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BOOK OF ABSTRACTS

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COMPARATIVE ANALYSIS OF SCAR MANAGEMENT STRATEGIES IN PLASTIC SURGERY

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Background: In the realm of plastic surgery, the pursuit of aesthetic perfection is often accompanied by the challenge of minimizing visible scars. From traditional approaches such as topical treatments and silicone sheets, to cutting-edge technologies like laser therapy and regenerative medicine, the options available to both surgeons and their discerning clientele are diverse.

Objective: The aim is to dissect and compare various strategies employed to optimize aesthetic outcomes and enhance patient satisfaction.

Material and methods: Comparative analysis of articles based on studies and reviews regarding different scar management strategies.

Results: Following the monitorisation of 100 patients between 2012 and 2020 who underwent wide local excisions for skin neoplasms, mastectomy, facial trauma surgery or burn reconstruction surgery, there was a slight difference in the level of satisfaction expressed by the patients regarding the surgical outcomes. 70% of those using pulsed-dye laser, CO2 laser, 5-fluorouracil, corticosteroids, bleomycin, and scar massage reported an improvement in the scar appearance one year after healing, compared to 35% of those who did not use any methods to manage the quality of the scar. For the prevention of hypertrophic scars, tension reduction and wound edge eversion seemed to have high efficacy, whereas for keloid scars, effective supportive additions to excision include corticosteroids, mitomycin C, bleomycin, and radiation therapy. Silicone sheeting or gel is universally considered as the first-line prophylactic option for hypertrophic scars and keloids, and its efficacity was also stated for 80% of the patients who used it. Pressure garments are beneficial for more widespread scarring, especially after burns.

Conclusions: Although scars can never be completely eliminated in an adult, the aforementioned techniques seem to improve the appearance of the scars, as well as patient satisfaction.

Keywords: Scar, plastic surgery, aesthetic, laser

EVALUATION OF SURGICAL TREATMENT OF OBESITY IN PATIENTS DIAGNOSED WITH SEVERE OBESITY

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Background: Severe obesity is a complex and chronic medical condition characterized by an excessive accumulation of body fat that can have profound and detrimental effects on an individual's health and well-being. It goes beyond mere cosmetic concerns, impacting multiple organ systems and increasing the risk of various serious health problems.

Objective: The aim of this study was to investigate the impact of laparoscopic sleeve gastrectomy (LSG) in a group of Romanian individuals with severe obesity. The lab tests were taken before the surgery and one year after the procedure. The data collection contained anthropometric measurements, clinical and paraclinical parameters both before and after the surgical procedure.

Material and methods: A prospective study comprising thirty-three patients. Evaluations were performed before surgery and after 1 year. All individuals included in this study (28 females, mean age 41.76 ± 10.785 years, mean body mass index (BMI) 46.345 ± 7.508 kg/m2) underwent a laparoscopic gastric sleeve surgery.

Results: One year postoperatively, significant decreases were observed in BMI (from 46.345± 7.508 kg/m2 to 29.914±4.405 kg/m2), weight (from 128.27±23.036 kg to 82.85±12.867 kg), and abdominal circumference (from 133.73±22.302 cm to 96.30±12.169 cm) compared to preoperative levels. Also, blood sugar (111.113±31.726 mg/dl to 100.121±19.396 mg/dl), LDL (121.535±38.207 mg/dl to 115.727±40.673 mg/dl) and TG (150.133±67.796 mg/dl to 124.545±45.259 mg/dl) decreased after 12 months postoperatively. In contrary, there were no significant changes in serum levels of HTC (41.614±3.370 % to 40.663±4.114%) and HGB (13.718±1.284 g/dl to 13.727±1.484 g/dl).

Conclusions: There is a notable correlation between reduced systemic levels of BMI, blood sugar, LDL and TG, as well as excessive weight loss following laparoscopic sleeve gastrectomy (LSG) in individuals with severe obesity. This study contributes to the existing literature by demonstrating the beneficial effect of laparoscopic sleeve gastrectomy (LSG) on severe obesity patients.

Keywords: Weight-loss, anthropometric measurements, laparoscopic sleeve gastrectomy

LICH-GREGOIR TECHNIQUE OF URETERAL-BLADDER REIMPLANTATION – A PEDIATRIC SURGERY PROCEDURE USED IN GYNECOLOGIC ONCOLOGY

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Background: An ureteric-bladder reimplantation is performed when the ureter is injured at a distance lower than 5 cm from the ureteric-bladder junction. There are several ureteric bladder reimplantation technique. The Lich-Gregoir technique was initially imagined in pediatric surgery in cases of ureteric reflux.

Objective: To describe the Lich-Gregoir technique and its use in gynecologic oncology surgery.

Material and methods: Two patients with a laparoscopic radical hysterectomy performed for early cervical cancer have developed a low ureteric fistula probably because of thermal ureteric injury or devascularization.

Results: The 2 fistulas have developed at 3-4 weeks after radical surgery. Both patients experienced urine leakage through the vagina. After methylene blue test injected into the bladder as excluded a vesico-vaginal fistula an uro-CT has confirmed a left uretero-vaginal fistula close to the bladder. In both patients the placement of an urinary stent by cystoscopy was unsuccessful. So, a ureteral-bladder reimplantation was planned. The Lich-Gregoir technique was used in both patients. No intra or postoperative complications were encountered. Both patients were discharged after the 10th post operative day after the removal of bladder catheter.

Conclusions: The Lich-Gregoir technique is a reliable technique that can be used for urinary complications in gynecologic surgery.

Keywords: uretero-vaginal fistula, cervical cancer, ureteric-bladder reimplantation

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TECHNIQUES OF PERINEAL DEFECTS CLOSURE AFTER RADICAL SURGERY

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Background: Perineal defects following radical surgery pose a significant reconstructive challenge due to their complexity and the need for functional and aesthetic restoration. Understanding the variety of surgical options available, based on defect characteristics, is critical in surgical planning and patient care

Objective: The objective of this study is to describe and evaluate the effectiveness of various surgical techniques, including rhomboid flap, lotus flap, V-Y flap, and VRAM flap, for the closure of perineal defects following radical surgery.

Material and methods: In a tertiary university clinic, various techniques were utilized to close perineal defects.

Results: The study found that adherence to key conditions—well vascularized tissue, no tension at the suture line, careful surgical technique, and rigorous antiseptic care—resulted in no intra or postoperative complications. Specific techniques were preferentially used depending on defect size: rhomboid flaps for small defects, V-Y flaps for larger posterior, lateral, or anterior defects, and musculocutaneous flaps, such as VRAM or gracilis, for the largest defects.

Conclusions: This study underscores the vital role of specialized surgical knowledge in gynecology oncology, particularly in plastic surgery techniques, for effectively addressing perineal defects. The ability to select the appropriate technique, tailored to the defect's size and location, is crucial for ensuring optimal surgical outcomes and patient recovery.

Keywords: Perineal Defects , Surgical Techniques , Radical Surgery , Flap Reconstruction , Gynecology Oncology

TOTAL LAPAROSCOPIC RADICAL HYSTERECTOMY IN CERVICAL CANCER

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Background: The oncologic safety of laparoscopic radical hysterectomy is a contentious topic in recent years in the specialized literature. This refers to the debate surrounding the extent to which laparoscopic radical hysterectomy ensures safety in terms of cancer-related outcomes. The controversy may involve discussions on the effectiveness and reliability of this surgical approach in achieving oncological goals, and it reflects ongoing research and differing perspectives within the medical community.

Objective: The assessment of recent data on laparoscopic radical hysterectomy.

Material and methods: A PubMed search was conducted to retrieve relevant articles published within 2020 to 2023. The results of this search can be crucial for staying up to date on recent advancements, research findings, and developments in the chosen subject matter.

Results: Considering a minimally invasive approach is advisable primarily for low-risk tumors (size < 2 cm and clear margins post-conization). The preferred and standard method for radical hysterectomy involves an open abdominal approach. Results from a prospective randomized trial indicated that minimally invasive radical hysterectomy had lower rates of disease-free survival (DFS) and overall survival compared to the open abdominal approach. Recent epidemiological studies also found that minimally invasive radical hysterectomy was associated with shorter overall survival in patients with stage IA2–IB1 cervical cancer. Additionally, individuals who underwent minimally invasive surgery without prior conization had a 5.63 times higher likelihood of relapse compared to those opting for an open approach with prior conization.

Conclusions: The feasibility of total laparoscopic radical hysterectomy is explored for invasive cervical cancers measuring less than 2 cm. It is preferable to perform this procedure in patients who have undergone a prior conization.

Keywords: radical hysterectomy,cervical cancer, laparoscopic

CAN SARS-COV-2 OR COVID-19 VACCINE LEAD TO NEW ONSET OF RHEUMATOID ARTHRITIS?

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Background: COVID-19 had changed the outcome of the old and new patients. Vaccines had been developed to prevent the onset of the disease. New cases of autoimmune diseases, especially rheumatoid arthritis were reported after the onset of the disease or after the vaccination.

Objective: Rheumatoid arthritis is a systemic inflammatory autoimmune disease that can lead to disability. Our main aim was to raise awareness about the possible connection between the SARS-CoV-2/ COVID-19 vaccine and the developing of rheumatoid arthritis (RA).

Material and methods: A retrospective, observational study was performed in the Rheumatology Department of the Emergency County Hospital of Targu Mures. A numbered of 4000 patients were included in the study starting from December 2020 until may 2023. The demographic data as age, ethnicity, gender, co-morbidities, the onset of the disease, patients meeting the classifications criteria for RA, the presence or the absence of COVID-19 disease or vaccination were noted. The data were collected and submitted to the MedCalc software.

Results: We identified 518 patients that fulfilled the classification criteria for RA. Out of them 10.25% developed RA after the disease onset and 2.85% after the vaccination. The PubMed data base showed a 37.62% of exposed to COVID-19 patients developed RA and a number of 2 case reports of onset of RA post COVID-19 vaccination.

Conclusions: The results obtained showed an unexpected incresead number of new onset of RA, similar with the data published. As for incriminating the vaccine as a risk factor for RA, we didn't have substantial data from the literature as well as from local data base.

In summary, the need of complete data bases with released results concerning new onsets of autoimmune diseases are needed.

Keywords: SARS-CoV-2, rheumatoid arthritis, COVID-19 vaccine

CYANOGENIC VS. NON-CYANOGENIC CHDS IN DIGEORGE SYNDROME

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Background: DiGeorge syndrome also known as Velocardiofacial Syndrome (VCFS) is caused by microdeletion 22q11 and forms a series of anomalies that include: Cardiac anomalies, Facial anomalies, Thymic hypoplasia, Cleft palate, and Hypocalcemia. DiGeorge is the most common chromosomal microdeletion syndrome, representing 0.050%, most being sporadic cases.

Objective: This study aims to find a correlation between Cyanogenic Congenital Heart Defects (CHDs) and the DiGeorge Syndrome.

Material and methods: We conducted a retrospective, observational study on a group of 8 patients with DiGeorge, hospitalized throughout the years 2017-2022 in the Neonatal Intensive Care Unit (NICU) of the Emergency Clinical Hospital Targu Mures, a tertiary care hospital. The statistical analysis was conducted using Microsoft Excel and GraphPad 9.5.1, by applying the exact Fishers test.

Results: This study shows that from 8 births presenting CHDs and DiGeorge Syndrome, cyanogenic CHDs were present in 62.5% (6) of them and non-cyanogenic in only 38% (2). The studied professional literature, reports that non-cyanogenic CHDs are predominant with an average of 85% of all cases. We report that after statistically analyzing the data, we found it to be of statistical significance ($p=0.0081, p<0.05$), our cases presenting a minority in non-cyanogenic CHDs.

Conclusions: Although our study showed statistical significance through the data analysis, for a study to really prove this there is a need for a larger pool of subjects.

Keywords: DiGeorge, CHD, Cyanogenic, Non-Cyanogenic

HEMOLITYC UREMIC SYNDROME (HUS), A COMPLICATION OF FOOD POISONING, THAT CAN LEAD TO KIDNEY FAILURE

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Background: Hemolytic uremic syndrome (HUS) is a rare but serious disease that causes erythrocyte destruction, which can lead to kidney failure. The main cause is diarrheal infection (usually with Escherichia coli), and rarely, it can be a hereditary disorder of cobalamin C metabolism.

Objective: This study aimed to emphasize the importance of screening individuals who had previously had an episode of food poisoning and were at a 'high risk' for kidney failure as a consequence of HUS. These include the elderly, children younger than five years, people with weakened immunity systems, and pregnant women.

Material and methods: To gather information, materials were retrieved from PubMed, National Kidney Foundation, and Google Scholar using the keywords "hemolytic uremic syndrome", "food poisoning" and "kidney failure". The information presented was carefully selected from the most recent articles from around the world that were specifically related to infection with Escherichia coli as a cause of hemolytic uremic syndrome.

Results: The results of the analysis showed that about 2-7% of E. Coli O157 infections lead to HUS. Even if the percentage is very low, most of the persons who already had an episode of food poisoning and are vulnerable do not consider HUS a possible complication. These can eventually progress to this disease and, in most cases, to kidney failure. If kidney function goes below 10 percent of normal, the patient will require dialysis or a kidney transplant.

Conclusions: It would be beneficial to this category of patients if they could prevent a possible new infection by regular screening and proper food safety measures.These simple tests can prevent another food poisoning that can lead to HUS and kidney failure, and even if patients recover, there will still be significant organs damage.

Keywords: hemolytic uremic syndrom, food poisoning, kidney failure

NEUROLOGICAL EFFECTS OF GLUTEN CONSUMPTION IN PEOPLE WITH UNDIAGNOSED CELIAC DISEASE OR NON CELIAC GLUTEN SENSITIVITY (NCGS)

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Background: Gluten structure contains peptides that can trigger gluten-related disorders, including celiac disease and non-celiac gluten sensitivity (NCGS). In patients with these conditions, peptides can cause intestinal damage, severe malabsorption and nervous manifestationsas as a consequence.

Objective: The purpose of this study was to significance of gluten sensitivity testing, particularly in infants, because of the common symptoms of celiac disease or NCGS and other neurological disorders.

Material and methods: To gather information, materials were retrieved from Web of Science, PubMed, and Google Scholar using the keyword “gluten sensitivity.” The information presented was carefully selected from the most recent articles from around the world that were specifically related to the neurological effects of these conditions. Additionally, an article on a child with celiac disease who was misdiagnosed with autism was analyzed.

Results: The results of the analysis showed that, on average, people with gluten-related neurological symptoms were diagnosed almost 10 years later than those with intestinal symptoms. The National Institute for Health and Care Excellence (NICE) recommends that healthcare professionals consider testing for gluten sensitivity in people with “unexplained” neurological symptoms. These symptoms range from severe headaches (42%), anxiety and depression to gluten ataxia and peripheral neuropathy. If infants are not treated for gluten sensitivity, they may develop speech disorders, slow thinking, and cognitive difficulties.

Conclusions: Although there is still much to know about gluten sensitivity, it is certain that neurological symptoms can occur without the appereance of gastrointestinal ones. It would be beneficial to this category of patients if the deferential diagnosis included gluten sensitivity testing. This simple procedure would ease the burden of living a life complicated by undiagnosed symptoms.

Keywords: gluten sensitivity testing, celiac disease, gluten ataxia

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ENDOSCOPIC REMOVAL OF SELF-INFLICTED URETHRAL FOREIGN BODY - CASE REPORT

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Background: The discovery of foreign bodies in the urethra and bladder are quite common lately, even though in the literature there were not many cases described in the past. The majority of self introduced foreign bodies occur in an erotic-sexual environment, but there may be other reasons: psychiatric pathology, therapeutically, accidentally etc.

Objective: The aim of this report is to approach a case of a 51 years old male patient who went to the Emergency Service complaining of penile pain for about a month. The pain appeared after the insertion of two metal bodies in the urethra that he could not recover.

Material and methods: Detailed history revealed that he introduced that objects in order to maintain the erection. It is important to emphasize that the patient suffers of mental retardation. A radiographic examination was performed which reveals the existence of some radiopaque objects present at the level of the membranous urethra. The laboratory analyzes indicated leukocytosis, the urine summary – hematuria, leukocyturia and the urine culture test confirmed the presence of 3 different types of germs.

Results: Endoscopic extraction of the 2 objects (confirmed to be approximately 10 cm nails) was performed under spinal anesthesia with mechanical dilatation of the bulbar stricture. No areas of injury or active urethral hemorrhage were evident. Antibiotic therapy was initiated with Cefrtiaxon (7 days) and, in addition, anti inflamatories and analgesics.

Conclusions: The patient showed a favorable post-surgical evolution, good general condition, diuresis maintained with spontaneous voiding, clear urine and was discharged with medical recommendations, psychiatric ones being very important.

Keywords: Foreign body in urethra, endoscopic extraction, radiopaque objects, mental retardation

SPLENECTOMY FOLLOWING A GIANT SPLENIC ANEURYSM – CASE REPORT

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Background: The splenic artery is defined as aneurysmal when a focal dilatation is observed in its diameter of greater than 50% compared to the normal vessel diameter. True splenic artery aneurysms (SAAs) involve all layers of the wall, each of which is intact and thinning. Modifiable risk factors include atherosclerosis, portal hypertension, pregnancy and connective tissue disorders such as Marfan syndrome.

Objective: The aim of this report is to approach a case of a 68 years old patient who was transported to the hospital by the SMURD mobile intensive therapy service, complaining of continuous diffuse abdominal pain. Following the tomography investigation, a voluminous round-oval structure of approximately 81 mm in axial plane located retropancreatic and in contact with the splenic hilum was detected, most likely a giant dissected aneurysm of the splenic artery.

Material and methods: The patient was transferred to the operating thetare of the general surgery department, being in a state of hemorrhagic shock due to the rupture of that aneurysm. During surgery, the diagnosis was confirmed and the presence of a massive hemoperitoneum (3500 ml of blood) was found, which was recovered with "Cell-Saver" and autotransfused to the patient. Splenectomy was performed, opening and exploration of the aneurysm with closure of a splenopancreatic branch, through its suture, peritoneal lavage and multiple drainage. The histopathological description confirms the clinical diagnosis.

Results: The postsurgical evolution was favorable, with the balancing of vital functions, under complex antibiotic treatment, blood transfusions and vasoactive support. The patient was discharged surgically cured and with recommendations.

Conclusions: The aneurysm of the splenic artery endangers the patient's life, but if it is diagnosed early, there is hope for the patient's complete recovery by implementing the surgical and clinical treatments required by the case.

Keywords: giant splenic aneurysm, splenectomy, dissecting aneurysm

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THE IMPORTANCE OF MAGNETIC RESONANCE IMAGING ULTRASOUND TARGETED FUSION PROSTATE BIOPSY

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Background: The gold standard technique in diagnosing prostate cancer (Pca) was the 10 to 12 core systematic transperineal or transrectal biopsy, ultrasound guided. Due to the multiple false negative results obtained by the classic systematic biopsy of the prostate, the MRI targeted prostate biopsy brings changes in the accuracy of the diagnosis of Pca.

Objective: The objective of the case is to demonstrate the accuracy and improvement of the diagnosis of Pca by performing an ultrasound targeted biopsy with MRI fusion.

Material and methods: We report a case of a 67-year-old patient with core systematic transrectal prostate biopsy performed 10 months ago for imagistic-MRI suspicion of Pca, where the ASAP result was revealed. PSA value was 6.2 ng/ml in the present. Another MRI was performed that revealed a nodule, 8 mm length, located at the apex of the right lobe of the prostate that is suspect for Pca Following the MRI result, it was decided to practice an ultrasound-targeted fusion prostate biopsy.

