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HIPERFUNCTIA PARATIROIDIANA ITINERAR CHIRURGICAL: 63 CAZURI OPERATE

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Introducere: Multiplele aspecte etiopatogenice si anatomo-clinice ale hiperparatiroidismului (HP): pri-mar (HPP), renal (HPR), familial, din NEM etc constituie o patologie care realizeaza o continua provocare. In afara fenotipului si simptomatologiei polimorfe, a noilor achizitii diagnostice si terapeutice, frapeaza contrastul dintre incidenta/prevalenta sindromului in crestere in tarile dezvoltate – mai ales pe seama observatiilor asimptomatice - si seriile limitate numeric sau cazurile izolate cu manifestari "istorice", pu-blicate in literatura natiunilor "in tranzitie" sau subdezvoltate.

Material si metoda: Din 1986 in clinica noastra au fost operate 63 observatii de HP: 20 HPP – adenoame =17, carcinoame=2, paratiromatoza=1 si 43 HPR – HP secundar (HPS)=23 si tertiar=20. Am inregistrat 44 femei si 19 barbati (raport 2,3/1) cu limite de varsta 15 – 67 (medie 47) ani. Diagnosticul si indicatia chi-rurgicala au fost stabilite clinic prin prezenta suferintei renale – urolitiaza multipla sau recidivata in HPP – insuficienta renala cronica in regim de hemodializa in HPR, sindrom osos manifest – osteoporoza, du-reri osoase, chisturi si fracturi, manifestari neuromusculare, psihonevrotice, digestive si cardiovasculare in ambele varietati. Datele de laborator au obiectivat valori anormale ale calciului seric total si ionizat, fosforului si fosfatazei alcaline si in special ale iPTH iar explorarile localizatoare au inclus ultrasonografia – mai putin concludenta in leziunile multiglandulare si mai recent scintigrafia cu 99mTc-tetrophosmin. Rezultate: Toate cazurile au fost operate practicandu-se exereza simpla in 17 adenoame si "in bloc" cu lobul tiroidian ipsilateral in doua cancere (unul fiind o recidiva la 4 ani dupa indepartarea unui adenom), intr-un adenom chistic intratiroidian ca si in cazul de paratiromatoza (de asemenea recidiva dupa exere-za extra muros a unui adenom). In observatiile de HPR au fost executate 24 paratiroidectomii subtotale (in 20 observatii reusindu-se exereza standard a 3 si ½ glande, in rest indepartandu-se 3 sau doar 2 paratiroide) si respectiv 19 paratiroidectomii totale (6 cu autotransplant glandular si 13 simple). Din considerente tactice sau pentru leziuni asociate explorarea/exereza chirurgicala a fost extinsa la tiroida (29 cazuri) sau timus (20 cazuri). Examenul anatomopatologic a precizat diagnosticul final in toate obser-vatiile. Rezultatele imediate si in timp au fost bune in special in HPP. Nu au fost hipocalcemii persistente chiar in cazul paratiroidectomiilor extinse dar am notat o paralizie recurentiala, un hematom al lojei si recidiva in doua cazuri de autotransplant antibrahial ca si cea a unui cancer la 4 ani dupa extirparea unui adenom (leziune noua ?). Concluzii: Paratiroidectomia – cu rafinamentele sale recente: minim invaziva, endoscopica sau asistata robotic – este singurul tratament eficace si definitiv in HPP si constituie o terapie simptomatica impor- tanta, desi suboptimal, in cazurile de HPR (a caror tratament ideal este transplantul renal). Exerezele paratiroidiene trebuie practicate doar de specialisti antrenati in aceasta chirurgie.

