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.