Results: The result of the histopathological examination of the target nodule indicates a prostate adenocarcinoma, Gleason score of 3+3=6, cT2aN0M0, ISUP 1.

Conclusions: Magnetic resonance imaging ultrasound targeted fusion prostate biopsy provides information with higher specificity for the diagnosis of Pca. Optimal results are highlighted by overlapping the images obtained by MRI and ultrasound.

Keywords: Ultrasound-targeted fusion prostate biopsy, Pca, Gleason score

MINIMALLY INVASIVE SURGERY FOR HIGH-GRADE UPPER TRACT UROTHELIAL CARCINOMA - A CASE BASED REPORT

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Background: Upper urinary tract urothelial cell carcinoma (UTUC) is a relatively rare form of cancer that develops in the lining of the renal pelvis, ureter, or both. It is found in 5-10% of the patients, more frequently diagnosed in men over 70, with a 2/100.000 incidence. Laparoscopic nephroureterectomy (LNU) has similar oncological and surgical results, as the open nephroureterectomy(ONU), but faster recovery and shorter hospital stay.

Objective: The objective of this paper is to emphasize the advantages of the laparoscopic approach in the surgical treatment of upper urinary tract carcinomas.

Material and methods: We present the case of a 57-year-old male patient, admitted to the Urology Clinic with macroscopic haematuria and left lumbar pain. The patient has a history of right kidney percutaneous nephrolithotomy performed for a pelvic stone of 7 mm and obesity with a BMI of 45,2. Computed tomography(CT) scan revealed a tumoral mass of 22/28 mm dimensions, grade II hydronephrosis of the left kidney, no sign of distant or lymphonodular metastasis. We performed laparoscopic left nephroureterectomy with partial cystectomy through transperitoneal approach with 3 trocars. Operating time was 140 min. Histopathological results revealed a papillary urothelial carcinoma with a high grade of malignancy-G3, invading the subepithelial connective tissue of the left renal pelvis, stage pT1NxMxR0, resection margins not infiltrated by the tumor.

Results: No intraoperative or postoperative complications were encountered. There was minimal blood loss (50 ml) and the surgical drain was successfully removed after 48 hours. The patient was discharged on the 4th postoperative day.

Conclusions: The laparoscopic approach has many advantages that include the possibility of preparing the ureter up to the bladder without endoscopic time, respecting the oncological limits, the better visualization of anatomical structures, short length of hospital stay, minimal blood loss, decreased surgical side pain, and shorter postoperative convalescence.

Keywords: UTUC, laparoscopic nephroureterectomy, haematuria

TOTAL HIP ARTHROPLASTY FOR RAPIDLY PROGRESSIVE OSTEOARTHRITIS OF THE HIP - A CASE BASED REPORT

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Background: Rapidly progressive osteoarthritis of the hip(RPOH) is an orthopedic condition characterized by the quick degeneration of the hip joint, mainly in women over 60. This condition is known for its rapid progression to joint disability, involving severe damage to the femoral and acetabular structures. The etiopathogenesis of RPOH is not well understood, adding to the difficulty in early diagnosis due to the absence of specific laboratory, pathological, or radiological markers at the onset of the disease.

Objective: The primary goal of this study is to describe the distinct clinical symptoms of RPOH and evaluate the effectiveness of various treatment strategies.

Material and methods: We present the case of a 70-year-old female who initially presented on August 2023 with a non-traumatic, activity-induced hip pain without radiographic signs of joint degeneration. A subsequent evaluation in October 2023 revealed severe pain, diminished joint mobility, muscle atrophy, and limb shortening. Diagnostic imaging showed extensive femoral head collapse, cartilage loss, subchondral cystic changes, and reduction in joint space. Elevated inflammatory markers(CRP and ESR), iron-deficiency anemia, and a urinary tract infection were also observed. Assessments using the Western Ontario and McMaster Universities Osteoarthritis Index(WOMAC) and Harris Hip Score(HHS) were conducted before and after surgery to measure functional impairment and recovery.

Results: The patient underwent total hip arthroplasty(THA) following the treatment of anemia and UTI. Preoperative WOMAC and HHS scores indicated severe hip dysfunction, and postoperative scores demonstrated significant improvements. The WOMAC score improved from 24 to 96, and HHS increased to 85 out of 100, indicating a substantial reduction in pain, stiffness, and functional limitations.

Conclusions: This case highlights the importance of early recognition and treatment of RPOH. THA, whether cemented or cementless, is effective in restoring joint function in RPOH patients, as evidenced by the improved postoperative WOMAC and HHS scores.

Keywords: RPOH, femoral head collapse, THA, WOMAC Score

GIANT INCISIONAL HERNIA UPON LOCALLY ADVANCED DOUBLE LOCATION, ENTERAL AND LEFT COLIC SQUAMOUS CARCINOMA COMPLICATED WITH ENTEROCUTANEOUS HERNIA PERFORATION AND FISTULA

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Background: Squamous cell carcinoma of the small intestine is a rare form of cancer (less than 0.2% of malignancies of the gastrointestinal malignancies), a disease of unclear etiology and dismal prognosis.

Objective: The surgery improved the quality of life via a surgery meant to relieve the digestive obstruction in a patient depending on parenteral nutrition.

Material and methods: A 70-year-old patient with a particularly heavy surgical history presented with intestinal obstructive episodes in context of multiple relapsed giant incisional hernia, complicated in the last sixth months by the development of an enterocutaneous fistula in this area, with enteral stenoses attributed peritoneal adhesions inducing severe malnutrition and secondary anemia. He associated COPD and obstructive jaundice treated by ERCP with sphincterotomy. A colonoscopy was performed confirming diverticula and a descending colon ulcer. Biopsy revealing squamous cell carcinoma. Surgery encountered a hostile abdomen, the intraoperative surprise being a huge tumor mass, which invades the distal half of the small intestine, the adjacent abdominal wall (altogether with the enterocutaneous fistula opening), in addition to the known colic tumor. Cattell-Braasch type colo-mesenteric detachment was performed enabling en bloc complex enterectomy with partial ablation of the mesentery root associating segmental splenic angle colectomy and cholecystectomy. Entero-enteral and colo-colic isoperistaltic and latero-lateral anastomoses were performed.

Results: Entero-mesenteric-parietal monobloc excision surgery, colectomy and the restoration of digestive continuity made possible the resumption of oral nutrition, solved the fistula and restored to some extent and partially autonomised the patient, affected however by the severity of the pulmonary comorbidities.

Conclusions: The double reconstruction of the digestive tract made oral nutrition possible, solved the fistula problem, the abdominal volume being substantially reduced by surgery, a single layer abdominal closure was sufficient to treat incisional hernia as well.

Keywords: enteral squamous cell carcinoma, external digestive fistula, giant eventration

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A GIGANTIC SPLEEN CASE IN A PATIENT WITH ACUTE MYELOID LEUKEMIA

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Background: Acute myeloid leukemia is a type of cancer which occurs from the malignant transformation of the myeloid stem cells or myeloid progenitors. It is characterized by the rapid growth of abnormal cells and is more common in adults and very rare in children under the age of 15.

Objective: We aim to present the consequences of an acute leukemia on the spleen, the largest lymphatic organ in the human body and their treatment.

Material and methods: A 65 year old male was admitted in the Hematology unit accusing frequent infections, prolonged bleeding caused by a minor cut, lack of appetite and fatigue. The complete blood count raised the suspicion of a possible acute leukemia, baring in mind that after just three days the number of white blood cells reached almost 40 thousands per microliter. The diagnosis has been established using bone marrow aspiration and biopsy. Furthermore, the CT scan showed a gigantic spleen, surpassing the liver, pressing on the abdominal organs. It was decided to proceed with a splenectomy, considering it was disturbing the life of the patient and also having a great risk of breakage, a potentially lethal complication.

Results: Preoperative embolization of the main splenic artery was performed one day prior in order to reduce the vascular flow to the spleen. It was difficult to remove, because it was tightly attached to its adjacent structures and it weighted 6,3 kilograms, taking into consideration that the average is around 20 grams. One day postoperative, he had a bleeding identified on the drain, which was solved by performing another embolization on the remaining of the splenic trunk.

Conclusions: In conclusion, even though the surgery was successfully done, the acute leukemia could not be cured and the patient passed away several months after.

Keywords: AML, splenectomy, proliferation, gigantic

PACEMAKER STRATEGY IN LESS 2KG CHILDREN

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Background: Pacemakers are electric activity generating devices used to treat patients with bradycardia or symptomatic heart blocks and in patients with heart failure. In very low birth weight, early pacing strategy is required in congenital complete heart block.

Objective: Our objective is to implant transitory epicardial leads to a neonate of 1,6 kg for the reason that the weight is not sufficient and the dimension is not adequate for a normal pacemaker.

Material and methods: The newborn suffers from third-degree atrioventricular block, her mother is known to have systemic lupus erythematosus, an autoimmune condition affecting multiple systems. In pregnancy, fetal heart block is the most common manifestation. Temporary epicardial pacing wires are used during 1–3 months, until the body weight reaches 2 kg for pacemaker implantation. The systems that can be used in insertion of pacemakers are: transvenous, epicardial and leadless systems. In our case, it has been used the epicardial system where the electrodes attach directly to the heart`s surface and generate direct stimulation through the pulse generator. Since the newborn weighted 1600g, the operating team decided to use a short-term solution and insert temporary pacing electrodes and after two months chose implantation of a pacemaker when the child weighted 3200g.

Results: After the first intervention, whereas external temporary pacing wires are implanted, the baby develops harmoniously and gets the required weight for the permanent pacemaker. She also responded well to the second intervention and had no remarkable complications.

Conclusions: External pacing can be a fast and easy solution to neonates born premature with the weight less than 2kg. This procedure is not considered a long-term solution but is effective until permanent pacemaker can be implemented due to not having a lot of risk.

Keywords: Temporary pacemakers, fetal heart block, epicardial system

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SURGICAL TREATMENT OF MASSIVE ANGIOMYOLIPOMA- CASE REPORT

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Background: Renal angiomyolipoma is a benign tumor composed of three main elements: adipose tissue, smooth muscle cells and vascular elements.

Objective: The aim of this paper is to present the case of a patient with right angiomyolipoma that compresses the neighboring organs.

Material and methods: A 70 years old female patient showed up to the Gastroenterology Clinic accusing chronic constipation and loss of appetite. After the performance of abdominal-pelvic CT with contrast agent, a right renal tumor formation is revealed, in the cT2bN0M0 stage, measuring 147x119mm, making compression on neighboring organs. On October 18th, 2023, under general anesthesia with orotracheal intubation, right total nephrectomy is performed.

Results: The histopathological exam reveals a solid, apparently encaps tumor structure, with the appearance of adipose tissue and non-homogeneous on the section, that affects the renal parenchyma. Based on these criteria, the diagnosis of angiomyolipoma was established.

Conclusions: Although the angiomyolipoma usually needs just the patient's follow-up due to its favorable prognosis, in this case the late detection and chronic constipation required a total nephrectomy.

Keywords: angiomyolipoma, renal tumor, chronic constipation, total nephrectomy

GASTRIC NECROSIS:CASE REPORT IN A IMMUNOSUPPRESED PATIENT

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Background: Gastric necrosis is a life threatening condition resulting from insufficient blood supply and ,consequently oxygen to the tissue,with various etiologies such as ischemia due to sepsis,shock and thromboembolism,or as a result of volvulus and vasculitis.

Objective: The aim of our presentation is to highlight the role of the endoscopy in evaluating the treatment for increasing necrosis of the stomach.

Material and methods: We present a case of a 42 year old man with a 20 year history of type 1 diabetes who underwent a kidney transplant three years ago due to end stage renal failure. As part of his chronic treatment ,he receives antihypertensive medications, prednisolone and tacrolimus.He was urgently admitted with epigastric pain and tenderness,tahycardia and abdominal distension. CT revealed increased thickness of the gastric wall without signs of perforation and with a normal appearance of the transplanted kidney. A nasogastric tube was placed for gastric decompression.Resuscitation with fluids,esomeprazole and antibacterial treatment with vancomycin and meropenem was initiated.Endoscopy confirmed the necrotic and ischemic appearance in 2/3 of the antrum .Sucralfat 4x20 ml was added to the treatment .On the 5th day of follow up ,endoscopy revealed a slight regression of necrosis with improvement in abdominal examination and a return to normal of acute phase reactants.In the 5th week, it was observed that ischemic changes in the mucosa had completely regressed,and the patient is currently asymptomatic.

Results: The regression of gastric necrosis in an immunosuppresed patient is relatively rare and depends on the triggering cause of ischemia ,the time of pacient treatment and the effectiveness of it ,which could not be defined without the periodic checkup of endoscopy.

Conclusions: Although ,gastric necrosis is a a morbid condition,our pacient is a living proof that with appropriate and timely treatment,it can have a favorable prognosis.

Keywords: endoscopy,immunosuppresed,gastric necrosis,ischemia

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GATROSCHIS: CLOSING THE GAP, A CASE REPORT

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Background: Gastroschisis is a congenital birth defect characterized by an opening in the abdominal wall through which the intestines protrude. Unlike omphalocele, another abdominal wall defect where the abdominal organs are covered by a sac, in gastroschisis, the intestines are exposed directly to the amniotic fluid. The surgical approach varies based on the baby's overall health and stability. This surgery is usually performed soon after the birth, but it can be postponed, depending on the surgeon's judgment.

Objective: The main objective of this case report is to highlight the importance of closing the abdominal wall defect with primary suturing using bilateral lateral-abdominal release incisions.

Material and methods: We present the case of a female premature newborn from a non-monitored pregnancy, delivered through C-section. In the delivery room, an abdominal wall defect (gastroschisis) was discovered, which was surgically repaired. However, the postoperative course was not favorable, with the following symptoms: repeated vomiting and absent bowel sounds. In response to these issues, the feeding was modified, leading to a significant improvement in the patient's general condition. Additionally, a DSA was identified, but it is not causing any issues.

Results: After the closure of the abdominal wall defect, the patient started to show favorable progress after 2 weeks. The frequency of vomiting decreased consistently, and the presence of bowel movements was noted, with an upward trend in weight curve. Consequently, the antibiotic therapy for the newborn is discontinued, as there are no clinical or paraclinical signs of infection.

Conclusions: In the end, the patient is transferred from the Neonatal Intensive Care Unit (NICU) to the Pediatric Surgery Department to monitor the postoperative progress of the baby girl. She is in good general condition, afebrile, with pink skin, normal cardiac and respiratory values, a clean and dressed postoperative wound, tolerating appropriate feeding (approximately 70 ml per feed, every 3 hours). The patient can be discharged.

Keywords: gastroschisis, premature newborn, bilateral latero-abdominal release incisions

INCIDENTAL DISCOVERY: ASYMPTOMATIC OSTEONECROSIS OF THE SECOND METATARSAL HEAD IN A YOUNG PATIENT WITH HALLUX VALGUS

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Background: Metatarsal bones are long bones located in the middle part of the foot, playing an important role in providing support for the arch of the foot. Osteonecrosis of the second metatarsal head is a not so common condition which tipically is described as the death of bone tissue, often associated with vascular insufficiency. This case explores an incidentally discovered asymptomatic case of osteonecrosis in a young patient who presented with another foot pathology, hallux valgus.

Objective: The primary objective is to report and document a case of asymptomatic osteonecrosis of the second metatarsal head and its association with hallux valgus in a young patient. Secondary objectives include understanding the natural course of the osteonecrotic lesion and determining any potential impact on hallux valgus management

Material and methods: A young female patient with no history of trauma or systemic conditions presented with hallux valgus deformity. During preoperative imaging for hallux valgus correction, an incidental finding of osteonecrosis of the second metatarsal head was made. Radiographic evaluation, including X-rays and magnetic resonance imaging, was performed to assess the extent and characteristics of the osteonecrotic lesion, also known as Freiberg infraction or Kohler II disease.

Results: The patient underwent successful hallux valgus correction surgery, and the asymptomatic osteonecrotic lesion was monitored without specific intervention. Postoperative follow-up revealed resolution of hallux valgus deformity, and the osteonecrotic lesion exhibited stability and limited progression. The patient showed no symptoms during the whole observation period.

Conclusions: Asymptomatic osteonecrosis of the second metatarsal head can coexist with other foot pathologies, such as hallux valgus, in young patients. Management decisions should be individualized, considering the limited progression and lack of manifestations in cases of incidental osteonecrosis. This case emphasizes the importance of thorough preoperative imaging and tailored treatment plans for optimal patient care.

Keywords: metatarsus, hallux valgus, necrosis

CASE REPORT - SYNCHRONUS RECTAL ADENOCARCINOMA AND PULMONARY ADENOCARCINOMA

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Background: Rectal and lung cancer are some of the most frequent cancer types, but cases that highlight synchronous rectal and lung tumours were rarely treated in literature.

Objective: This case report aims to present a rare case of a pacient with synchronous adenocarcinoma of the lungs and rectum.

Material and methods: We present the case of a-67-years-old male who came to consult accusing rectal bleedings. A colonoscopy has been made and it revealed the presence of a rectal mass, situated at approximately 10 centimeters after the anal orifice, from which a biopsy was collected. The histopathological investigation revealed an adenocarcinoma. In the same time, on the thoracic-abdominal-pelvic CT a tumorous mass of 2 centimeters in diameter has been found on the superior pulmonary lobe. A biopsy was collected under CT guidance from the pulmonary nodule, the histological diagnosis revealing a non-small cell carcinoma. The first surgery consisted in the Dixon laparoscopic resection of the rectum and sigmoid, with end-to-end colo-rectal anastomosis. A month later, after a favourable post-surgery evolution, another intervention was performed for the pulmonary carcinoma, resulting in a right bilobectomy of the middle and upper part of the lung.

Results: After a complication-free post-operative evolution, the pacient continued neo-adjuvant chemotherapy in the oncology department. The histopathological exam of the removed pieces, for both rectum and lung, revealed an adenocarcinoma.

Conclusions: Even though finding a tumorous mass situated in the lungs on patients diagnosed with rectal cancer is most frequently due to metastases, the clinician must take into consideration the presence of a synchronus lung cancer.

Keywords: synchronous adenocarcinoma, rectum, lung.

FRACTURE AND MIGRATION OF A PORT CATHETER IN THE HEART

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Background: Central venous access devices play a vital role in clinical medicine for delivering various treatments such as antibiotics, cytotoxic medicines, blood products, and parenteral nutrition. Port-A-Cath is an implantable vascular access device that consists of a catheter and a fixed chamber, used to infuse drugs.

Objective: We present a case of a 54-year-old man with stage 4 colorectal adenocarcinoma who received radiotherapy and chemotherapy trough a port-a-cath. The patient was referred to the cardiovascular department presenting fractured and migrated chemotherapy catheter.

Material and methods: The port catheter fractured and moved from the superior vena cava through the right atrium and eventually into the right ventricle. The port-a-cath was successfully removed using an endovascular approach, via the right femoral vein under local anesthesia. The fixed chamber was surgically removed using a percutaneous retrieval technique under local anesthesia.

Results: Early detection of such issues is crucial, and chest radiography or angio-CT scans are recommended. Prompt removal of the migrated catheter is necessary to avoid life-threatening arrhythmias. Postoperative echography showed no damages after the removal of the port catheter.