SURGICAL ITINERARY IN PARATHYROID HYPERFUNCTION: 63 CASES OPERATED ON

Background: Hyperparathyroidism (HP) is a constantly evolving entity with multiple clinical varieties i.e.: primary (HPP), renal (HPR), familial, in MEN etc, proteiform phenotype and symptomatology, continous modernizing diagnosis and therapeutic methods and striking differences in epidemiology between de-veloped nations and the 3rd world's or "in transition" countries. Material and methods: The study population comprised 63 patients with HP operated on from 1986 in our clinic. There were 20 cases with PHP (17 adenomas, 2 carcinomas and one parathyromatosis) and 43 cases with RHP (23 secondary and 20 tertiary). The series included 44 women and 19 men (ratio 2,3/1), aged 15-67 (range 47) years. As a rule the documentation of signs and symptoms as well as recording of the surgical indications were consistently thorough. The presence of multiple and recurrent urolithiasis in HPP and renal failure on hemodialysis in HPR as well as bone, muscular, neuropsychiatric, digestive and cardiovascular manifestation in both syndromes are constantly described. Laboratory data indicated abnormally levels of serum calcium, phosphorus, alkaline phosphatase but especially of the iPTH. Locali-sation procedures included ultrasonography less valuable for multiglandular lesions and recently 99mTc-tetrophosmin scan. Results: All the cases were operated on: 17 simple exeresis for adenomas and 4 "en bloc" resections to-gether with the thyroid lobe for two carcinomas, intrathyroid cystic adenoma and parathyromatosis one case each. In HPR 20 patients underwent standard subtotal parathyroidectomy (3 and ½ glands) but in 3 cases only 3 or even 2 glands were founded and 19 total parathyroidectomy respectively (6 with auto- transplantation). Thyroid (n=29) and thymus (20) resections were practiced for associated lesions or tac- tical reasons. Pathology established the final diagnosis. Immediate and late results were good especially in HPP. Persistent hypocalcemia was not encountered even in extended resections but we avow a cervi-cal hematoma,a recurrent laryngeal nerve palsy, two antibrahial recurrences and a carcinoma developed four years after resection of an adenoma (new lesion ?).Conclusions: Parathyroidectomy with its recent refinements in minimally invasive, endoscopic, video- and robotic techniques constitutes the gold standard therapy for HPP and still remains the only perma-nently effective method offering an improved quality of life in HPR. These operations must be done by high-specialised surgeons.

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NODULUL TIROIDIAN SOLITAR: PARADIGME DIAGNOSTICE SI TERAPEUTICE

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Controversele privind diagnosticul si atitudinea terapeutica in nodulul tiroidian solitar (NTS) sunt propor-tionale numeric cu incidenta/prevalenta la nivel mondial a acestei entitati constituind o continua provo-care pentru specialistii in domeniu. Discrepanta dintre frecventa importanta a NTS si numarul relativ redus al tumorilor maligne tiroidiene nu anuleaza teama de a ignora un cancer ceea ce conduce la o chirurgie maximalista sau chiar

nonnecesara intr-o proportie importanta de cazuri. Astfel in cazul unui NTS problemele majore devin diferentierea intre o leziune benigna si una maligna si stabilirea riscului –scazut sau ridicat in ultima eventualitate. Desi nu exista criterii ferme de atestare a malignitatii unui NTS "inocent", insistenta anamnezei si examenul clinic permit selectarea cazurilor suspecte desi cateodata identificarea unui (micro)carcinom tiroidian poate fi comparata cu "cautarea unui ac intr-un car de fan"! Explorarile de laborator si examenele localizatoare includ dozarea TSH, ultrasonografia, scintigrafia cu iod si technetium, PET [(18)F-FDG] simpla sau asociata cu CT si punctia-biopsie cu ac subtire (eventual eco-ghidata), ultima considerate standardul de aur in diagnosticul NTD "explicand scenariul clinic sau le-ziunea" dar furnizand totusi 20% rezultate "nedeterminate" (suspecte sau leziuni foliculare). Totusi o strategie diagnostica agresiva este obligatorie in cazul NTD putand reduce in mod semnificativ proportia interventiilor inutile crescand totodata numarul operatiilor curative pentru cancer tiroidian. Din punct de vedere therapeutic atitudinea optima se inscrie in limite largi intre simpla monitorizare +- terapie su-presiva cu hormoni tiroidieni, chirurgie conservatoare (lobistmectomie) chiar in unele (micro)cancere si tiroidectomia aproape totala/totala. Propria noastra filozofie profesionala se opune generalizarii rigide a tiroidectomiei totale in majoritatea tireopatiilor chirurgicale, pledand pentru o atitudine intraoperatorie adaptata pentru fiecare caz in parte, lobectomia totala fiind totusi operatia minima recomandata. Sa facem bine ceea ce stim bine sa facem!

