the patient. (Figure 1). After surgery, the general state was brutally exasperated, with the syndrome of intestinal occlusion. Being considered a post-surgery complication, it shall be intervened in the forth day of unfavorable evolution. During surgery, it is not observed nothing but a dynamic ileus and the severe swelling of mesentery. It was practiced ileostomy of release. (Figure 2). Unfavorable post-surgery evolution. It is observed the same syndrome of intestinal occlusion. The physical state became critical. Transfer to the Surgery Clinic, Floreasca Hospital. After a clinical and paraclinical reevaluation it is practiced a new surgical intervention for the same syndrome of intestinal occlusion and it is observed a thicker mesentery, of 8-10 cm, and stasis in portal circulation (Figure 3). Post – surgery evolution is critical with death in the fifth day, by cardiopulmonary arrest. The case is sent directly to the Institute of Forensic medicine for malpractice in appendicectomy surgery. After 60 days, the IML conclusion: syndrome Budd-Chiari by ingestion of methyl alcohol, producing an occlusive endophlebitis on the suprahepatic veins with post-hepatic blocks which developed a malign form of portal hypertension with lethal evolution.

D85

CONSIDERAȚII CLINICO-TERAPEUTICE ASUPRA UNUI CAZ RAR DE OCLUZIE INTESTINALĂ

Darii E.

Clinica Chirurgie II, Târgu Mureş

Introducere: Ocluzia intestinală reprezintă 20% din totalul cazurilor de abdomen acut chirurgical din România. Cunoaștem 4 tipuri majore de cauze: sindrom aderențial peritoneal post-operator, tumori intestinale, volvulus intestinal, hernii sau eventrații abdominale strangulate. Herniile abdominale interne (paraduodenale, transmezenterice, pericecale, intersigmoidiene, paravezicale) reprezintă 0,2%-0,4% din toată patologia herniară. Material şi metodă: Vom relata cazul unei paciente internate în urgență cu abdomen acut chirurgical și semne de ocluzie intestinală. Pacienta în vârstă de 21 ani

acuza dureri abdominale, grețuri, vărsături, absența tranzitului intestinal de 8 ore. Clinic: apărare musculară la palpare, mai accentuată peri-ombilical; imagistic: câteva nivele hidroaerice mici peri-ombilical. Se practică laparotomie exploratorie, se constată înglobarea intestinului subțire începând de la Treitz și până la joncțiunea ileocecală într-un sac peritoneal separat, adițional; intestinul gros (cecul, colonul ascendent, transversul cu epiplonul, descendentul și sigmoidul) având o topografie normală în jurul acestei pungi peritoneale. Ultima avea un defect de aproximativ 1,5 cm diametru aproape de joncțiunea ileocecală prin care a ieșit o ansă de ileon terminal, fiind strangulată la acest nivel, dar viabilă. În rest organele cavitații peritoneale și a spațiului retroperitoneal cu aspect și topografie normală. S-a practicat excizia pe circumferință a acestui sac în care se conținea tot intestinul subțire, considerându-se un defect congenital, astfel jejunul și ileonul au luat o poziție normală în cavitatea peritoneală. Concluzie: Herniile abdominale interne sunt o entitate chirurgicală întâlnită mai rar, din acest motiv am considerat importantă aducerea la cunoștință a acestui caz care deocamdată nu suntem siguri în ce categorie din clasificarea herniilor abdominale interne se poate încadra, fiind un defect congenital, care s-a manifestat la vârsta de 21 ani.

CLINICAL AND TREATMENT ASPECTS OF A RARE CAUSE OF INTESTINAL OBSTRUCTION

Introduction: Intestinal obstruction represents 20% from all cases of acute abdomen in our country. There are 4 major causes: postoperative adherences, intestinal tumors, intestinal torsion and strangulated hernias. Internal abdominal hernia represents 0.2-0.4% of all types of hernias. Materials and methods: It is a case of a 21 years old woman admitted in the emergency department with clinical signs of acute abdomen and intestinal obstruction. She complained of abdominal pain, nausea, vomiting and absence of intestinal transit for about 8 hours. Physical examination revealed acute pain with muscular involuntary guarding, especially in the mid- abdominal area. Upright roentgenogram of the abdomen showed some small air-fluid levels periumbilicaly. No previous operation. Pregnancy test was negative. It was performed an exploratory laparotomy. Intraoperatory we found that the small bowel from the Traits till the ileocecal valve was in an aditional hernial sac. Near the ileocecal valve the sac had a defect and through it the part of the ileum herniated, being strangulated, but viable. The large bowel and the organs of the abdominal cavity had a normal aspect and position. The entire sac was removed, being considered a hereditary defect. The bowels took the normal position in the peritoneal cavity. Postoperative course was simple. Conclusion: Internal hernias are extremely rare surgical entities and are diagnosed only when became complicated especially with intestinal obstruction. Our duty was to report this case because we are not sure how to classify this type of hernia; this hereditary abnormality witch was silent till the age of 21.