Conclusions: While not frequently discussed, complications such as catheter fractures and cardiac migration can pose a serious risk to patients, occurring in roughly 0.1% of cases. Timely identification and appropriate surgical intervention can be effective in preventing further complications. Patients should also be advised to avoid rigorous physical activity that could put excessive strain on the shoulder. In one instance, we successfully managed a case involving a port catheter fracture that had migrated to the right chambers of the heart, using a hybrid approach, combining both endovascular and surgical techniques.

Keywords: Port-A-Cath, heart, fracture, migration.

A RARE CASE - STERNAL METASTASIS OF SEROUS OVARIAN CARCINOMA

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Background: The ovarian cancer represents one of the most common women malignancies. It usually is an aggressive tumour that frequently gives distant metastases.

Objective: This presentation aims to highlight an extremely rare case of sternal metastasis of an ovarian cancer discovered eight years ago.

Material and methods: We present the case of a-71-years-old female diagnosed with low-grade serous ovarian carcinoma 8 years ago, for which curative surgery was performed at that time, associated with adjuvant chemotherapy with Paclitaxel, Carboplatin and Bevacizumab. The patient reports a progressively growing formation on the left anterior thoracic wall. The craniothoracic-abdominal-pelvic CT revealed the presence of an 89x62 mm tumoral mass on the left anterior thoracic wall which originates in the sternum and invades the left pectoral muscle, without any other thoraco-abdominal macroscopic pathological lesions. The multidisciplinary team has decided that the best treatment is the surgical excision of the tumor. The surgical resection of the sternum was made en bloc with the tumour, followed by the reconstruction of the sternum with polypropylene net and two steel bars.

Results: The pacient was discharged 10 days later, after a complication-free post-operative evolution. The histopathological examination of the resection piece revealed the sternal metastasis of a serous ovarian cancer.

Conclusions: Despite the fact that the extensions of ovarian cancer to the thoracic wall are extremely rare, it needs to be taken into consideration for patients who present thoracic wall tumors and have had ovarian cancer in the past.

Keywords: Ovarian carcinoma, sternal tumor, metastasis.

BEYOND THE VEIL: A UNIQUE PRESENTATION OF SYNCHRONOUS OCCULT BREAST CANCER

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Background: Synchronous bilateral breast cancer is a scarce breast carcinoma (1-3%) defined as the presence of invasive or in situ different tumors that arise in both breasts within 6 months.

Occult breast cancer is a rare form of breast cancer (0,1-3%) characterized by metastasis in the axillary lymph nodes without any evident primary breast lesion.

Objective: The objective of this case is to illustrate the approach to handling a unique and uncommon breast carcinoma.

Material and methods: We present a case of a 51-year-old woman who was admitted to the hospital for a right breast nodule mammographically diagnosed in late 2022. Clinical examination revealed congestion in the central quadrant of the right breast, with no axillary adenopathies. The left breast displayed normal conformation but a noticeable left axillary adenopathy. The right breast ultrasound showed an imprecisely delimited hypoechoic plaque with included microcalcifications and a few axillary lymph nodes. The left breast ultrasound showed left axillary adenopathy with tumoral aspect. A biopsy was performed for both tumors. Pathological examinations established the diagnosis of right breast NST invasive carcinoma and left metastasis of micropapillary carcinoma. The imaging evaluation did not indicate secondary lessions.

Results: The multidisciplinary team decided for neoadjuvant treatment followed by surgical intervention. Upon being presented with the options together with the plastic surgeon, the patient chose bilateral radical mastectomy. The pathological examination of the surgical specimens confirmed the diagnosis of synchronous and occult breast cancer with a good response to the neoadjuvant treatment, especially the axillary adenopathy from the site of the occult breast cancer.

Conclusions: The management of breast occult and synchronous carcinoma underscores the important role of a biopsy for contralateral axillary adenopathy, providing vital insights for accurate diagnosis and informed treatment decisions.

Keywords: Synchronus breast cancer, Occult breast cancer, Radical mastectomy

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LOW GRADE APPENDICEAL MUCINOUS NEOPLASM- A CASE PRESENTATION

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Background: Appendiceal mucinous neoplasm is a rare disorder that doesn’t show a specific symptomatology and for this reason it is usually misdiagnosed at first. Out of all appendicectomies this pathology represents around 0.2-0.7%.

Objective: The objective of this case presentation is to highlight the importance of a correctly conducted treatment and to pay great attention to the possibility of the presence of an appendicular neoplasm that is masked by the symptoms of acute appendicitis.

Material and methods: We introduce the case of a 48 year old male who presented himself at the emergency department with the typical symptomatology of acute appendicitis and was admitted in 06.05.2023., at the surgical department 1 of the Clinical Emergency Hospital Targu Mures.

Results: The histopathological diagnosis showed low grade appendiceal mucinous neoplasm with acellular mucin that dissects the appendicular wall and extends on the surface of the serosa. The margin of the surgical resection is free of epithelial injury but with the presence of acellular mucin on the surface of the serosa. The stage of the tumor was: pT4a.

Conclusions: The chosen treatment in this case should be an appendectomy with a partial resection of the cecum, with great care to avoid perforation of the appendiceal wall which could lead to the dissemination of neoplastic cells or mucus in the peritoneum, thus excluding the possibility of developing peritoneal pseudomyxoma.

Keywords: acute appendicitis, appendiceal mucinous neoplasm, peritoneal pseudomyxoma.

LATE COMPLICATIONS OF URETERAL STENTING: A CASE STUDY AND MANAGEMENT STRATEGIES

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Background: Ureteral stents have an indispensable status in urological practice. Progressively longer indwelling times increase the risk of major complications including calcification and cellular adhesion, which favor urinary tract infection and stone formation.

Objective: Our goal is to highlight the late complications associated with ureteral stenting and their management.

Material and methods: We present a case involving a 75-year-old patient with a medical history of a substantial abscessed cyst in the right kidney, which was drained in 2020, bilateral renal lithiasis, CKD, grade II right hydroureteronephrosis, and a right ureteral stent implanted in 2020, with the recommendation for its removal in the following year. On September 19, 2023, the patient sought emergency care, reporting right lumbar pain. Subsequent investigations, including laboratory tests and CT scans of the abdomen and pelvis, revealed leukocytosis, thrombocytopenia, hepatocytolysis, anemia, and a positive urine culture. Imaging displayed calcification throughout the entire surface of the right ureteral stent and grade II right hydroureteronephrosis. The chosen therapeutic approach involves replacing the right ureteral stent. However, due to the mentioned complications, this cannot be safely performed. Therefore, the selected surgical strategy included Punch lithotripsy at the distal loop and two sessions of ESWL on the proximal loop, resulting in partial fragmentation of the stones. Despite these interventions, attempts to extract the ureteral stent were unsuccessful.

Results: After the procedures were conducted, the patient's condition improved, the right lumbar pain subsided, and the laboratory constants normalized. She is scheduled to attend follow-up appointments for ongoing specialized treatment that aims to address the remaining calcified portion by utilizing ESWL or ureteroscopy and the replacement of the right ureteral stent.

Conclusions: Calcification of stents poses a significant challenge for endourologists, and indwelling times should be minimized in order to prevent complications.

Keywords: Ureteral stent, ESWL, Punch lithotripsy.

MANAGEMENT OF A MULTIPLE TRAUMA WITH PELVIC AND SPINAL FRACTURE - INTERDISCIPLINARY APPROACH

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Background: Multiple trauma cases are often result from high-energy impacts. Typically, pelvic fractures are associated with spine injuries in these type of pacients and due to their complexity , such lesions require an interdisciplinary team for a better outcome.

Objective: This case report aims to highlight the high degree of difficulty that polytrauma presents from orthopedic perspective

Material and methods: We present the case of a 54 year old patient who arrived at the emergency room with anterior and posterior spinal fracture associated with left pelvic fracture caused by a crushing polytrauma. After hemodynamic stabilization, the patient underwent a first surgery conducted by a mixt team consisting of orthopedic and general surgeons. An arcuate incision was performed above the iliac crest to remove a retroperitoneal hematoma and the left iliac vein was sutured . The iliopsoas was dislocated in the wound and fracture reduction was achieved using osteosynthesis with a plate , three screws in the iliopubic ramus and six screws at the level of left iliac crest, After 5 days, our patient underwent a second surgery with the purpose of achieving fracture reduction and osteosynthesis of the left iliac crest by using another plate and six screws

Results: The postoperative evolution was favorable, with the patient being afebrile, hemodynamically and respiraotrily stable, and a decrease in local pain, the surgical wounds in the process of healing

Conclusions: In summary this case report sheds light on the intrincate challenges posed by polytrauma pacients. The successful collaboration between orthopedic and general surgeons in the initial surgery reflects the crucial role of an interdisciplinary approach.

Keywords: polytrauma osteosynthesis interdisciplinary approach.

TOTAL HIP ARTHROPLASTY FOR ADVANCED CROWE TYPE IV DYSPLASIA : EFFICACY, OUTCOMES, AND LONG -TERM FOLLOW-UP IN A YOUNG PACIENT

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Background: Coxarthrosis, a deteriorative joint disease affecting the hip, can be resulting from developmental dysplasia of the hip (DDH). In cases of advanced DDH with a Crowe classification, total hip arthroplasty (THA) becomes a crucial intervention. This case report explores the management of coxarthrosis secondary to severe congenital hip dysplasia in a young patient with advanced Crowe type IV dysplasia.

Objective: The primary objective is to assess the efficacy and outcomes of total hip arthroplasty in a patient with advanced Crowe type IV dysplasia. Secondary objectives include evaluating postoperative pain, functional improvement, and radiographic outcomes.

Material and methods: A retrospective examination was carried out on a young female patient diagnosed with advanced Crowe type IV dysplasia. Preoperative assessment, surgical details, and postoperative follow-up data were collected. Functional outcomes were measured using validated scoring systems, and radiographic assessments were performed to evaluate implant positioning and joint stability.

Results: The patient underwent successful total hip arthroplasty, with meticulous attention to surgical technique and implant selection. Post-operative assessments revealed significant pain relief, improved hip function, and radiographic evidence of restored joint congruency. The patient demonstrated satisfactory outcomes in terms of mobility and quality of life during the postoperative monitoring phase.

Conclusions: Total hip arthroplasty proves to be an efficient and practical treatment option for advanced Crowe type IV dysplasia, providing substantial pain relief and functional improvement. Long-term follow-up is essential to monitor implant durability and patient satisfaction in this specific population.

Keywords: Dysplasia, Arthroplasty, Hip Function

UNVEILING THE UNCOMMON: POLYTRAUMA ARISING FROM NEUROLOGIAL PATHOLOGY – SUICIDAL ATTEMPT CASE REPORT

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Background: Polytrauma cases often have multiple causes, typically being associated with accidents. However, some cases are more unique, with the neurological pathology of the patient being the primary cause

Objective: The objective of this report is to draw attention to the atypical etiology of multiple trauma, specifically a suicidal attempt.

Material and methods: We present the case of a 25 year old woman who arrived at the emergency department with multiple injuries and a sudden onset of restricted movement as a result of a fall from the 4th floor, indicating a suicidal attempt. After clinical and radiological examination she was diagnosed with polytrauma due to defenestration, comminuted fracture type IIIA with bone loss of the left calcaneus, left ischio-pubic and ilio-pubic branch fracture and fracture of vertebral L1. Intraoperatively, a lack of bone substance and contamination of the wound with soil was observed at the level of the left calcaneus . She was transferred to the Neurosurgery department for the repairing of the vertebral body where it was noted that the wound had infected(microbiological examination being positive for Pseudomonas Aeruginosa). After targeted antibiotic therapy, our patient underwent a second surgery. This time the mixed surgical team composed of Orthopedics and Plastic Surgery performed debridement of the wound, excision of devitalized and septic soft tissues and application of negative pressure wound therapy (Vivano). She was immobilized in a postoperative plaster cast. Plastic Surgery covered the remaining skin defect with a graft harvested from the left inguinal region.

Results: Favorable wound evolution, with effective wound healing and control of infection was achieved . As the patient is discharged with improved surgical status and ongoing healing process, a psychiatric consultation was requested.

Conclusions: In summary this case report underscores an uncommon but significant factor for polytrauma cases - neurological pathology.

Keywords: polytrauma suicidal attempt neurological pathology

BIFOCAL FEMUR FRACTURE MANAGEMENT: A CASE REPORT

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Background: Fractures involving both the proximal femur and the femoral shaft, known as bifocal femoral fractures, are considered infrequent, with reported prevalence rates ranging approximately between 1% and 12%. Vascular injury after femoral shaft fractures is a life-threatening complication, occurring in 2% of patients.

Objective: The aim is to emphasize the unpredictability and complexity involved in the treatment of high-energy traumas.

Material and methods: This case involves a 41-year-old patient who experienced a fall from height resulting in a right subtrochanteric femur fracture and a comminuted diaphyseal fracture. Surgical intervention was conducted, involving open reduction and internal fixation using an intramedullary nail system with proximal locking using two screws. Intraoperatively, an aggressive diaphyseal bone fragment causing secondary injury to the posterior perforating veins was observed, requiring urgent involvement of the vascular surgery team. Once effective hemostasis had been accomplished, stabilization of the posterior diaphyseal fragment was achieved using an orthopedic cable. Due to moderate to severe intraoperative hemorrhage, the decision was made to close the wound without distal nail locking. Subsequently, a secondary intervention was performed 4 months later to address complications. The second surgery involved a thorough pseudoarthrosis cure, open reduction of the fracture, and further osteosynthesis with locking plates, screws, and additional orthopedic cables for enhanced stabilization. A bone substitute was introduced to rectify the remaining bone defect.

Results: At discharge, the patient displayed favorable conditions following successful surgical treatment. Partial weight-bearing is expected after 6-8 weeks, anticipating complete healing within 6 months. Full recovery and restoration of movement depend on the patient's adherence to physiotherapy.

Conclusions: This case emphasizes the challenges in managing complex fractures associated with high-energy trauma and vascular injuries. Sequential interventions were necessary to manage complications such as pseudoarthrosis and bone defect, leading to a satisfactory outcome for the patient.

Keywords: Traumatic injury, bifocal femur fracture, orthopedic surgery

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SIMULTANEOUS BILATERAL TOTAL HIP ARTHROPLASTY (SBTHA) IN A SELECTED PATIENT: CASE REPORT

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Background: Total hip arthroplasty (THA) is one of the most successful orthopedic procedures in recent decades. However, there are still disagreements if to perform simultaneous BTHA or staged bilateral THA. Although SBTHA has low complication rates, great patient satisfaction, and is cost-effective, some believe that performing SBTHA during the same anesthetic session is related to increased morbidity and difficult rehabilitation.

Objective: This case report presents an ideal patient for SBTHA who had a fast recovery from surgery after a long preoperative illness.

Material and methods: Our patient is a 52-year-old male, with elevated risk factors for femoral head avascular necrosis (FAVN) – history of smoking, alcohol consumption, corticosteroid use who had a reduced range of motion (ROM) – Harris Hip Score (52), and pain for 3 years-bilateral hip osteoarthrosis secondary to FAVN Steinberg stage IV A. SBTHA was chosen, the patient was placed in a supine position, spine anesthesia and femoral block was made. Surgery was performed with an anterolateral approach, and uncemented titanium hip endoprosthesis with an oversized ceramic head and 40 mm insert was used. Surgery time was 180 minutes "skin-to-skin", with patient repositioning. Blood loss (600ml), tranexamic acid used intravenously. Femoral block was used for postoperative pain management, with no drains and for the prevention of deep vein thrombosis, a multimodal approach was employed.

Results: Post-op, early mobilization at 18 hours with partial bilateral weight bearing. Full weight bearing at 7 weeks, body weight squats and lunges at 12 weeks, and almost normal ROM - Harris Hip Score (93). Very good radiological osteointegration at 12 weeks.

Conclusions: SBTHA is a valuable option for the treatment of bilateral hip osteoarthritis in a carefully selected patient. Benefits of this procedure include excellent clinical results, high patient satisfaction, a single anesthesia, and a shorter overall recovery time that accelerates the return to everyday life and work.

Keywords: Total hip arthroplasty, hip arthritis, ceramic hip, HHS

AORTO-FEMORAL BYPASS IN A STAGE 4 PERIPHERAL ARTERIAL DISEASE

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Background: Peripheral Arterial Disease is a condition characterized by the narrowing or blockage of the arteries that supply blood to the extremities, most commonly the inferior ones, the primary cause being atherosclerosis.

Objective: We aim to present the consequences of cumulative risk factors on the peripheral vascular system and their possible treatment.

Material and methods: A 58 year old male, who was diagnosed several months prior with Peripheral Arterial Disease stage 4 Fontaine, is accusing severe pain and cramping in the gluteal region, thighs and calves at rest, which debuted 2 years ago. At the clinical examination, we could observe ischemic trophic ulcerations affecting the fingers and the distal third of the right calve, which is a common characteristic for such an advanced stage. He is known for having Type 2 Diabetes insulin-dependent for 20 years, essential hypertension, ischemic cardiomyopathy, heart failure class 2 NYHA and chronic tobacco addiction, all combined significantly increasing the risk of a vascular disease. In our clinic, he was diagnosed with Leriche Syndrome which classically presents with a triad of claudication, impotence and absence of femoral pulses alongside occlusion of the left common iliac artery by performing a CT Angiography scan.

Results: After a Fogarty embolectomy was attempted, without success, they proceeded with a median laparotomy, reaching the peritoneal cavity first and then the retroperitoneum where they discovered a severe calcification of the aorta and the iliac arteries bilateral. The decision was to perform a left aorto-femoral bypass using a Dacron graft.

Conclusions: Early detection and management of PAD are crucial to reduce the risk of complications and the need for amputation. Regular medical check-ups, especially for individuals at risk, can help in the early identification of PAD, allowing for timely intervention and better outcomes.

Keywords: PAD, risk factors, bypass, Leriche Syndrome

SEVERE VARUS AND POOR BONE QUALITY TOTAL KNEE ARTHROPLASTY: CASE REPORT

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Background: Knee arthroplasty is required for severely damaged knee joints with poor alignment and limited range of motion to live a normal life. Varus deformity is common in knee arthritis, and proper alignment is required for optimum function and long-term implant survival, with total knee arthroplasty (TKA) serving as the gold standard.

Objective: The aim of this case report is to present a TKA in an elderly and obese patient with severe varus knee arthritis, osteoporosis, and high cardiovascular risk.

Material and methods: An 87-year-old female with obesity (BMI=37), osteoporosis, high blood pressure, ischemic heart disease, and aging spine syndrome presented to the orthopedics department complaining of knee pain and difficulty walking. She was advised to have TKA but postponed the procedure for several years until walking became impossible (Oxford Knee Score pre-op = 16). We chose a cemented revision implant (Smith & Nephew rotating hinged knee) for the TKA due to more than 27 degrees of varus misalignment, multifactorial osteoporosis, multidirectional joint instability, and poor rehabilitation potential. We considered this implant to be the first choice for a fast and low-complication surgery with a good functional result and long-term survival due to good primary bone fixation in the meta diaphyseal area and a constrained central pivot. General anesthesia with a femoral block was used. Surgery time: 88 minutes, 450 ml of blood loss controlled with tranexamic acid. No intraoperative or postoperative complications.

Results: Early mobilization with partial weight bearing 24 hours after surgery. Full weight bearing at 3 weeks, normal gait at 8 weeks, mechanical axis corrected by around 20 degrees, great patient satisfaction and mobility (Oxford Knee Score 6 weeks post-op), and adequate radiological integration. Oxford Knee Score 6 weeks post-op = 32.