NODULAR THYROID DISEASE: DIAGNOSIS AND THERAPEUTIC PARADIGMS

Controversies about nodular thyroid disease (NTD) are proportionally numerous with their great world-wide incidence/prevalence representing a continous elusive challenge of the endocrine pathology. Benign NTD are a common finding in striking annoyance with the relative rarity of thyroid malignancies but a great number of specialists are dominated by the fear of being unaware of a cancer which lead to a maximalist attitude and systematic sometimes unnecessary surgery. So the main problems in this pathology remains to differentiate between benign from malignant disease and discriminate low-risk from high-risk cancer.In addition to this there are not commonly accepted screening and diagnosis strategies and even the medical management is often controversial. However no criterion permits an at-testation of the malignancy of an "innocent" nodule, the accuracy of the interogatory and the clinical examination will allow the individualization of suspect cases but sometimes the identification of a thyro-id (micro) carcinoma is compared with seeking a needle in a hay cock. Laboratory tests/imaging modali-ties included TSH assayement, thyroid ultrasound, scintigraphy with iodine or technetium, [(18)F-FDG]-PET alone or with CT and fine needle aspiration biopsy (eventually US-guided). The later considered the most valuable step in the diagnosis of NTD which "can explain the clinical scenario or lesion" still provi-des a 20% cases of "nedeterminates" (suspicious or folliculary) lesions. Nevertheless an aggressive diagnosis strategy is mandatory and can reduces the proportion of needless operations and in the same time increases the effective interventions for thyroid cancer. From a surgical perspective the optimal NTD treatment frames in large limits from simple observation +- thyroid hormone suppressive therapy, conservative surgery i.e. lobectomy+isthmusectomy [even in some (micro) carcinomas !] to systematic near total or total thyroidectomy. Our personal surgical philosophy is against a rigid generalisation of total thyroidectomy in near all thyroid lesions but for an adapted intraoperative attitude for each parti- cular case total lobectomy being the minimum accepted exeresis. We must do better what we know well !

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MANAGEMENTUL MEDICO-CHIRURGICAL ÎN DIAGNOSTICUL ŞI TRATAMENTUL ESOFAGULUI BARRETT

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Introducere. Esofagul Barrett reprezintă metaplazia columnară a epiteliului pavimentos al esofagului, cu o icidență de 8-20 %. In acest grup de bolnavi riscul dezvoltării cancerului de esofag crește de 30-40 de ori.

Material și metode : Pe un termen de 15 ani în clinica chirurgie FEC MF au fost tratați 47 pacienți cu esofagul Barrett (EB) la un număr total de pacienți cu BRGE 356, ceea ce constituie (13,6%). În această perioada a fost întrodus algoritmul de diagnostic și tratament precum și implimentate pe scară largă metodele de tratament miniinvazive endoscopice și laparoscopice.

Rezultate și concluzii. Rezultatele imediate și la distanță ale tratamentului multimodal al pacienților cu EB sunt controlabile și comparabile și evidentă necesitatea încluderii precoce a metodelor de trtament endoscopic și laparoscopic al BRGE.

Medical and surgical management in diagnosis and treatment of Barrett's esophagus

Introduction. Barrett esophagus represents columnar metaplasia of squamous epithelium of the esophagus, with an incidence of 8-20%. The risk of developing of esophageal cancer in this group of patients is increased 30-40 times.

Material and methods: In a period of 15 years in the department of surgery CEM were treated 47 patients with Barrett's esophagus (EB) in a total of 356 patients with GERD, which is (13.6%). During this period, the algorithm of diagnostic and treatment was introduced and widely implemented miniinvasive methods of endoscopic and laparoscopic treatment.

Results and conclusions. Immediate and remote results of multimodal treatment of patients with EB are controllable and comparable and it is necessary to include early the methods of endoscopic and laparoscopic trtament of GERD.
