

files of patients evaluated in the dynamic after ECHOC and clinical data. The standard preoperative patients have had performed: ECG, ECHOC, before being indicated the cardiac cateterism and angiography. The ECHOC investigations have been made repeatedly over 10 days postoperative, 1 month, 3 months, 6 months and then once a year to analyze the dynamics of the remaining gradient caused by the obstruction of right ventricular output tract (ORVOT) and material used in plastic right ventricular output tract (RVOT) and pulmonary artery (PA). Between the patients with radical correction 43 were re-operated after the inter-systemic anastomosis in the history, to 2 of which were performed 2-stage palliative, to one - 3 steps out in order with unfavourable pulmonary artery anatomy. In 2 cases for the anastomosis ligature and plastic of AP branch circulatory arrest was performed. For the ventricular outlet tract plasty have been used these methods: patch of outlet tract ventricular in 38.8%, 47.9% transanular patch, implantation of homograft 4.1%, 4.96% suture of the tract, corrected by atrial and pulmonary artery approach in 4.24% cases. The transanular patch has been applied in patients with intersystemic anastomosis previously in 45% cases and in 52% cases of primary radical correction. The relationship between ventricular and aortic pressure after the correction was 0.53 in the group with transanular patch compared with 0.45 in the group with resection of the ring. Postoperative lethality represented 20.6%, with its subsequent reduction in the last 2 years up to 4.1%. The favorable functional result was obtained in patients with implanted homograft and suturing the right ventricular outflow tract. The regurgitation at the pulmonary artery was observed in patients with transanular patch plasty which presents a risk factor for repeated surgery. The surgical treatment depends of two important things: proper removal ORVOT without compromising pump function and closure of VSD. The application of the intersystemic anastomosis as first stage, creating favorable conditions for radical correction, reduces the need to transanular patch application. The radical correction applied for children under 3 years cause growth of postoperative lethality in the absence of the necessary endowment profile sections.

Induced Pain in Intensive Care Unit: Are there Sex Differences?

Adrian Belii, Natalia Covrighin, Cristina Eremia, Marina Vahnovan

State Medical and Pharmaceutical University "Nicolae Testemitanu", Chisinau, Republic of Moldova

The induced pain (procedural pain) is a short-term pain caused by a doctor or other medical staff during therapeutic or diagnostic action in foreseeable circumstances and likely to be prevented by adopted measures. Induced pain prevalence is between 43-56% for adults, 59% – for children and up to 93% – for newborns. Over 660 painful gestures were identified, with an average of 1.8 gestures per patient per day. From all studied painful gestures, intense pain and extremely intense pain was attested at 57% of patients. Scheduled treatment of postoperative pain has no influence on induced pain. So, it is imperative to ensure additional analgesic treatment. At our knowledge, the induced pain was no subject to any study in Republic of Moldova till now. Therefore, we aimed to describe incidence and pain intensity for some sources of induced pain in the intensive care unit (ICU) and to identify any gender differences. The study included 99 adult patients (M – 39 F – 60), hospitalized postoperatively in ICU. Patients completed a specifically designed questionnaire, where they noted supported painfully diagnostic or therapeutic interventions and also, the intensity of pain (assessed by visual-rating score VRS 0-10). Statistical tests used: t-Student, Chi² with Yates correction. One $p < 0.05$ was considered statistically significant. Both groups (M vs. F) were comparable according to level of education, ASA score, and range of interventions. Instead, F group were significantly older (61.7 ± 14.7 [95CI: 57,9-65,4] vs 47.1 ± 15.0 [95CI: 42,2-52,0] years, $p < 0.0001$). Spectrum and incidence of induced pain sources were recorded (M vs F): intravenous injection (97-98%), intramuscular injection (87-95%), bladder catheterization (79-88%), dressings (79-83%), wound drains (59-60%), neuraxial puncture (49-48 %), peripheral venous line (51-48%), tracheal tube (36-47%), naso-gastric tube (33-30%), arterial puncture (18-23%) with no significant differences between

groups. The only exception: subclavian vein catheterization was more common in women because of more advanced age of patients in group (20% vs 10%, $p < 0.0001$). As very painful (SVA > 5) were reported: arterial puncture (in 50% cases), subclavian vein catheterization (22%), neuraxial puncture (13%), nasogastric tube (12%), bladder catheterization (12%), peripheral venous line (7%), and other interventions (<5%). The conclusions are: 1) induced pain in intensive care unit has an extremely high incidence, intensity and variety of sources. 2) Generally were not identified gender differences in the spectrum, frequency and intensity of induced pain.

Laparoscopic Treatment of Simple Renal Cyst

Dorin Tanase, Alexandru Piterschi

Academic adviser: Emil Ceban, M.D., Associate Professor

State Medical and Pharmaceutical University "Nicolae Testemitanu", Chisinau, Republic of Moldova

Laparoscopic resection of simple renal cyst is a method of choice (N.A. Lopatkin, 1999; I. Coman, 2000; R. Boja, 2000; E. Angelescu, 2003), including by excision of symptomatic and recurrent cysts, as an alternative to open and percutaneous surgery (Z.A. Kadyrov, 2000.). Laparoscopic treatment of simple renal cysts is a well-standardized urological operation, with minimal complications and practically no risk of recurrence (Rassweiler, 1998). New technologies of endoscopic surgery are becoming gradually the gold standard in the treatment of many urological diseases. Analysis of the treatment results and presentation of own experience in laparoscopic resection of simple renal cysts. The study was made on the basis of 17 operated patients with simple renal cyst (5 men and 12 women) during 2009 - 2010 years in the Department of Urology from Clinical Republican Hospital, Moldova. Patient age ranged from 21 to 65 years (average 48.3 years). Mandatory screening of the patients included ultrasound and intravenous urography, and in some cases, CT in the urographic mode and selective angiography. In 8 (47%) patients the cyst was found on the left (17,6% - middle segment, 29,5% - upper segment of the kidney), 9 (53%) patients on the right (17,6% - middle and 35,2% - inferior segment of the kidney). All cysts located at the middle segment were of lateral location. As a result of instrumental examination were revealed unvascular liquid formations with a diameter from 5,6 up to 10,5 cm (mean 7.8 cm) with extra renal location. Laparoscopic resection of renal cysts was implemented in 15 (88,2%) cases. From the total number of operated patients laparoscopic resection was converted to open surgery in 2 (11,8%) cases due to technical difficulties of laparoscopic resection of renal cysts. From the total number of operations, simultaneously with laparoscopic resection of renal cysts were performed: in one case (5,9%) laparoscopic cholecystectomy, in the second case (5,9%) laparoscopic cholecystectomy and laparoscopic resection of a hydatid cyst of the liver. Hospitalization period of the patients averaged 6.2 days, postoperative period was 2.8 days. The duration of operation ranged from 28 to 62 minutes, average length - 34.6 minutes. A check up of patients after 3 and 6 months after surgery showed no recurrence of cysts. Results of treatment of simple renal cysts by laparoscopic surgery are comparable with open operations, and have such great advantages as: reducing of the length of patients' hospitalization, the lack of postoperative scars, rapid postoperative recovery and earlier return to the social and working life. Transperitoneal access in laparoscopy allows solving several surgical problems simultaneously (laparoscopic cholecystectomy, resection of the liver cyst, plastia of the esophageal hernia, etc.).