Conclusions: Revision TKA implants are a suitable option for knee arthritis cases with severe misalignment and poor bone quality to achieve fast functional results, with revision implant drawbacks such as wear and tear and a lower long-term survival rate as secondary consequences.

Keywords: Total knee arthroplasty, severe varus, revision TKA

NAVIGATING THE CHALLENGES OF TREATING POLYTRAUMA PATIENTS WITH MULTIPLE PELVIC INJURIES- A CASE REPORT

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Background: Pelvic injuries are notorious for their potential to lead to rapid exsanguination and multiple complications. Every 3 minutes of hemodynamic instability increases the mortality rate in pelvic fractures by 1%.

Objective: The main objective was the therapeutic management and treatment of a polytrauma patient with multiple pelvic injuries.

Material and methods: I examined the case of a 52-year-old man who was admitted to the emergency department with a complex pelvic crushing injury. Imaging assessments revealed a left anterior column acetabular fracture, accompanied by moderate displacement of the iliac wing and multiple retroperitoneal hematomas. The contrast pelvic CT revealed also an active extravasation and we suspected a corona mortis rupture. Subsequent arteriography of the left external iliac artery showed a minor contrast blush. A catheter embolization procedure was conducted on the corona mortis, successfully stopping any further signs of active bleeding. Considering the patient's relatively stable hemodynamic condition, we conducted an open reduction and internal fixation procedure under radiological guidance. The primary goals were to prevent further bleeding and to restore the normal anatomical structure of the hip bone. To address the anterior column fractures through open reduction and internal fixation, we employed an ilioinguinal approach, starting from the periphery and working towards the center. This involved lag screw osteosynthesis, plate fixation of the iliac crest, and the application of a pelvic brim neutralization plate. The iliopsoas and retroperitoneal hematomas were uncomplicated and of moderate volume, leading us to choose a conservative treatment.

Results: The individually customized therapeutic approach and treatment have led to a successful recovery without any post-operative complications. Antibiotics and anticoagulants to prevent deep vein thrombosis were administered. We also added indomethacin to prevent heterotopic ossification.

Conclusions: Effectively managing these critical injuries demands a multidisciplinary team using all available resources and an algorithmic approach that considers the severity of the injuries and surgical risks.

Keywords: acetabular fracture, corona mortis rupture, osteosynthesis

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LONG GAP ESOPHAGEAL ATRESIA, ANORECTAL MALFORMATION WITH CARDIAC MALFORMATION – THE ROLE OF PEG – CASE PRESENTATION

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Background: Esophageal atresia is a congenital medical condition characterized by the incomplete development of the esophagus.

Objective: The main goal of this case report is to underscore the significance of gastrostomy for feeding using the PEG method (nutritional support and aspiration prevention) and the importance of cervical esophagostomy for salivary diversion in a long gap esophageal atresia patient.

Material and methods: We present the case of a newborn male delivered through a C-section who was transferred to the Pediatric Surgery Department due to an anorectal malformation. An exploratory laparotomy and colostomy were performed, and he was then transferred to the NICU with the following signs: an acoustic stethoscope revealing absent bowel sounds, recurrent nasogastric tube insertion into the esophagus, air-filled dilatation of the small intestine and colon, and apnea episodes. Additionally, in the cardiac examination, a left-to-right atrial septal defect and a persistent arterial duct were identified. A consultation with pediatric surgery revealed that the patient had esophageal atresia. After this diagnosis, surgery was performed. Given the long gap form, end-to-end anastomosis was not possible, so gastrostomy and cervical esophagostomy were performed.

Results: The postoperative evolution was initially clinically and paraclinically favorable, with a decrease in acute-phase reactants. However, feeding proved challenging, and the child exhibited a descending weight curve. The patient's overall condition worsened, prompting a consultation with pediatric surgery, and a reintervention was performed, including exploratory laparotomy, gastrostomy, adhesiolysis, and jejunal lavage. The patient was transferred from the pediatric surgery operating room in a critically ill general state. After a few days, the patient experienced a cardio-circulatory arrest that did not respond to resuscitation maneuvers.

Conclusions: Despite the unfavorable evolution of the patient, PEG and cervical esophagostomy proved to be valuable instruments for feeding and salivary diversion.

Keywords: gastrostomy, cervical esophagostomy, colostomy

PENTALOGY OF CANTRELL OR NOT?

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Background: An omphalocele is a congenital abdominal wall defect in which the intestines, liver, and occasionally other organs protrude outside the abdomen and are covered only by peritoneum. Treatment usually involves surgery to place the abdominal organs back into the abdominal cavity and close the opening. The timing and approach to surgery depend on the size of the omphalocele and associated medical conditions. One of the rarest association is the Pentalogy of Cantrell, where defects of the heart, pericardium, diaphragm, sternum, and abdominal wall are present.

Objective: The main objective of this case report is to highlight the importance of extended left subcostal laparotomy, reduction of the stomach from the thoracic cavity into the abdominal cavity, surgical repair of the anterior diaphragmatic hernia, closure in layers.

Material and methods: We present the case of a newborn male weighing 2580 mg, delivered through cesarean section with suspicion of a intrauterine diaphragmatic hernia and omphalocele. It is noted that the vesicular murmur is present only unilaterally. The baby is transferred to the intensive care unit for further investigations. The overall condition of the newborn is severely affected with cyanotic skin. Subsequently, a consultation with the pedriatric surgery department is requested, confirming the diagnosis of omphalocele and diaphragmatic hernia. Additionally, in the cardiology consultation, the presence of dextrocardia and an atrial septal defect with right to left shunt is noted. Untipical Cantrell Pentalogy is suspected after surgery due to the absence of pericardium.

Results: After the surgery, the patient is transferred from the operating room in a severely compromised general condition without anesthesia reversal, FiO2-40%, Vt-15, Peep-4, RR-34, Sp-99%, the presence of bilateral vesicular murmur is observed. After 48 hours anesthesia is reversed and started feeding, promising evolution.

Conclusions: In conclusion, the newborn, initially presenting with suspicion of intrauterine diaphragmatic hernia and omphalocele, exhibited a pre-surgery unilateral vesicular murmur. Following a diagnosis confirmation and surgical intervention, the baby, despite postoperative challenges, displayed a notable shift with the emergence of bilateral vesicular murmurs. Contrary to the complexity of malformations the evolution is spectacular.

Keywords: ompaholcele, diaphragmatic hernia, malformations

COMPREHENSIVE THERAPEUTIC MANAGEMENT OF POLYTRAUMA: A CASE STUDY OF MULTISYSTEM INJURIES FOLLOWING A MOTOR VEHICLE ACCIDENT IN AN ELDERLY PATIENT

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Background: Polytrauma occurs when a patient sustains multiple injuries, some of which may result in significant disability and even be life-threatening. Worldwide, the most common cause of polytrauma is motor vehicle accidents.

Objective: The primary objective was to provide therapeutic management and treatment for a polytrauma patient who had suffered a car accident.

Material and methods: I reviewed the case of a 68-year-old woman admitted to the emergency department with multiple organ injuries following a car accident. After conducting several radiographic examinations, a CT scan, and a 3D CT reconstruction, we diagnosed hemothorax, splenic contusion, a transverse left humeral fracture, an open left tibial and fibular fracture, and a right radiocarpal dislocation. Initially, we focused on stabilizing the patient's hemodynamics and ensuring the stability of the splenic injury and hemothorax. For the transverse humeral fracture on the left, due to fragment movement, we performed external fixation followed by an open reduction and internal fixation with plates and screws. The type 1 right radiocarpal dislocation was stabilized after a closed reduction, and immobilization with a cast was prescribed. The type 1 left open distal tibial and fibular fracture (Gustilo and Anderson classification) featured a clean wound smaller than 1 cm with no skin crushing. Immediate open reduction and internal fixation (ORIF) were performed on the fibula and tibia, involving osteosynthesis with plates and cortical screws. All neurovascular structures were decompressed and returned to their anatomical positions.

Results: Prompt evaluation of the injuries and swift action led to a recovery without major complications. Postoperatively, the patient received antibiotic therapy and conservative treatment for the hemothorax and splenic contusion. She was discharged after 20 days and advised to undergo a progressive mobilization.

Conclusions: The management of polytrauma patients has significantly evolved in recent decades, owing to the development of trauma systems, improved pre-hospital assessment, transport, and in-hospital care. These advancements, supported by complementary investigations, have contributed to a notable decrease in mortality rates.

Keywords: polytrauma, fracture, open reduction, internal fixation

MANAGEMENT OF COMMINUTED TIBIAL PLATEAU FRACTURE IN A GERIATRIC PATIENT: A CASE REPORT

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Background: Tibial plateau fractures are a common type of injury that can occur because of falls or other trauma, and are usually more common in older adults, as bones become more brittle and in people who are overweight or obese, due to the extra joint stress.

Objective: The objective is to describe the successful management of a comminuted tibial plateau fracture of an elderly patient.

Material and methods: We present the case of a 74-year-old woman with grade 1 obesity, who came to the emergency room with a right tibial plateau fracture, resulted from a fall. Due to the case severity and complexity, a surgical approach is needed. CT investigations revealed a comminuted fracture of the right tibial plateau with displacement of bone fragments in the proximal third of the right fibula. Additionally, oedematous infiltration of adjacent soft tissues and fluid collection with hematologic densities were observed behind the right patella. The patient underwent surgery to repair the fracture. Double surgical approach was chosen, and L3-L4 spinal anaesthesia was performed. The fracture was reduced openly, and two titanium anatomical plates were used to stabilize it: one lateral in the shape of an “L” and one medial in the shape of a “T”, both with angular stability. The lateral plate was secured with seven screws, while the medial plate was fixed with two wide medial screws and two screws with angular stability. Intraoperatively, a significant degree of comminution with bone compaction resulting from the trauma and a comminuted fracture of the peroneal head were additionally identified.

Results: The patient presented an adequate recovery and regained her range of motion following physiotherapy.

Conclusions: The case study demonstrates the successful management of a comminuted tibial plateau fracture in geriatric patients using double surgical approach and open reduction with internal fixation.

Keywords: tibial plateau fracture, geriatric patient, open reduction, titanium anatomical plates

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RARE SOLITARY FIBROMATOUS TUMOR OF THE THIGH - CASE REPORT

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Background: Solitary fibrous tumor is a benign, rare tumor characterized by cell proliferation of soft tissues. It can be located in any part of the body, but has a greater affinity for the pleura or other serous structures.

Objective: The presentation of a rare type of solitary tumor located in the thigh.

Material and methods: We present the case of a 46-year-old male patient with a history of asthma, who comes to the surgery clinic for an appointment due to a formation of soft parts at the proximal level of the anterio-internal part of the thigh. The local examination reveals a prominent tumor formation of approximtely 7x7 cm, of a remittent consistency and irregular outline, adherent to the adjacent tissues. Laboratory tests show elevated urea and glucose levels. The treatment carried out is a surgical excision of the tumor formation. After the surgical intervention the formation is sent for a histopathological exam. The histopathological examination describes an encapsulated tumor with a translucent, irregular outer surface and an intact capsule. On section, the tumor presents a multinodular appearance. Microscopically, we observe hypercellular nodular areas, with spindle cells among small vascular structures. Increased mitoses are seen in hypercellular areas and small foci of necrosis. Immunohistochemical specific markers are positive.

Results: Following the histopathological and immunohistochemical examination, the diagnosis of a solitary tumor with an intermediate risk of progression is made at the level of the proximal 1/3 antero-internal part of the left thigh. The post-surgical evolution is good.

Conclusions: The occurance of a solitary fibrous tumor at the thigh level is very rare. The elective treament is a surgical one , and the diagnosis of certainty is made on the basis of the histopathological examination.

Keywords: benign, rare, solitary formation

THE APPROACH OF BILATERAL UROLITHIASIS ASSOCIATED WITH ACUTE KIDNEY INJURY

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Background: Urolithiasis is a medical condition characterized by the presence or formation of calculi within the urinary system. These calculi can manifest in various locations within the urinary tract, including the kidneys, ureters, bladder, or urethra.

Objective: The purpose of this case report is to present the approach of an unusual case of bilateral kidney obstruction with secondary acute kidney injury.

Material and methods: A 55-year old male, previously healthy, with no history of urogenital pathologies presented to the emergency department with a 2-3 days history of severe left flank pain, nausea and vomiting. Ultrasonography was performed and revealed bilateral moderate hydronephrosis. A non-enhanced computer tomography was then performed and showed a 13,86 mm obstructive ureteric calculus on the right side and a 19 mm kidney pelvic calculus on the left side. At the same time the right kidney appeared to be hypotrophic. Biochemical parameters showed serum creatinine 2.6 mg/dl, urea nitrogen 78 mg/dl and serum potassium 5.61 mmol/L.

Results: Following the diagnosis of bilateral obstruction and acute kidney injury, double "J" stents were placed bilateral. Following to this, extracorporeal shock wave litothripsy (ESWL) for the right ureteric calculus was performed and for the left kidney pelvic calculus was performed percutaneous nephrolithotomy (PCNL). Postoperative evolution of the patient was uneventful and stone free.

Conclusions: Urolithiasis is the most common cause for ureterohydronephrosis and without appropriate emergency care it can quickly develop into acute kidney injury (AKI). Non-invasive procedures as PCNL or ESWL have been shown to be highly efficent in the medical literature and our case does not prove otherwise.

Keywords: Urolithiasis, ureterohydronephrosis, ESWL, PCNL

FINANCIAL STRESS PROVOKED SCHIZOPHRENIA IN A 43-YEAR-OLD MALE

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Background: Schizophrenia is a chronic mental disorder. It is characterized by positive symptoms, such as delusions, bizarre behaviour, hallucinations and disorganized speech, as well as negative symptoms including flat or inappropriate affect, avolition, anhedonia and alogia. Schizophrenia is approximated to affect 1% of the population globally. Individuals with schizophrenia may have difficulty participating in everyday activities and engaging with other people. Lifelong pharmacological and psychosocial therapy can help manage the condition.

Objective: This paper aims to explore the case of a 43-year-old male diagnosed with schizophrenia triggered by stressed related to his prosecution in 2020.

Material and methods: The patient presented to the Psychiatric Department in Targu Mures, Romania in May 2023 with delusions of grandeur, prejudice, persecution, conceptual disorganization, slurred speech, anxiety and flattened affect. He was previously diagnosed with schizophrenia one-year prior to this episode. The onset of his symptoms occurred 2-years prior to the current episode, when he was prosecuted on the grounds of financial misconduct. His delusions are focused on this particular event. The patient is however, unaware of his condition. The diagnosis of schizophrenia was established according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria.

Results: The patient was hospitalized for two-months, during which he underwent four consecutive antipsychotic treatments with Risperidone, Aripiprazole, Quetiapine and Clozapine, with minimal alleviation of symptoms. The patient also participated in group therapy.

Conclusions: The exact causes of schizophrenia are unknown. Research suggests that genetics, family history, environmental factors as well as highly stressful or life-changing events may trigger schizophrenia. In most cases, the exact event provoking the onset of schizophrenia cannot be established. However, in the described case, the patients' delirium is focused on the particular event provoking the point of onset. Patients frequently try several medications before finding one that successfully manages their symptoms.

Keywords: Psychiatry, Schizophrenia, Psychosis, Antipsychotics

NUTMEG INDUCED PSYCHOSIS IN A 19-YEAR-OLD FEMALE

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Background: Nutmeg is harvested from the dried fruits of the Nutmeg Tree (Myristica fragrans). Its abuse for its hallucinogenic properties, which can be attributed to the naturally occurring compound Myristicin found in nutmeg, which shares structural similarities to MMDA and mescaline, is well reported in scientific literature and dates back to the Crusades. The first reported case of nutmeg poisoning occurred in 1576. Ingestion of over 5 grams can mimic symptoms of an anticholinergic toxic episode. These include hallucinations, palpitations, and feelings of impending doom.

Objective: This paper aims to explore the case of a 19-year-old female who presented in November 2023 to the Psychiatric Department in Targu Mures, Romania with psychosis after consuming large quantities of nutmeg.

Material and methods: The patient was previously diagnosed with two depressive episodes with suicidal tendencies and borderline personality disorder (BPD). She stopped medical treatment with Paroxetine 20 mg/day three-weeks prior to calling the emergency services thinking she was having a panic attack. However, she was psychotic and presented with visual and auditory hallucinations, severe anxiety as well as depersonalization with selective negativism and inhibition. The patient stated that the symptoms started after she consumed large quantities of nutmeg. She also has a 3-year history of self-harm and substance abuse with crystal, Delta-9-tetrahydrocannabinol (THC) and alcohol, both of which can be attributed to her BPD.

Results: The patient was admitted, and after three days of antipsychotic treatment with Paroxetine 20 mg/day, Risperidone 2 mg/day and Orfiril (Valproic Acid) 1000 mg/day, the patient stabilized and their hallucinations and delusions disappeared.

Conclusions: Nutmeg induced psychosis is prevalent in modern society. It is important to provide good supportive care as there is no antidote. Nutmeg poisoning should be considered in all patients presenting with an acute psychotic episode accompanied by symptoms resembling an anticholinergic toxic episode.

Keywords: Psychiatry, Nutmeg Poisoning, Psychosis, Antipsychotics

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INTRACARDIAC MASSES - ALWAYS A REASON FOR CONCERN?

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Background: Intracardiac masses represent an infrequent finding during ancillary imaging tests used for various cardiopathies. While tumors are an undesired result, thrombi or embryological remnants are regarded as more easily manageable formations.

Objective: The aim of this case report is to draw attention to the importance of utilising accurate imaging methods for proper characterisation of intracardiac masses.

Material and methods: We present the case of a 65 years old female patient with a medical history including primary hypertension and valvular disease, complaining about palpitations, exertional dyspnea, fatigue and atypical chest pain. She was admitted to the cardiology department, where she was diagnosed with atrial fibrillation with rapid ventricular response (Afib RVR) and heart failure NYHA class III. Transthoracic echocardiography revealed intracardiac masses in both atria. She was scheduled for cardioversion a month later, during this time receiving oral anticoagulation. Prior to cardioversion a transesophageal echo was performed, highlighting the persistence of the right atrial formation.

Results: In order to allow for a more detailed description of the intra-atrial mass the patient was referred to an MRI scan, which confirmed the presence of a hypertrophied crista terminalis, excluding neoplasia or an embryological remnant. Considering the harmless character of this finding, no other procedure was performed.

Conclusions: The discovery of intracardiac masses on basic cardiac imaging tests such as a transthoracic echocardiography should not raise concerns until more accurate investigations are performed. MRI is deemed as gold standard when describing intracardiac formations, which eventually made the diagnosis in our particular case.

Keywords: intracardiac mass, transesophageal, crista terminalis

INTERSTITIAL LUNG DISEASE IN DERMATOMYOSITIS: A PROGRESSIVE PATTERN?

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Background: Dermatomyositis (DM) is a multifactorial chronic autoimmune disorder with characteristic skin changes and involvement of different organ systems, including the muscles, blood vessels, joints, esophagus, and lungs. In terms of epidemiology, DM affects both children and adults. It is triggered by environmental factors like UV exposure, drugs, infections, and lifestyle choices in genetically susceptible individuals.

Objective: Our aim is to highlight the correlation between dermatomyositis and interstitial lung disease by performing biological and imaging investigations.

Material and methods: We present the case of a 52-year-old female patient known from her personal pathological history with dermatomyositis, type 2 insulin-requiring diabetes, and right mastitis, which was operated on in 1997. She was admitted to the Pulmonology Clinic with the following complaints: dyspnea on small efforts, astenia, and fatigue. The following investigations were performed: laboratory tests, myositis profile test, body plethysmography, impulse oscillometry, diffusion sb, chest x-ray, and computer tomography.

Results: The laboratory revealed elevated levels of proteins and LDH and an elevated VSH (inflammatory profile). Also, the myositis profile was positive for anti-Ro52 antibodies. The pulmonary function tests revealed a restrictive ventilation disorder, and the HRCT scan revealed interstitial lung disease with injury of non-specific type, predominantly basal localization with matte glass appearance and reticulations, without honeycombing. Periodic evaluations carried out at 6 months (functional tests, walking tests and clinical) showed no functional, clinical or imaging progression of interstitial lung damage.

Conclusions: The study aims to emphasize the role of dermatomyositis as an underlying disease in the progression of interstitial lung disease, and the high level of anti-Ro52 antibodies justifies the inflammation predisposing to the development of destructive processes in conjunctive tissue.

Keywords: dermatomyositis, interstitial lung disease, dyspnea, antibodies

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LEUKOCYTE DOUBLING TIME IN ACUTE MYELOMONOCYTIC LEUKEMIA- A CASE REPORT

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Background: AML is a malignant hematopoietic condition marked by the presence of mutations in genes encoding transcription factors crucial for the normal differentiation of myeloid cells. Neoplastic cells are ensnared in a state of suspended development at an early stage, leading to the accumulation of blasts in this region.

Objective: Our aim is to emphasize the atypical dynamics of biological parameters in the setting of clonal proliferation of myeloid precursors and the clinical impact on patient homeostasis.

Material and methods: We present a 40-year-old patient with an unknown medical history admitted on 02.08.2023 to the UPU-SMURD service due to loss of consciousness, severe fatigue lasting four days, pallor, and painful gingival swelling. At admission he presents leukocytosis: 280.230/μL with monocytosis: 222.510/μL, normochromic normocytic anemia, Hb: 11.20g /dL, thrombocytopenia: 56.000/μL and acute renal lesion: urea 36.38 mg /dL, creatinine: 2.35 mg /dL, GFR: 32.74 ml/min. The investigations included laboratory tests, blood smears, cell phenotyping, hormone and tumor marker immunology, and X-rays.

Results: On 03.08.2023, the patient presents marbled skin, petechiae and ecchymosis in the lower limbs constituted in the last 24 hours. The blood count reveals increasing leukocytes: 459.460/μL, worsening anemia: Hb 8.7g/dL and a ferritin of 9639 ng/mL. The blood smear suggests the presence of atypical cells: 89% in the blood, with monocytotic appearance, and in addition, cell phenotyping presents blasts expressing CD33: 99%, CD13:50% and CD15:71%, completing the immunophenotypic aspect of acute monocytic leukemia. The next day, the patient presents L: 415.030/μL, following cytoreduction, Hb: 7.3 g/dL, liver and kidney injury, urea: 47 mg/dL, creatinine: 3.67 mg/dL, GFR 19.5 ml/min, implanting dialysis catheter. The patient's condition deteriorated significantly, resulting in a subsequent declaration of death.

Conclusions: AML is a malignancy which replaces hematogenous marrow, compromising erythropoiesis and causing bone marrow insufficiency, negatively impacting prognosis.

Keywords: blasts, anemia, thrombocytopenia, monocytosis

PULMONARY INJURY IN MYOTONIC DYSTROPHY TYPE 2: STEINERT-CURSCHMANN SYNDROME

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Background: Myotonic dystrophy type 2 is characterized as an autosomal dominant syndrome, featuring disturbances in membrane excitability that lead to prolonged muscle contractions, subsequently resulting in impaired relaxation. Patients undergo multisystemic involvement, wherein the triad of muscle weakness, myotonia, and muscle atrophy is compounded by simultaneous issues in the pulmonary, cardiac, endocrinological, and ophthalmological regions.

Objective: Our aim is to underscore the established correlation between Steinert-Curschmann syndrome and concomitant pulmonary lesions, accentuating the multisystemic implications of this condition.

Material and methods: We present the case of a 54-year-old patient diagnosed with DM2 in 2016. The disease has directly impacted her heart, leading to diastolic dysfunction NYHA 2, ineffective left ventricle dilation and grade 1 mitral and tricuspid insufficiency. Additionally, she associates fertility disorders, having 2 spontaneous abortions in her past medical history and menopause installed at 36 years old. At the same time, endemic thyroid dystrophy with cystic degeneration is noted among the diagnoses of the patient. Upon presentation to the Pneumology department, she reports symptoms such as fatigue, cough with muco-purulent expectoration, paroxysmal nocturnal dyspnea and at progressively lower efforts, myopathic facies and abnormalities in movement. The following examinations were conducted: laboratory tests, chest CT, body plethysmography, diffusion SB test, and endocrinological assessment.

Results: Respiratory functional assessments unveil a restrictive pattern, while the imaging investigtions, including native CT and high-resolution CT, reveal nonspecific interstitial lesions characterized by “ground glass opacities” and multiple centrilobular pulmonary nodules, without evidence of a progressive phenotype.

Conclusions: Myotonic dystrophy type 2 is a rare pathology defined by the progressive, disseminating, and exacerbating nature of induced lesions, demanding an interdisciplinary approach to address its clinical impact. The etiological factor remains a source of uncertainty within the medical community.

Keywords: DM2, ground glass opacities, multisystemic implications

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MULTIDISCIPLINARY APPROACH TO A SEVERE CASE OF CROHN’S DISEASE

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Background: Crohn’s disease is an inflammatory bowel disease with numerous extraintestinal manifestations, immune-mediated, with chronically progressive evolution.

Objective: This report aims to present a case of Crohn’s disease with pancolonic and small bowel involvement with multiple and severe extraintestinal manifestations.

Material and methods: 34-year-old patient with severe first onset of Crohn’s disease with pancolonic and large bowel involvement 10 years ago. Initial therapy with azathioprine and 5-aminosalicylic acid loses it’s effect 4 years ago, patient presenting severe relapse. Anti-TNFalpha antibody therapy, adalimumab, is instituted with maintenance of remission for 3 years. The appearance of a complex perianal fistula requires treatment with mesenchymal stem cells, darvadstrocel, with favorable evolution. With loss of response to adalimumab she presents with severe relapse outbreak one year ago. Anti-integrin α4α7 antibody therapy, vedolizumab, is instituted with induction of remission, but with the development of a severe cytolytic and cholestatic syndrome. Liver imaging reveals choledochal stenosis, which resolves with endoscopic cholangiography and balloon dilatation. Liver biopsy reveals lesions of primary sclerosing cholangitis, moderate fibrosis. Therapy with ursodeoxycholic acid associated with PPAR-alpha agonist, fenofibrate, is instituted with improvement of the hepatic enzymes levels.

Results: Extraintestinal manifestations are the hallmark of severe forms of Crohn’s disease, requiring a careful positive and differential diagnosis. Therapy targeted at abnormalities of the immune response allows induction and maintenance of remission, control or cure of extraintestinal manifestations. The interdisciplinary approach makes it possible to make the most of existing therapeutic resources.

Conclusions: Targeted biologic therapy dramatically improves the course of severe Crohn’s disease with extraintestinal manifestations, curing or controlling potentially life-threatening manifestations or those with a major impact on quality of life. Positive, differential diagnosis and therapy of the disease is based on interdisciplinarity and knowledge of the immunological mechanisms involved.

Keywords: Severe Crohn’s disease, perianal fistula, sclerosing cholangitis

FUNGI IN BRONCHIECTASIS – A CASE REPORT

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Background: Bronchiectasis is a chronic inflammatory condition characterized by permanent bronchial lumen dilatation. An incomplete resolution of the recurrent bacterial infection and chronic inflammation, promotes fungal spore survival in the respiratory tract and play an important role in the progression of the disease. When compared to other Candida species, Candida glabrata seldom serves as an infectious agent and is found in normal respiratory flora.

Objective: Our aim is to highlight the correlation between bronchiectasis and fungal presence in pulmonary secretions through biological and imaging investigations.

Material and methods: We would like to present the case of an 83-year-old non-smoker female, without professional exposure, who was admitted to the Pulmonology department with hemoptysis, pain in the right hemithorax, heavy sweating and nausea. The patient had multiple hospitalizations in the last year and her medical history includes severe bronchial asthma, grade II high blood pressure, recent myocardial infarction (2023), stage II heart failure and eating disorders. Physical examination and laboratory investigations were carried out, without significant modification. The postero-anterior chest radiography revealed right basal bronchiectasis and a subcostal opacity in the right parahilar region. Additionally, a high-resolution computed tomography was performed which confirmed the presence of the bronchiectasis with cystic content, presumably aspergillomas, in the right inferior lobe.

Results: The next day, a bronchoscopy was performed and edema and bilateral purulent discharge in the bronchial mucosa were detected. The bronchial aspirate tested positive for Candida Glabrata colonies, prompting the start of specific antifungal medication with Flucozanol.

Conclusions: It Is known that bronchiectasis leads to impairment of immunity, and associated with old age and eating disorders can lead to opportunistic infections with agents that doesn't normally pose a treat to healthy individuals.

Keywords: bronchiectasis, fungal respiratory infection, Candida glabrata, impaired immunity.

UNRAVELING THE COMPLEXITIES: STRATEGIES AND DILEMMAS IN THE MANAGEMENT OF CROHN'S DISEASE

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Background: Crohn's disease, a chronic and inflammatory condition of the gastrointestinal tract, presents a challenge in medical management due to unpredictable flare-ups and a spectrum of symptoms ranging from abdominal pain to severe complications. This imposes a substantial burden on individuals and healthcare providers.

Objective: To raise awareness about the challenges this disease can impose.

Material and methods: A 63 years-old diabetic and hypertensive patient, treated in the last 3 months for a recurrent enterocolitis, was evaluated in Gastroenterology outpatient clinic complaining of diarrheal stools (more than 10/day) with mucus, colic pain in the hypogastrium and weight loss (20 kg in 3 months). The clinical examination reveals 2 perianal fistulas, pain on palpation in the hypogastrium and the left flank, raising suspicion of Crohn's disease. Mild leukocytosis, thrombocytosis, moderate iron deficiency anemia, hypoalbuminemia, increased inflammatory tests and fecal Calprotectin>1000 microg/g are easily detected. Abdominal ultrasound is performed which describes sigmoid parietal thickening, with signs of stenosis. Rectosigmoidoscopy is attempted but fails due to external compression, therefore the patient is referred for imaging. A tumoral process is identified in abdominopelvic CT and pelvic MRI, showing invasion through fistulization into the nearby ileal loop.

Results: The patient was sent to the surgery. Intraoperatively, a locally advanced sigmoid colon tumor was found with invasion in the last ileal loop and ileocolic fistula, without other macroscopically obvious secondary determinations at the level of the peritoneal cavity. Surgery was successfully completed.

Conclusions: In cases of repeated enterocolitis, it is essential to investigate potential underlying causes, such as inflammatory bowel disease or cancer. Therefore, a thorough clinical examination is crucial, focusing on specific indicators like weight loss and the presence of fistulas in our particular case. Despite the advancements made, Crohn's complexity necessitates ongoing collaborative research and a patient-centered approach for improved quality of life and therapeutic efficacy.

Keywords: Crohn's disease, Rectosigmoidoscopy, Fistulas

SOUND WAVES AND RENAL COMPLEXITY: EXPLORING THE CONTRIBUTION OF CONTRAST-ENHANCED ULTRASOUND (CEUS) IN DIAGNOSING COMPLEX RENAL CYSTS.

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Background: The Bosniak classification system, which categorizes renal cysts according to imaging features, aids in evaluating malignancy probability. Bosniak 4 cysts, characterized as complex renal cysts with a high likelihood of malignancy, typically exhibit a malignancy rate ranging from approximately 60% to 100%, indicating a substantial risk.

Objective: Contrast-enhanced ultrasound (CEUS) can play a valuable role in the evaluation of Bosniak 4 renal cysts. CEUS can provide additional information to help characterize the lesion and guide further management.

Material and methods: A female patient, aged 63 years old, previously known with a history of grade III hypertension, dilated cardiomyopathy, heart failure NYHA II/III, chronic kidney disease stage G5D KDIGO under the treatment with hemodialysis, normochromic macrocytic anemia, secondary hyperparathyroidism was admitted to the Emergency Department with dizziness, vertigo, headache and hypertension. She was transferred to the Nephrology department, where she was found with multiple cysts in both kidneys on thoraco-abdominal ultrasonography. One of the cystic formations shows pseudoparenchymatous mass inside, and Doppler USv cannot be performed due to movement artifacts. After one week a contrast-enhanced ultrasonography (CEUS) with SonoVue was performed.

Results: After the injection of 1.8 ml of contrast agent, a late uptake is observed into the restant renal parenchyma after 35 seconds and almost simultaneously the entry of bubbles is visualized also in the mass. The wash-out phenomenon is also late, but the vascular signal persists after 2 minutes. The lesion was also confirmed as vascularized by a CT scan, but the patient's condition did not allow the intervention.

Conclusions: Contrast-enhanced ultrasound (CEUS) addresses the limitations of traditional ultrasound, enabling real-time imaging of microperfusion with superior spatial and temporal resolutions compared to CT and MRI. It has previously demonstrated notable diagnostic precision in renal imaging, particularly in distinguishing renal masses and providing clarification for uncertain renal lesions.

Keywords: Contrast-enhanced ultrasound (CEUS), Renal cysts, Bosniak IV

A RARE CAUSE OF INFECTIVE ENDOCARDITIS AFTER MELODY VALVE IMPLANTATION IN A PEDIATRIC FALLOT PATIENT

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Background: Transcatheter pulmonary valve implantation (TPVI) is frequently necessary in children with right ventricular (RV) dysfunction after correction of tetralogy of Fallot (TOF). Infective endocarditis (IE) after TPVI remains a challenging adverse event. Although rare, Bartonella spp. are among the most common causes of culture-negative IE.

Objective: We describe Bartonella henselae culture-negative IE occurring 8-months after Melody valve implantation.

Material and methods: After an initial diagnosis of TOF, the patient was palliated in neonatal period and a complete repair was performed at the age of 18-months. Six months later, a18mm Contrega-conduit was used to reconstruct the RVOT for significant pulmonary regurgitation (PR). At the age of 13, the patient underwent Melody valve implantation for significant PR. Eight months later, the patient was admitted with signs of RV failure, without fever. Echocardiography revealed clear images of IE of the Melody valve with severe pulmonary valve stenosis. MRI detected dilated RV with low EF(28%). Due to rapid hemodynamic deterioration, he was transferred abroad, into an intensive care unit. Serial blood cultures were negative. In the context of right-sided valve IE, the decision was made to proceed with surgery while parenteral antibiotics were administrated. The foreign body material was removed, and the RVOT was reconstructed by homoplasy with a 23mm homograft. Bartonella henselae grew from the prosthetic tissue.

Results: The patient underwent an uneventful post-operative evolution with 6-week course of intravenous antibiotic treatment. Peri-operative echocardiography confirmed a normal functioning pulmonary valve homograft.

Conclusions: Right-sided prosthetic valve IE is not an uncommon complication and can be life-threatening. This case report highlighted the importance of a high index of clinical suspicion for Bartonella spp. in blood culture-negative endocarditis in patients with Melody valve endocarditis. Homograft remains the best surgical substitute in the context of right-sided prosthetic valve IE.

Keywords: Transcatheter valve prosthesis, infective endocarditis, tetralogy of Fallot

RARE COMPLICATION OF MULTIPLE MYELOMA: CARCINOMATOUS MENINGITIS - A CHALLENGING CASE REPORT

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Background: Carcinomatous meningitis represents the dissemination of malignant cells from the primary tumor to the leptomeningeal layers of the CNS. Leptomeningeal myelomatosis is a rare complication of multiple myeloma, occurring in less than 1% of patients.

Objective: This paper presents a case of refractory IgG Lambda Myeloma complicated by carcinomatous meningitis during third-line chemotherapy.

Material and methods: We describe the case of a 68-year-old male patient diagnosed with IgG Lambda Myeloma in March 2021. He underwent intensive treatment resulting in a very good partial response. In October 2023, while on Lenalidomide maintenance, he presented to the Emergency Department with peripheral facial paralysis and dysarthria. The CT scan showed a 15mm nodular lesion in the frontal intra-axial and left cerebellar region associated with satellite edema. The lesion was homogenous, intensely enhanced with contrast, suggestive of tumoral myelomatosis. Additionally, extra-axial enhancement in cerebral furrows indicated the association with meningitis, possibly carcinomatous in this context.

Results: As the patient's condition rapidly deteriorated, confirmatory lumbar puncture was not feasible due to cerebral involvement. Palliative care (Morphine & Midazolam) was initiated in the absence of diagnostic and therapeutic possibilities. Unfortunately, three days later, due to significant cerebral damage, the patient passed away.

Conclusions: Although rare, carcinomatous meningitis should be considered in patients with Multiple Myeloma, as there has been an increasing trend in this complication over the last decade. Regrettably, the prognosis remains bleak, offering limited therapeutic interventions, with an average survival of merely two months during treatment.

Keywords: Carcinomatous Meningitis, Multiple Myeloma, Complication

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ANTICONVULSIVANTS - FREQUENT TRIGGER FOR IDIOSYNCRATIC ADVERSE REACTION: A CASE REPORT

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Background: Idiosyncratic drug reactions are adverse effects that cannot be explained by the known mechanisms of action for the active ingredient, do not occur at any dose within the general population and are mostly unpredictable within susceptible individuals.

Objective: Our aim was to illustrate the importance of the appropriate aproach in the diagnosis process by presenting a case of idiosyncratic adverse reaction to carbamazepine.

Material and methods: We present a case of an 8-year-old girl, diagnosed with epilepsy and under treatment with Carbamazepine.

Results: The onset of actual disease started 2 days before the admitting, with fever and rash. Due to these symptoms, she was admitted to the Pediatrics Clinic for specialized tests. The physical examination highlights the presence of maculopapular exanthema on the anterior and posterior thorax, as well as the lower and upper limbs. The patient underwent for laboratory analyses test and a CT brain scan. In this case the laboratory test and the imagistic investigation did not revealed any patological findings. The neurological examination identified painful sensitivity in the frontal and ethmoidal regions to cranial percussion. The therapeutic treatment consisted in stopping the treatment with Carbamazepine. After the initiation of treatment with Diazepam and antiinflamatory terapy with Dexamethasone, a favourable clinical progression was observed. The patient was discharged in a state of good general condition with accompanying recommendations.

Conclusions: Based on this findings, the case was concluded as a manifestation of an idiosyncratic response to Carbamazepine in an 8-year-old female subject who had antiepileptic therapy roughly two weeks prior, after an episode of loss of consciousness

Keywords: Idiosyncratic drug reaction, Carbamazepine, diagnosis, child

FAVOURABLE OUTCOME IN TREATING ATOPIC ASTHMA WITH ANTI-IGE THERAPY – A CASE STUDY

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Background: Bronchial asthma (BA) is now the most common chronic condition in the industrial world, with atopic asthma being the most frequent form, causing significant health problems globally. For atopic sever uncontrolled BA when conventional treatments are unsuccessful, we may consider immunomodulation.

Objective: We would like to demonstrate the favourable outcome of treating an uncontrolled and severe atopic asthma with monoclonal antibodies anti-IgE therapy.

Material and methods: Case report of the complex treatment in a uncontrolled atopic BA. A 65 year-old male with BA, allergy to house dust and a history of a lung lobectomy due to congenital bronchiectasis presented in the Pulmonology clinic with dyspnea, wheesing, productive cough. He has an incompletely controlled BA since 2017 with multiples exacerbations, arterial hypertension, gastro-esophagian reflux, hyperuricemia and dyslipidemia. Clinical exam and paraclinic procedures revealed laryngitis, lung hyperinflation, diffuse crackels, emphysema and fibrosis and lobar bronchiectasis on chest x-ray, ventilatory severe obstructive disorder and low SaO2, hyperuricemia, dyslipidemia. In addition, cardiac investigations shown hypertension. Allergy tests revealed an allergic BA with increased IgE and eosinophils. The therapeutic plan for this patient was the add-on to the inhaled combination of corticosteroids and beta-2-simpatomimetics bronchodilators, a high dose of omalizumab 600mg every 2 weeks subcutaneously.

Results: The anti-IgE therapy led to significant improvements in lung function and Asthma Control Test questionnaire, as well as no adverse effects or exacerbations, including during the COVID period. The patient currently has had a favourable evolution over 2.5 years since the beginning of omalizumab.

Conclusions: This study underlines the success in our patient of anti-IgE therapy for severe atopic BA with recurrent exacerbations. Omalizumab treatment led to excellent control as well as no adverse effects, displaying high efficacy of this treatment for long time.

Keywords: atopic asthma, anti-IgE therapy, atopy

SYSTEMIC INVOLVEMENT IN SARCOIDOSIS: A CHALLENGE FOR THE MULTIDISCIPLINARY TEAM

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Background: Sarcoidosis, a granulomatous pathology known for its complex multi-system involvement, represents a challenge both in terms of establishing a diagnosis and from a therapeutic management standpoint. Sarcoidosis can affect any organ. Intrathoracic involvement occurs in 90% of patients. Common extrapulmonary manifestations include: skin lesions, uveitis, liver/splenic involvement, abdominal lymphadenopathy, peripheral arthritis.

Objective: The main objective is to highlight the correlation between sarcoidosis and associated pulmonary lesions, emphasizing the multisystemic implications of this pathology.

Material and methods: We present the case of a 37-year-old female patient diagnosed with stage II sarcoidosis. A series of examinations were conducted to establish the diagnosis, starting with the analysis of the patient's medical history, followed by clinical tests, radiological explorations, endoscopic examinations, respiratory function tests, as well as laboratory tests.

Results: The pathology begins with ocular edema and optic neuritis, along with diffuse inflammation of the tracheobronchial mucosa, without pleuropulmonary changes, showing multiple mediastinal lymphadenopathies, with gradual progression towards optic nerve atrophy and vision impairment in the right eye. This was accompanied by the appearance of a fibronodular lesion, in the upper left pulmonary lobe, and multiple micronodules with a sclero-fibrotic appearance, at the level of the right middle lobe. The diagnosis was supported by the results from the bronchoalveolar lavage. The current pneumological evaluation does not demonstrate the progression of pulmonary lesions from an imaging standpoint and neither does it show functional impairment in respiratory tests, which is why treatment was not initiated.

Conclusions: The presented case emphasizes both the diversity of manifestations and the complex evolutionary course, as well as the importance of a rigorous examination in order to establish the correct diagnosis, the necessity of constant monitoring to evaluate progression, and the need for a personalized therapeutic approach in patients with sarcoidosis.

Keywords: Sarcoidosis, Optic Neuritis, Mediastinal Lymphadenopathy, Granulomatous inflammation

CARING FOR THE 1%: NON-ALCOHOLIC TOXIN-INDUCED CIRRHOSIS – A CASE REPORT

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Background: Hepatic cirrhosis is the final, irreversible stage of various chronic liver diseases, characterized by inflammation and fibrosis of the liver. The leading causes of hepatic cirrhosis are non-alcoholic fatty liver disease, hepatitis B and/or C virus, followed by excess ethanol consumption, the remaining causes only accounting for 1% of cases.

Objective: The following paper aims to present the case of a patient suffering of hepatic cirrhosis attributed to occupational exposure.

Material and methods: A 61-year-old female patient, under treatment for hypertension, was admitted to the hospital with nausea, hematemesis one day pre-admission and melena two days pre-admission. Bloodwork revealed hemoglobin 7,7 g/dl, INR 1,48 and 120.000 thrombocytes/microliter. Biochemistry also revealed alanine aminotransferase 67.6 Units/L, aspartate aminotransferase 64.4 Units/L and gamma-glutamyl transferase 43.1 Units/L. After blood exteriorized through the patient's nasogastric probe, endoscopy revealed 3 second to third degree variceal tracts and 2 bleeding first degree variceal tracts, where 4 variceal ligation bands were applied, also associating portal gastropathy. Abdominal echography revealed an unevenly contoured liver, with an inhomogeneously dense echostructure, swollen biliary bladder and a 13,6 cm spleen.

Results: The absence of both anti-HCV antibodies and HBs antigen ruled out viral causes, while negative testing for antinuclear antibodies qualified an autoimmune etiology as unlikely. Sideremia, ferritin and total iron binding capacity were all within normal parameters, thus dismissing hemochromatosis, while normal ceruloplasmin levels excluded Wilson's disease. The patient denied any significant alcohol consumption, though has revealed working in quality check at a local battery manufacturing facility for 9 years, exposing herself to lead dust and various industrial solvents, thus making the case for post-exposure toxin-induced cirrhosis.

Conclusions: Although most cases of hepatic cirrhosis are caused by alcohol abuse and hepatitis, this is not always the case, as presented, and medical professionals must keep these "other" causes in mind when treating and/or diagnosing cirrhosis.

Keywords: Cirrhosis, Hepatotoxicity, Uncommon

EDTA-INDUCED PSEUDO THROMBOCYTOPENIA-CASE REPORT

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Background: Ethylenediaminetetraacetic acid (EDTA) is a well-known calcium chelator having the advantage of not distorting blood cells, making it ideal for hematology tests. EDTA-induced pseudo thrombocytopenia is a phenomenon of in vitro platelet clumping due to autoantibodies that recognize platelet antigens modified by EDTA. The phenomenon is present in both healthy subjects and patients with various diseases, and its incidence has been reported to be 0.09 to 0.21%.

Objective: Our aim is to present a rare case of (EDTA)-induced thrombocytopenia.

Material and methods: We present the case of a 65-year-old female known with Alzheimer's disease and type 2 diabetes with multiple presentation to follow-ups (approximatively three months apart in the last 8 years). She was admitted to the emergency room complaining of: inappetence, fatigue, and asthenia. The laboratory tests were performed, and an unusual phenomenon was discovered.

Results: The hematology tests revealed severe thrombocytopenia (21.0*10^4/μL) and leukocytosis (13.25*10^3/ μL) though the patient was not known to have hematological pathology. A second sample was collected using Na-citrate and a blood smear was performed. In Na-citrate sample a normal number of PLTs was counted (359*10^4/μL). On the blood smear, PLT aggregation suggestive for pseudo thrombocytopenia was observed.

Conclusions: The main hallmark of EDTA-induced thrombocytopenia is platelet aggregation. As shown, the phenomenon may appear in patients that are not previously known with this condition. In order to distinguish between true thrombocytopenia and EDTA-induced thrombocytopenia, other anticoagulants such as sodium citrate, oxalate, and heparin are used, which usually normalize the platelet counts. This phenomenon can be suspected on the platelet histogram, and a manual review of the blood smear can confirm the presence of these aggregates.

Keywords: thrombocytopenia, leukocytosis, citrate, platelet aggregation

HIGH-GRADE SEROUS CARCINOMA WITH APPENDICULAR METASTASIS

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Background: High-grade serous carcinoma (HGSC), the predominant late-stage epithelial ovarian cancer, is often diagnosed in advanced stages due to a lack of noticeable symptoms. Despite debated origins, upon reaching the ovaries, it rapidly spreads, causing metastasis and complications.

Objective: This case report unveils an appendiceal infiltration of high-grade serous carcinoma (HGSC) and emphasizes the critical role of immunohistochemistry in the diagnostic process.

Material and methods: A 68-year-old woman was admitted for left inguinal adenopathy evaluation. The macroscopic examination revealed a solid, irregular 55x35x30mm tissue specimen, including a lymph node and adipose tissue. Microscopically, the normal structure of the lymph node was replaced by a tumoral proliferation of cells with clear or eosinophilic cytoplasm, forming sporadic glandular and papillae-like structures. The tumoral cells had evident cytoplasmic and nuclear atypia, an elevated nuclear-cytoplasmic ratio, extended pleomorphism with monstrous cells, large vesicular or hyperchromatic nuclei of varying sizes, with prominent nucleoli, and increased mitotic rate of 25 mitoses/10 fields HPF. Necrotic areas were observed. Evident lymph node capsule invasion was confirmed. The immunohistochemistry revealed that tumoral cells had strong positivity for anti-p53 and anti-WT1 antibodies. Additionally, 70% of tumor cells were anti-ER positive, while 1% showed anti-PR positivity. Following further investigations, the patient received a diagnosis of inoperable ovarian neoplasm, peritoneal carcinoma, and secondary umbilical hernia. Limited surgical procedures included omentectomy, exploratory laparoscopy, transverse colon resection, omphalectomy, appendectomy, and peritoneal biopsies, all revealing tumoral infiltration matching the initial sample's immunohistochemical profile.

Results: Following histopathological assessment, the patient received a diagnosis of multiple lymphatic, peritoneal, and appendicular metastases of HGSC and an eventration sac containing numerous tumoral deposits of HGSC.

Conclusions: Histopathology and immunohistochemistry are pivotal for diagnosing metastatic HGSC, accurately identifying highly atypical cells through specific markers.

Keywords: high-grade serous carcinoma, immunohistochemistry, appendicular metastasis

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FOREIGN BODY ASPIRATION - DIAGNOSIS AND TREATMENT – CASE PRESENTATION

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Background: Bronchial aspiration of foreign bodies (FB) is very common especially in children and elderly. It is potentially life-threatening requiring urgent management. Symptoms go as far as asphyxiation, hemoptysis, retrograde infection or even lung abscess. It can rapidly lead to respiratory failure or sepsis.

Objective: Case description and treatment of an 84 y/o patient with neurocognitive disorder due to vascular dementia which aspirated a piece of walnut and forgot about it. He also suffered a heart attack at 72 y/o that resulted in heart failure NYHA 2.

Material and methods: The patient was admitted in the Pneumology Clinic with irritative cough, rest dyspnea and localized wheezing. After a negative COVID-test anamnesis was performed. Chest radiography shows bilateral interstitial infiltrates, more prominent on the right. Laboratory analysis were normal including thrombocytes, leucocytes and the INR. The vital constants were normal. With the suspicion of FB inhalation the patient underwent fiberoptic flexible bronchoscopy (FOB) under local anesthesia that revealed in the right main bronchus a piece of walnut coated by thick secretions and blood. Dormia basket gets a better grasp of irregular FB by retracting the wires but not too hard because especially organic matter may break into smaller pieces.

Results: After extraction mucosal edema, congestion by sputum and small areas of necrosis with hemorrhages can be observed. Sterile serum and topic vasoconstrictors were administrated. Patient was further treated for acute bronchitis caused by reaction against FB with broad spectrum antibiotics, mucolytics and anti-inflammatory drugs. Then he was closely followed-up by clinical surveillance and chest x-rays in order to detect residual complication.

Conclusions: FB inhalation is an emergency and diagnosis could be hindered as clinical signs are nonspecific. FB extraction by FOB is difficult but crucial to prevent complications: granuloma, atelectasis, infection or stenosis.

Keywords: Bronchoscopy, Foreign body, Aspiration, Bronchitis

A CASE REPORT ON PITUITARY MACROADENOMA, POSTOPERATIVE PANHYPOPITUITARISM AND MULTIDISCIPLINARY MANAGEMENT

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Background: The pituitary gland is responsible for maintaining endocrine homeostasis by regulating various hormonal pathways. Its main functions consist in balancing the release of hormones through multiple feedback pathways and controlling most of the body's endocrine functions. Clinically, pituitary tumors are the most common pathologic cause of hypothalamic-pituitary axis dysfunction. This case report explores the challenges posed by a non-functional pituitary macroadenoma, including its clinical manifestations, surgical intervention, postoperative complications, and the subsequent development of panhypopituitarism.

Objective: This report aims to document the clinical evolution of a patient with a non-functional pituitary macroadenoma, emphasizing challenges in postoperative care. By observing the development of panhypopituitarism, the objective is to enhance understanding of managing patients with pituitary pathologies, shedding light on the interplay between surgical interventions, endocrinological responses, and the course of recovery.

Material and methods: A 64-year-old patient presented with decreased visual acuity and narrowing of the visual field, without other neurological disorders. Imagistic investigations revealed an expansive intracranial process identified as a non-functional pituitary macroadenoma with a compressive effect on the optic chiasm. The patient underwent transnasosphenoidal surgery for tumor resection.

Results: The post-operative imaging evaluation showed the presence of residual tumor, responsible for the opto-chiasmatic syndrome, for which the patient underwent a second surgery through transcranial approach. After the second surgery, the patient's evolution was favorable, although the damage of the pituitary axis imposed subsitutive hormonal replacement therapy with Prednisone, dexamethasone and Levo thyroxine. The hydroelectrolytic imbalance was managed by initiating desmopressin and parenteral administration of sodium.

Conclusions: This case report aims to document the clinical evolution of the patient, highlighting the importance of postoperative care and the need of multidisciplinary approach in order to successfully manage the tumoral pathologies which affect the pituitary axis.

Keywords: Pituitary gland, pituitary macroadenoma, panhypopituitarism, transnasosphenoidal surgery

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MIXED-TYPE AMIODARONE-INDUCED THYROTOXICOSIS – CASE REPORT

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Background: Amiodarone is a potent agent commonly indicated for multiple arrhythmias, but may lead to thyroid disfunction due to its high iodine content and cytotoxic effect. There are two types of amiodarone-induced thyrotoxicosis: type 1 characterized by overproduction of thyroid hormones and type 2 characterized by destruction of the thyroid follicles with an increased release of preformed hormones. These types can sometimes co-exist, resulting in a mixed-type.

Objective: The aim of this case presentation is to emphasize the co-existence of these two types of amiodarone-induced thyrotoxicosis and to describe the therapeutical management.

Material and methods: We present the case of a 53-year-old patient diagnosed with atrial fibrillation for which Amiodarone was prescribed. Two years later, he complained of losing 6 kilograms in the past month and having symptoms specific for hyperthyroidism. His thyroid function tests showed a suppressed TSH (0.001 uUI/mL) and elevated levels of free T4 (3.19 ng/dL) and free T3 (13.23 pg/mL), with the absence thyroid peroxidase and TSH receptor antibodies. Ultrasound revealed an inhomogeneous, normal size thyroid, with diminished vascularity, but with a few hypervascular spots in the periphery. A mixed-type amiodarone-induced thyroiditis was suspected. Treatment with antithyroid drugs was started, with an initial good response, due to which glucocorticoid treatment was postponed. The patient was closely followed-up.

Results: While reassessing the patient, there was an inadequate increase in fT4 and fT3 levels, along with high inflammation markers, for which treatment with prednisone was initiated. The combination of the two drugs with periodically adjusted doses resulted in an improved thyroid function two months after commencing treatment, as evidenced by paraclinical studies (fT4 – 1,78 ng/dl and fT3 – 2,49 pg/ml).

Conclusions: Establishing the type of amiodarone-induced thyroiditis is very important for the therapeutical management of the case, keeping in mind that mixed-type thyrotoxicosis also exists.

Keywords: thyrotoxicosis, amiodarone, atrial fibrillation

ACUTE "APPARENT ONSET" OF A SYSTEMIC LUPUS ERYTHEMATOSUS WITH SEROFIBRINOUS PLEURISY IN A PATIENT WITH THROMBOCYTOPENIC PURPURA AND HEPATITIS C - CASE REPORT

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Background: Systemic lupus erythematous (SLE) is an autoimmune systemic multi-visceral disease with the presence of broad ranges of autoantibodies, especially antinuclear antibodies. The diagnosis is made on clinical and serological findings.

Objective: Emphasize the importance of multidisciplinary approach in a patient with systemic signs/symptoms.

Material and methods: A case report of a special "apparent onset" and long evolution in a particular case of a SLE.

Results: A 41-year-old female, nonsmoker, known with "idiopathic" thrombocytopenic purpura diagnosed 20 years ago (with intermittent activation and corticotherapy) was admitted in the pulmonology clinic in emergency. She presented chest pain, rest dyspnea, dry cough, poly-arthralgia, night sweats, and palpitations. A physical exam revealed a diminished lung murmur with bilateral crackles. Investigations included laboratory tests: large panel of serological autoantibodies, imaging studies, pleural punction, cardiologic and rheumatologic exams. Diagnostic workup revealed SLE based on the presence of specific antibodies, low complement C3, thrombocytopenia, polyserositis, nephritis, and arthralgia. The presence of anti-hepatitis C antibodies indicated that viral hepatitis-C coexisted with SLE presenting a difficulty in initiating an immunosuppressive treatment. The patient was put on Hydroxychloroquine 400mg/day for 20 days, Prednisone 30m/day, repeated evacuation of the pleural collection, gastroprotective treatment, and a hyposodate diet.

Conclusions: The late diagnosis of SLE in the pulmonology clinic was triggered by the patient's pleurisy symptoms, highlighting the challenges of detecting autoimmune disease with atypical apparent pulmonary manifestations. The actual onset might have been manifested 20 years ago as thrombocytopenic purpura indicating a lent progressive/prolonged course. The intermittent cortisone treatment may have masked or obscured the SLE symptoms thereby delaying an accurate diagnosis by attenuating some of the symptoms. The case presents a challenge for the physician due to thrombocytopenic purpura and Hepatitis C virus.

Keywords: Systemic lupus erythematous, serofibrinous pleurisy, thrombocytopenic purpura, hepatitis C

BENIGN PROSTATIC HYPERPLASIA

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Background: Prostate enlargement or benign prostatic hyperplasia (BPH) is the most common pathology in men over 60 years of age. Benign prostatic hyperplasia is a condition with chronic evolution caused by hormonal influence on the prostate.

Objective: The main objective of treatments are to improve the quality of life. Enlarged prostate treatment options include watchful waiting, medication (α-blockers, 5-α reductase inhibitors, PDE-5 inhibitors) and, if needed, minimally invasive procedures or surgery.

Material and methods: A 73 year old male patient presents with lower urinary tract symptoms, bacterial urine culture showed > 100.000 CFUs/mL Pseudomonas Aeruginosa. During preoperative work-up, a maximum prostate-specific antigen level of 8,83 ng/ml was identified, the International Prostate Symptom Score was 19 and the debitmetry showed a 7 ml/s Qmax. Constrast-enhanced pelvic MRI reveals an enlarged prostate measuring 51/61/76,5 mm (ap/ll/cc) with a benign appearance. The peripheral area appears compressed, displaying a thinned aspect. At the prostatic base, in the central area from 1-5 o'clock (transitional), a nodule is observed. This nodule exhibits T2 hyposignal boundary diffusion zone restriction and progressive contracture, measuring 24/19/14 mm, resulting in a PIRADS score of 5. Several small lymph nodules are observed at the right obturator level, measuring 5 mm, and exhibit moderately low values on the hypercellular ADC map.

Results: Finally, therapeutic alternatives were discussed and TURP (Transurethral resection of the prostate) or simple prostatectomy was recommended. TURP was performed and the pathological result was benign. Postoperative evolution of the patient was uneventful. At one month urine culture was negative and the patient present an IPSS (International Prostate Symptom Score) = 8 and a 16 ml/s Qmax.

Conclusions: Transurethral resection of the prostate is the golden standard surgical treatment in benign prostatic hyperplasia, leading to improved symptoms and function.

Keywords: prostate, TURP, benign prostatic hyperplasia

PEDIATRIC CASE OF FULMINANT ACUTE HEPATITIS AT KAUH

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Background: The World Health Organization (WHO) was alerted by the United Kingdom (UK) on April 5, 2022, about a surge in severe acute hepatitis cases in previously healthy children. This mysterious outbreak has now affected over 400 children across 21 countries, manifesting as severe acute hepatitis with jaundice and elevated liver transaminases. Many cases exhibited gastrointestinal symptoms before the onset of jaundice, and while some recovered, others progressed to acute liver failure, necessitating liver transplantation.

Objective: This case details the progression of acute fulminant hepatitis in a pediatric patient.

Material and methods: On September 17 2023, a 5-year-old male, transferred as a case of acute liver failure and hepatic encephalopathy, exhibited symptoms a week prior: persistent vomiting, diarrhea, fever, abdominal pain. Initially diagnosed with a viral illness, the patient received antiemetic and metronidazole treatment. Four days later, generalized jaundice and dark urine manifested. Immediate interventions included blood transfusions, vitamin K, lactulose, N-acetylcysteine, tazocin, methylprednisolone, leading to improvement. A liver biopsy confirmed acute cholestatic hepatitis. Upon discharge on September 28, the patient displayed signs of improvement, continuing treatment with a prescribed regimen.

Results: Five days later, the patient presented to the outpatient clinic with hypokalemia, increasing INR (9), and elevated liver enzymes (ALT 459, AST 633). Admitted to the PICU for electrolyte correction, the patient's condition worsened, featuring neurological symptoms, generalized jaundice, and abdominal distention. Treatment included carbaglumic acid, PCC, and FFP. Brain MRI suggested metabolic origin, while ultrasound revealed fluid accumulation in the pelvis and perihepatic, perisplenic regions, along with gallbladder wall thickening.

Conclusions: Parents were counseled about the necessity of a liver transplant due to the deteriorating condition, ultimately resulting in the patient's demise. The prior diagnosis of SARS-CoV-2 infection suggests it as the primary cause of acute hepatitis, emphasizing the consideration of significant liver injury, including acute liver failure, in those infected with SARS-CoV-2.

Keywords: SARS-CoV-2, fulminant hepatic failure, elevated liver enzymes

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A RARE CASE OF EBSTEIN'S ANOMALY - CASE REPORT

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Background: Ebstein's anomaly, a rare congenital cardiac defect, has a prevalence of 2.4 per 10,000 live births, constituting less than 1% of newly diagnosed congenital disorders. It manifests as a distinctive form of tricuspid valve dysplasia, characterized by the downward displacement of the septal leaflet and atrialized right ventricle.

Objective: We present a case, occurring on March 15, 2023, at Târgu Mureș County Hospital, involving a boy born via cesarean section to a mother with preexisting insulin-dependent controlled diabetes.

Material and methods: The newborn, weighing 2870g and measuring 51cm, demonstrated an APGAR score of 7/1' and 9/5', with 92% oxygen saturation. Initial resuscitation included airway clearance, tactile stimulation, and ventilation with NeoPuff. Cardiorespiratory adaptation postpartum was appropriate. A systolic murmur II/6 led to a cardiac consult, revealing ECG right axis deviation and echocardiogram-confirmed moderate tricuspid insufficiency with a 1.2cm implantation gap from the mitral valve, aligning with a GOSE score of 0.66 (grade 2). The diagnosis of Ebstein's anomaly was established.

Results: Hospitalization spanned 5 days, addressing neonatal jaundice (Total bilirubin = 184 umol/L) and identifying via ultrasound a normal right kidney and a left kidney with a diameter of 5.85cm, dilatation of the lower calyx (calyx 0.7cm, renal pelvis 0.8cm): double renal pelvis on the left side. The evolution is favorable, and the neonate is discharged with good general condition, normal colored skin, normothermic, no peripheral oedema, cardio-respiratory balance, natural nutrition and upward weight curve. Follow-up recommendations included pediatric nephrology and cardiological re-evaluation in two months.

Conclusions: Ebstain's anomaly is a rare disease and there is still not enough data about risk factors and treatment protocol. Gestational diabetes is a significant risk factor to develop congenital heart diseases. Patients can live with this anomaly for a long time before any symptoms may occur. Discovered early, treatment can be either medical or surgical, depending on the severity.

Keywords: Ebstein's anomaly, congenital heart defect, tricuspid valve

LIVING WITH MULTIPLE RENAL ANGIOMYOLIPOMAS - A CASE REPORT

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Background: Renal angiomyolipoma (RAML) is a benign tumour that occurs in isolated sporadic cases or in association with genetic disorders such as tuberous sclerosis. It is usually asymptomatic, with imaging playing a central role in diagnosis and management. RAML can bleed spontaneously, possibly causing death.

Objective: The aim is to present the case of a rare tumour, multilocular RAML containing-blood vessels, smooth muscle cells and mature adipocytes.

Material and methods: In this paper we present the case of a 65-year-old female patient, who came to the nephrologist complaining of lumbar pain and hematuria. Patient's history revealed chronic kidney disease and renal risk factors: diabetes mellitus type II, coronary and hypertensive heart disease, autoimmune thyroiditis, and obesity grade I and cholecystectomy. Abdominal Ultrasound (US) and CT-scan were performed to detect the cause of the symptoms.

Results: US showed a fatty liver, a slightly inhomogeneous pancreas, and in the left kidney three focal lesions scattered throughout the parenchyma - with a transverse diameter of 4.1 cm and cranio-caudal diameter of 4.6 cm. One of the lesions deforms the renal contour and had a discrete vascular signal in Doppler examination. The contrast-enhanced CT-scan examination revealed four focal lesions, located in the left renal parenchyma that does not enhance in the arterial phase. Based on combined imaging modalities, we could diagnose a complex renal lesion. The patient does not require treatment for angiomyolipoma and will be monitored by US because AML can grow in size and very rarely become malignant. Those over 4 cm have an increased risk of bleeding.

Conclusions: It is important to periodically reassess patients with RAML as the condition can potentially lead to severe life-threatening complications.

KEYWORDS: RENAL ANGIOMYOLIPOMA, FOCAL LESIONS, HEMATURIA AORTIC COARCTATION AND WILLIAMS-BEUREN SYNDROME: A PAEDIATRIC CASE REPORT

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Background: Williams-Beuren Syndrome (WS) is a rare genetic disorder caused by a spontaneous deletion of a gene on the long arm of chromosome number 7. The condition is characterized by distinctive facial features, intellectual disability, hypercalcemia, and cardiovascular issues.

Objective: The objective of this paper is to present a Williams Syndrome clinical case - a rare genetic disorder that is estimated to affect approximately 1 in 10,000 individuals.

Material and methods: We present the case of a 10-year-old male child with clinical exam that revealed dismorphic facial features with hypertelorism, flattened chest, neuropsychomotor retardation, and cardiac auscultation with a systolic murmur. The abdominal ultrasound pointed out bilateral nephrocalcinosis, more pronounced on the left kidney. Additionally, the left kidney presented compensatory hypertrophy in response to the right kidney's hypoplasia. Kidney involvement requires treatment and pediatric nephrology periodic monitoring.

Results: From cardiac point of view, the pacient is diagnosed with supravalvular pulmonary stenosis, atrial septal defect (ASD), coarctation of the aorta, all associated with phenotype of genetically confirmed Williams Syndrome. 24-hour Ambulatory Blood Pressure Monitoring was performed, which revealed increased blood pressure, scenario that needed antihypertensive drugs.

Conclusions: Early diagnosis and intervention are critical for managing the patient with Williams Syndrome and congenital heart disease. This work was supported by the internal research grant of UMFST George Emil Palade Targu Mures, Grant number 163/8/10.01.2023.

Keywords: Williams Syndrome, nephrocalcinosis, child, coarctation of the aorta

DUAL HISTOLOGICAL VARIANTS OF BREAST CARCINOMA IN THE SAME PATIENT: A CASE REPORT

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Background: Breast cancer, a malignancy originating from epithelial cells within galactophorous ducts or breast lobules, exhibits significant variability among patients. As the most prevalent malignant tumor in women, approximately 1 in 9 European women are projected to experience breast cancer during their lifetime.

Objective: This presentation aims to underscore a prominent challenge in clinical practice—the nuanced comprehension of both intertumoral and intratumoral heterogeneity in breast cancer. Specifically, we will focus on elucidating the distinctive features of prevalent histological types such as invasive breast carcinoma of No Special Type (NST) and lobular breast carcinoma.

Material and methods: We present the case of a 73-year-old female with a clinical diagnosis suggestive of recurrent left breast carcinoma. In 2022, the patient underwent a left breast sectoral resection, and the specimen was sent for histological and immunohistochemical evaluation. In 2023, a biopsy from the same breast was collected, and the referral diagnosis to the pathology department indicated a recurrence of breast carcinoma. Immunohistochemical tests revealed a negative E-cadherin marker, guiding us towards a histopathological diagnosis of infiltrating lobular breast carcinoma, dispelling the suspicion of recurrence and highlighting a new subtype.

Results: Microscopic examination demonstrated a distinctive growth pattern of tumor cells, frequently forming single-file rows or Indian-file arrangements. Unlike ductal carcinoma, these cells lacked typical cohesion. Lobular breast carcinoma cells appeared small, uniform, and round under the microscope, with scant cytoplasm. The nuclei were small and monotonous, and their discohesive infiltration into surrounding tissues made them less likely to form a distinct mass.

Conclusions: This case emphasizes the importance of meticulous histopathological and immunohistochemical analyses for accurate subtype determination in recurrent breast carcinoma. Understanding the challenges posed by the histological pattern of infiltrating lobular carcinoma is crucial for precise diagnosis and tailored treatment strategies.

Keywords: infiltrating lobular carcinoma, histopathology, immunohistochemistry, diagnostic challenges

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SARS-COV-2-ASSOCIATED ACUTE PANCREATITIS: A COMPLEX CASE PRESENTATION AND DIAGNOSTIC CHALLENGES

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Background: Acute pancreatitis is an inflammatory and potentially life-threatening condition triggered by various factors. Typically, biliary tract diseases, hypertriglyceridemia or alcoholism serve as the primary causes, while in rare instances, it can be induced by a viral infection.

Objective: This paper aims to present a case of acute pancreatitis occurring in the context of SARS-CoV-2 infection.

Material and methods: We present the case of a 56-year-old female with hypertension and chronic venous insufficiency, who was admitted to the emergency department with symptoms of acute pancreatitis: intense upper abdominal pain that extended to the back and started 48 hours prior. Additionally, she accused dry cough and odynophagia and she tested positive for COVID-19. Physical examination reveals malaise, a distended abdomen with epigastric sensitivity, and the absence of intestinal transit. Anamnesis excludes alcohol consumption. Labor analysis: high amylase(2946 U/L) and lipase(1132 U/L); high LDH(395 U/L), VSH(95 mm/h); high acute phase reactants: CRP(350 mg/L), fibrinogen(812 mg/dL); leukocytosis with neutrophilia; high urine amylase levels(3176 U/L). The ECO and RMN did not present abnormalities in the biliary system; CT confirmed the diagnosis of acute pancreatitis Balthazar E(with pancreatic fluid collections). The patient showed improvement after receiving antiviral medication(Remdesivir), treatment for her electrolyte imbalance, and antibiotics, leading to her discharge. One month later, the patient returned to the hospital for reevaluation. An MRI revealed a large pancreatic pseudocyst located in the body and tail, which is exerting pressure on the greater curvature of the stomach.

Results: The elevated levels of inflammatory markers support the diagnosis of acute pancreatitis attributed to a viral infection with SARS-CoV-2. Anamnesis and imaging investigations ruled out the alcoholic or biliary etiology of the acute pancreatitis.

Conclusions: Acute pancreatitis is a critical emergency that requires accurate diagnosis and identification of the underlying cause to ensure appropriate treatment for the patient.

Keywords: acute pancreatitis,SARS-CoV-2,Balthazar E

AN EXTREME CASE OF HYPERNATREMIA IN A DOWN SYNDROME PATIENT

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Background: Hypernatremia is considered as a serum level over 145 mmol/L. Hypernatremia can be acute or chronic. It can also be mild(146-149mmol/L), moderate(150-169 mmol/L), and severe (170+ mmol/L). Hypernatremia can be classified as euvolemic, hypervolemic and hypovolemic. Hypervolemic hypernatremia can be caused by an excessive sodium intake.

Objective: We present the case of a 26-year-old female known with Down Syndrome, who is found unconscious and with dyspnea.

Material and methods: The patient known with Down Syndrome and institutionalized at a recovery center is found unconscious. She has been evaluated, intubated, and directed to the Targu Mures ER. The routine blood results indicate leukocytosis, neutrophilia, slightly elevated creatinine (2,6 mg/dl), elevated level of sodium (194 mmol/l), low level of potassium (K: 2,6mmol/l), elevated levels of chloride (Cl: 146 mmol/l), elevated PCR (103 mg/dl). CT scan reveals bronchopneumonia, parapneumonic pleurisy in low quantity, atelectasis of left lung.

Results: The patient undergoes treatment at ICU with antibiotics, restoration of fluid and electrolyte balance and chronic psychiatric treatment. Sodium serum levels are corrected from 194 mmol/L to 138 mmol/L, potassium level rises from 2.11 mmol/L to 3.79 mmol/L. They are both corrected gradually, during a month of treatment.

Conclusions: The evolution of the patient was favorable in spite of the severity of the hypernatremia. Reported cases of deaths by salt ingestion described serum sodium levels ranging between 175 and 255 mmol/L. Hypernatremia can occur due to decreased water ingestion or lack of thirst, and the groups at risk are patients with altered mental status, intubated patients as our female patient in this report. Nursing residents are also at risk of hypernatremia because they depend on caregivers for their water intake.

Keywords: hypernatremia, sodium, correction

WHAT IS HIDDEN BEHIND AN “ACUTE CORONARY SYNDROME”?

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Background: In recent years, a growing number of young patients are diagnosed with acute coronary syndrome(ACS). While coronary angiography and primary percutaneous coronary intervention are gold standard for diagnosis and treatment, some cases in young individuals lack visible coronary atherosclerosis, raising concerns about the underlying cause.

Objective: This paper aims to present the case of a premenopausal woman, with a history of deep vein thrombosis who presents in the emergency department for symptoms suggesting an ACS.

Material and methods: Based on the symptoms, the ECG changes (diffuse ST-segment depression) and the myocardial cytolysis enzymes (hs-cTnI 1265 ng/L, CK-MB 23.2 ng/mL), the diagnosis of NSTEMI was established. Echocardiography reveals thrombosis at the left ventricle’s apex. Emergency coronary angiography finds no atherosclerotic lesions in the coronary arteries. Anticoagulant treatment with unfractionated heparin is initiated, followed by a switch to oral anticoagulation, with immediate favorable evolution. The patient suddenly experienced intense pain in the right lower limb, accompanied by paresthesias, 5 days after admission. The objective examination reveals cold skin and no pulse in the lower limb. CT detects critical ischemia of the right lower limb, which proves intraprocedural during vascular surgery as a thrombotic occlusion. Given the presence of a thrombus in the left ventricle, the embolization was not plausible, raising the suspicion of thrombophilia.

Results: Genetic testing confirmed the diagnosis of thrombophilia, highlighting the heterozygote mutation on factor V Leiden (G1691A) and endothelial protein C receptor A1/A3 haplotypes. The patient was started anticoagulant treatment with warfarin (INR 2-3) with a favorable evolution and no recurrence of thromboembolic episodes at the 1, 3, 6 and 12 month follow-ups.

Conclusions: Thrombophilia poses a notable risk for myocardial infarction in young patients. Screening in individuals with thrombotic events is vital to prevent not only future heart attacks but also other acute thrombotic events.

Keywords: acute coronary syndrome,acute ischemia,thrombophilia

PERCHERON ARTERY

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Background: The Percheron artery represents a rare anatomical variation, affecting 4 to 12% of the global population. This condition is characterized by a single cerebral artery with an unusual course, supplying the talamus and hypotalamus. Interruption of blood flow in this artery results in a condition known as Percheron artery syndrome (PAS), which is challenging to diagnose due to the artery's small diameter.

Objective: The aim of this presentation is to demonstrate the efficiency of diffusion MRI as an indispensable tool in contemporary neuroimaging, particularly for exploring challenging cerebral areas.

Material and methods: This presentation describes the case of a 36-year-old female patient who presented to a neurologist with complains of confusion and reduced tone in the lower limbs. Physical examination revealed slow speech and locomotor problems. Based on the medical history, a centrally located pathology is suspected. Cranial CT revealed hypodense areas located bilaterally in the thalamus. For more detailed exploration, diffusion MRI revealed a restriction in the medial thalamus, highlighting occlusion and infarction of the Percheron artery.

Results: Consequently, angioplasty and stenting were performed, followed by anticoagulant therapy with heparine. Postoperatively , in the 5 th day of observation, regression of symptoms was noticed simultaneously with the stabilization of the INR. The patient became stable in a very short period, resuming daily activities without impediments.

Conclusions: In conclusion, diffusion MRI facilitated an accurate diagnosis, enabling the patient to receive timely and appropriate treatment, resulting in a positive progression of the disease and a significant impact of patient management.

Keywords: Percheron artery, diffusion MRI, medial thalamus

CHALLENGES OF THE CORONARY "SLOW FLOW" PHENOMENON: A CASE REPORT

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Background: Delayed contrast opacification in the absence of any coronary obstructive lesion can be caused by increased microvascular resistance, which is an indicator of the "slow flow" phenomenon. This can result in angina, secondary to myocardial ischaemia, or even acute coronary syndrome.

Objective: We present a case of a 65-year-old male patient with a known history of arterial hypertension and atrial fibrillation, admitted to the cardiology ward for chest pain during moderate physical activity, which subsided in approximately 10 minutes.

Material and methods: The ECG conducted upon admission showed sinus rhythm and flattened T waves in leads V1–V3. The echocardiography revealed an ejection fraction of the left ventricle of 60%. The patient performed the Bruce stress test, which was ceased due to chest pain, ST segment depression of 2mm in V3-V6, and ventricular bigeminy.

Results: Based on the positive stress test, we performed a coronary angiography, which excluded significant coronary stenosis but showed the presence of a "slow flow" phenomenon. Considering the symptoms, patient management included antianginal drugs coupled with atorvastatin.

Conclusions: The coronary "slow flow" phenomenon was explained through a potential microvascular dysfunction. Biopsy investigations have shown structural microvascular anomalies in patients with "slow flow", confirming this theory. The underlying pathophysiology is still subject to debate and controversy, and it is still unclear if this pathology is specific to coronary arteries or a symptom of endothelial or systemic vascular disease.

Keywords: coronary slow flow, microvascular angina, antianginal drugs

IN-TRANSIT SUBCUTANEOUS METASTASIS OF MELANOMA. FROM PRIMARY TUMOUR TO METASTASIS. A CASE REPORT

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Background: Melanoma is part of the malignant melanocytic skin cancers. As it has various forms, melanoma can be aggressive and metastasize, frequently as in-transit metastases in the skin.

Objective: The objective of our paper was to present a case of melanoma, with multiple in-transit subcutaneous metastasis on a time basis

Material and methods: We present the case of a 64-years old female patient, diagnosed in May 2022 with melanoma and with breast cancer, which presented two in transit metastasis after the complete excision of the lesion.

Results: In May 2022 the patient presented to the Plastic surgical Department for the excision of a skin lesion on the anteroexternal arm and with the surgical removal of 31 lymph nodes. Histopathological, the diagnosis was melanoma, Clark II level, excised within the surgical safety limits. Therefore, there were found metastasis in 8 out of 31 axillary lymph nodes. In December 2022, the patient returned for surgical removal of a soft tissue tumor from the right axillary region. The diagnosis was of subcutaneous (in-transit) melanoma metastasis. In October 2023, the patients had a surgical excision for the surgical scar after the main excision. Microscopically there was observed a fibrous scar and underneath, a proliferation of tumoral cells, with nest disposition was observed. The cells had epithelioid aspect, with pale cytoplasm, enlarged and hyperchromatic nuclei, with prominent eosinophilic nucleoli. Immunohistochemically, the tumoral cells were positive for SOX-10. The histopathological diagnosis indicated a subcutaneous (in-transit) metastasis of melanoma.

Conclusions: Despite complete surgical removal and oncological treatment, two distant in-transit metastases were discovered following the primary diagnosis of melanoma. Melanoma, known for its high aggressiveness, carries a significant risk of metastasis throughout the entire body.

Keywords: melanoma, immunohistochemistry, in-transit metastasis

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PERITONEAL CYSTIC BENIGN MESOTHELIOMA CAMOUFLAGED BY PRIMARY BILIARY CIRRHOSIS AMA - – CASE REPORT

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Background: Benign multicystic peritoneal mesothelioma (BMPM) is a rare condition where cysts form in the mesothelial tissue. It mainly affects women of reproductive age. It can be challenging to diagnose before surgery, and a definitive diagnosis requires histological evaluation of a surgical specimen. The examination reveals multiple cysts with thin walls, lined with a single layer or cuboidal mesothelial cells and filled with serous fluid.

Objective: The purpose of this case presentation is to show the importance of a correct diagnosis based on a proper investigation.

Material and methods: This case report presents a 55 years old female patient whose main complaints are the increase of the abdomen volume and an associated asthenia-adinamia syndrome. The medical history reveals a dizmetabolic hypertrophic cardiomyopathy, type 2 diabetes insuline-requiring, posthysterectomy and bilateral anexectomy and laparoscopic cholecystectomy. She is diagnosed with a possible chronic liver disease with unknown etiology, esophageal varices 1st degree, and afterwards the patient is sent for furthermore investigations and the establishment of a therapeutic dealing. After a transjugular hepatic biopsy, the diagnosis of a primary biliary hepatic cirrhosis AMA - class Child-Pugh B is confirmed. After a pneumologically exam and the decision to perform diagnostic laparoscopy, it is found a muddy peritoneal liquid 1.5L, liver in a stage of fibrosis, subombilical adhesions and a slightly sore peritoneum with few cystic masses on a surface.

Results: The peritoneal biopsy and the histopathological exam confirm the BMPM. The pathogenesis of BMPM is still unclear, but the female sex hormones and previous abdominal surgery are risk factors for BMPM.

Conclusions: BMPM is a rare lesion, and until 2009 only 146 cases were documented in literature. The best treatment is en bloc removal, which can avoid the recurrence.

Keywords: BMPM, hepatic cirrhosis, histological evaluation

AN ALTERNATIVE TREATMENT FOR SEVERE ACNE VULGARIS – CASE REPORT

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Background: Acne vulgaris is a chronic inflammatory disorder affecting the pilosebaceous unit, typically following a prolonged course. Besides the general remedy, photodynamic therapy (PDT) represents a new approach in treating severe acne using photosensitizing agents activated by light.

Objective: The aim is to present a new alternative to treating acne vulgaris for non-responsive pacients to general treatment.

Material and methods: The pacient, a 23 year old female, who has been suffering from acne vulgaris for 3 years, was treated with topical retinoids and systemic antibiotics showing no response. Although the guidelines suggest using systemic retinoids, the pacient is known with depression and anxiety, so the treatment with roaccutane was considered with high risk. A more effective therapy was the non-invasive technique, PDT using a cream that contains aminolevulinic acid and the pulsed dye laser (cynergy multiplex cynosure).

Results: After two sessions, PDT has proved excelent results, solving the post-acne scars, inflammatory lesions and even the persisiting cysts.

Conclusions: PDT has been proven to be an effective treatment in managing patients with acne vulgaris who do not respond to topical retinoids and antibiotics, as well as those who are not suitable candidates for systemic retinoids.

Keywords: acne vulgaris, photodynamic therapy, pulsed dye laser

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KNEE JOINT PAIN AS THE SOLE PRESENTING SYMPTOM OF ACUTE LYMPHOBLASTIC LEUKEMIA IN CHILDREN

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Background: Acute lymphoblastic leukemia (ALL) is the most frequent type of juvenile cancer, accounting for 25% of all childhood cancers, and most of them are B-lineage. At the time of the diagnosis the disease is usually disseminated, even though the symptoms are frequently non-specific when the patient is first examined.

Objective: The objective is to show the significance of a correct approach in a clinical exam since a differential diagnosis often makes the difference between life and death. Numerous pathologies often debut with vague symptoms, and it is critical to rule out all other probable causes.

Material and methods: We present the case of a 2-year-old patient who presents to the emergency unit with articular pain during active and passive movements of the left knee, pain persisting during the night, lame walking, and pain in the right hand. The general state of the patient and other organ systems did not show any signs or symptoms, so the first presumed diagnosis was arthritis. The X-ray infirmed the presence of a fracture, but the blood tests revealed leukocytosis with neutrophilia and lymphocytosis. The patient was then admitted to the pediatric clinic for further investigations.

Results: High levels of atypical lymphocytes were revealed in the peripheral blood and increased LDH. Bone marrow aspiration set the final diagnosis: acute lymphoblastic leukemia with B cells. We recall no family history regarding malignancies, thus the high levels of Anti-EBV IgG could trigger the disease.

The following treatment consisted of chemotherapy according to Protocol ALL IC-BFM 2009.

Conclusions: The musculoskeletal is frequently the first body system to exhibit overt signs of the acute type of ALL. Furthermore, the right diagnosis may be delayed because evaluation may be focused incorrectly on a supposed rheumatic disease or other mimicking disorders such as osteomyelitis or septic arthritis. A proper clinical strategy is required for an accurate diagnosis to be made in a timely way.

Keywords: Joint pain, acute lymphoblastic leukemia

MULTIFACETED MANAGEMENT OF UPPER GASTROINTESTINAL HEMORRHAGE IN A 68-YEAR-OLD PATIENT WITH CHRONIC ALCOHOLISM AND A HISTORY OF GASTRIC ULCER PERFORATION

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Background: A gastric ulcer is a sore or lesion developing on the lining of the stomach, caused frequently by the protective mucosal layer erosion. Common symptoms may include abdominal pain, bloating, and nausea. Such factors as gastric surgical interventions, Helicobacter pylori infection, excessive use of non-steroidal anti-inflammatory drugs, stress and frequent alcohol consumption may contribute to gastric ulcers.

Objective: The study aims to present a case of a patient aged 68 admitted to hospital with upper gastrointestinal bleeding caused by an anastomotic ulceration and multiple gastric ulcers, all being associated with the alcoholic liver cirrhosis.

Material and methods: The patient presented to the emergency room accusing hematemesis, melena and epigastric pain. From his medical history, a partial gastrectomy of the corpus performed in 2003 should be noted due to a perforating ulcer. Lab findings showed a severe anaemia. The emergency endoscopy showed one anastomotic ulcer (Forrest IB) and a sub-cardial laceration (Forrest III), followed by a mechanical and pharmacological hemostasis.

Results: However, during the next 24 hours, the haemoglobin levels fell significantly due to a major bleeding from the sub-cardial lesion, followed by the endoscopic hemostasis. Seven days after admission, the second rebleeding occurred when the patient started eating, with a hemorrhage from an anastomotic laceration, so the hemoclips were mounted.

Conclusions: Overall, the patient showed a favourable in-hospital evolution, stabilised hemodynamics, and good overall condition, allowing for discharge. Home care instructions, including medication adherence ensured ongoing recovery. Therefore, anastomotic ulcers, although successfully addressed through interventions of hemostasis, pose a risk of rebleeding. Implementing appropriate management strategies is crucial in preventing and addressing potential rebleeding episodes associated with such ulcers.

Keywords: Upper gastrointestinal bleeding, anastomotic ulcer, gastric ulcer, chronic alcoholism

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CASE REPORT – INTERMITTENT CORTISOL SECRETION IN AN ADRENAL INCIDENTALOMA

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Background: Adrenal incidentalomas are a rare pathology discovered incidentally during investigations for symptoms that do not suggest an adrenal disease. Most often, adrenal incidentalomas are nonfunctioning adrenocortical adenomas, and upon discovery, they must be investigated to determine if there is evidence of hormone excess.

Objective: Our aim is to present a rare case of an adrenal incidentaloma with an evolutive progression, discovered 5 years ago.

Material and methods: We are presenting the case of a 71-year-old female patient who was diagnosed with a 28 mm left adrenal incidentaloma in 2018 following an abdominal CT-scan. Subsequent to its identification, the patient underwent hormonal assessments, including dexamethasone overnight test (1.6 µg/dL), which indicated a non-secreting adenoma. Additionally, metanephrine levels were also examined, and since the results were normal, the diagnosis of pheochromocytoma was ruled out. During the follow-up period, the patient underwent repeated screening tests for autonomous cortisol secretion and CT-scans without finding any significant exacerbation. In November 2022, the initial intriguing cortisol values surfaced during an overnight dexamethasone test, revealing a result of 3.1 µg/dL. Following these investigations, in November 2023, it was determined that the pacient would undergo another set of screening tests for autonomous cortisol secretion, ruling out endogenous hypercortisolism. An abdominal CT-scan was also performed which highlighted a growth of the adenoma (27 mm) compared to the abdominal CT scan performed in june 2022 (22 mm).

Results: Since the patient is still under investigation, no medical treatment is being administered, and a surgical intervention is not considered for the moment.

Conclusions: Pacients with adrenal incidentaloma must be periodically investigated in order to rule out intermittent hormone excess and to establish an accurate personal treatment.

Keywords: adrenal incidentaloma, hypercortisolism, intermittent secretion

NEONATAL HYPERBILIRUBINEMIA – A PHYSIOLOGICAL CONDITION WITH SEVERE COMPLICATIONS

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Background: Neonatal jaundice is a common condition that occurs in newborns during their first days of life, and it can persist, resulting in severe neurological damage manifesting as seizures. The specific indicator is the yellowish hue of the skin (teguments) and the whites of the eyes (sclerae).

Objective: The objective of this case report is to highlight the significance of comprehending the potential effects of high bilirubin (Bi) levels and their associated side effects.

Material and methods: This case involves a one-month-old patient experiencing seizures in the context of prolonged neonatal jaundice.

Results: The patient's history revealed two admission due to unconjugated hyperBi, the first with severely increased unconjugated Bi levels, >30 mg/dl (within the 1 week of life) for which he received albumin transfusion, and the second after approximately 2 weeks of life with a Bi of 15 mg/dl, being discharged from the hospital with a Bi of 7.4 mg/dl. However, they returned a few days later with a total Bi of 26.61 mg/dl also due to unconjugated hyperbilirubinemia associated also generalized tonic seizures. No other abnormal laboratory parameters were noticed. The electroencephalogram showed no abnormalities. The transfontanellar ultrasound revealed linear hyperechoic bands in the left thalamus most likely related to the elevated recurrent hyperbilirubinemia. We also performed a genetic testing for Crigler Najjar and Gilbert syndromes which were negative. The patient's evolution was favorable with anticonvulsant treatment (phenobarbital) and phototherapy. The follow-up at three months of live revealed no seizures and a normal level of Bi.

Conclusions: Neonatal recurrent hyperbilirubinemia might results in severe neurological damage if not properly and timely managed.

Keywords: Jaundice, seizures, pediatrics, bilirubin

IMPORTANCE OF HPV VACCINATION IN CERVIX METAPLASIA

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Background: Every year aproximatively 600.000 women around the world are diagnosed with cervical cancer, 95% of these cases being caused by a persisstent HPV infection and an altered imunity. HPV type 16 and 18 are the most frequently associated with development of cancer.

Objective: Emphasizing the importance of HPV vaccination and annual Papanicolau and HPV testing.

Material and methods: We present the case of a 32 year old patient, nulliparous, who was tested positive for HPV 16 during a routine check. Her papanicolau test showed ASCH (atypical squamous cells) with HSIL (high grade squamous intraepitelial lesions). During the colposcopy there were identified acetowhite areas with coarse mosaic (11,1,3 o'clock) and a completely visible transition zone. The HPE identified LSIL CIN 1 with areas of HSIL CIN 2/3, followed by LEEP. The LEEP doesn't have a major impact on the fertility of the patient and it does not increase the risk of premature birth because the excision is limited.

Results: The surgical sample size was 2.5/1.5/1.5 cm, fully excisioned without any histological signs of malignisation. Safety margins of the ectocervix 7mm and endocervix 6mm. The patient was reccomended the full scheme of vaccination with Gardasil 9 (3 doses) and reevaluation after 6 months -> HPV negative and pap-smear negative for malignant intraepitelial lesions. Annual testing is reccomended.

Conclusions: This case highlights the efficiency of HPV vaccination and the importance of excisioning precancerous lesions of the cervix.

Keywords: HPV, vaccine, cervix, cancer

MENINGOENCEPHALITIS - A LIFE-THREATENING CONDITION IN INFANT

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Background: Meningoencephalitis is a very severe disease characterized by inflammation of the meninges and brain.

Objective: The aim of the case report is to underline that meningoencephalitis in infants are potentially life-threatening and treated patients can also develop sequelae.

Material and methods: We report the case of a 6-month-old female infant who had already been diagnosticated with pneumococcal infection in the previous admission. She was transferred to our clinic for generalized tonic-clonic seizures.

Results: The patient's history indicated that one day before admission, she experienced generalized tonic-clonic seizures for which rectal Diazepam was administered. The brain CT scan performed in the emergency department showed acute mastoiditis and white matter hypodensities. The patient was admitted to pediatric intensive care unit. The lumbar puncture performed on the first day of admission showed increased level of leucocytes, but the culture was negative because the antibiotic treatment had already been started from the previous hospitalization. The electroencephalogram release hypovoltage tracing, without irritative elements. After performing the paraclinical investigations, infectious disease consultation and neurological consultation we established the diagnosis of meningoencephalitis. We initiated wide spectrum antibiotics (meropenem and vancomycin), associated with dexamethasone, levetiracetam, and furosemide. The instituted treatment has led to a favorable evolution, the patient was afebrile, no longer exhibits seizure episodes and the patient was transferred from the intensive care unit to the pediatrics clinic. After 22 days after admission a control CT was performed, revealing maxillary sinusitis, ethmoidal sinusitis and mastoiditis. The patient was discharged after approximately 3 weeks with oral antibiotic treatment and anticonvulsant treatment at home.

Conclusions: Timely diagnosis and effective management strategies are very important in this challenging medical condition.

Keywords: Meningoencephalitis, infant, neurological sequelae

GESTATIONAL TROPHOBLASTIC DISEASE WITH A COMPLETE HYDATIDIFORM MOLE IN A 14-YEAR-OLD- A CASE REPORT

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Background: Hydatidiform mole, is a rare and benign gestational trophoblastic disease, that manifests during pregnancy, marked by abnormal fertilization, trophoblastic proliferation, and aberrant or absent embryo development. This pathology presents as either complete or partial moles.

Objective: The primary aim of this case was to investigate the risk factors associated with the development and progression of a complete hydatidiform mole.

Material and methods: The case under examination involves a 14-year-old primigravida (G1P1) who presented to the emergency department with severe abdominal pain and metrorrhagia. Following ten weeks of amenorrhea without medical surveillance, she experienced a spontaneous miscarriage. Uterine tissue collected post-evacuation revealed the absence of fetal tissue. Microscopical examination showed distinctive features included markedly hydropic and deformed chorionic villi, the formation of cisterns containing stromal fluid, and a diffuse proliferation of both cytotrophoblast and syncytiotrophoblast in various architectures. Additionally, there was an absence of fetal stromal blood vessels with an immature vascular network. Immunohistochemistry indicated the lack of p57 expression, which is a maternal inherence, supporting the diagnosis of androgenetic gestational disease with a complete mole (46XX).

Results: After analyzing the patient's condition, we noticed some risk factors, with age (14 years) emerging as a primary contributor. Studies suggest that the patient's socioeconomic status and ethnicity can also increase the potential of developing gestational trophoblastic disease. Unfortunately, we cannot rule out the possibility of consanguinity, which is also associated with significant genetic mutations. Following the exclusion of complications, the patient was discharged with favorable progress and preserved reproductive function.

Conclusions: A complete hydatidiform mole represents a rare entity characterized by the absence of fetal formation and early miscarriage. Its variable epidemiology is influenced by factors such as age and socioeconomic status. This highlights the need of comprehension the risks and the surveillance in cases of gestational trophoblastic diseases.

Keywords: pregnancy, complete hydatidiform mole, gestational trophoblastic disease

UNMASKING THE COMPLEXITY: A MULTIDIMENSIONAL APPROACH TO ORGANIC PERSONALITY DISORDER

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Background: Organic personality disorder, characterized by behavioural and personality transformations stemming from neurological or medical conditions. Confirming the diagnostic challenges necessitating comprehensive medical methodologies to determinate the presence of a medical condition

Objective: This case study delves into personality modification by scrutinizing neuroanatomical localization in functional disorders, seeking to establish correlations with similar cases in the existing literature.

Material and methods: A 42-year-old patient with no psychiatric history presented to the psychiatry department with a psychopathological profile featuring irritability, conflictuality delusional ideas of persecution and harm, affective inversion towards family, and hetero-aggressiveness. This polymorphic symptomatology began two months prior in the context of intrafamily tensions. Following clinical, somatic, psychiatric evaluation confirmed clinical modification of the baseline personality, prompting suspicion of an organic medical condition. The etiology is identified as a cerebrovascular condition that occurred one year ago. A neurological consultation and native head MDCT were recommended.

Results: Neurological consultation identified sequelae from a prior cerebral infarction. CT scan results confirmed ischemic lacunae in the bilateral lentiform nucleus. The psychological examination showed mild cognitive deficiency. Literature referencing supported a post-ischemic psychological impact in the lentiform nucleus area.

Conclusions: Diagnosis of organic personality disorder is established through the exclusion of other personality or neurocognitive disorders. This determination relies on thorough medical history, somatic clinical analyses, and psychological/psychiatric examinations, considering the polymorphic symptomatology encompassing paranoid ideas, behavioural disorders, and cognitive deficiencies.

Keywords: personality disorder, organic

A UNIQUE CASE OF BILATERAL ECTOPIC URETERS

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Background: The ureters are muscular tubes responsible for transporting urine from the kidneys to the urinary bladder, typically being positioned in the superolateral angle of the trigone within the urinary bladder.

Objective: While renal anomalies are common, particularly in the kidneys, the occurrence of ectopia in the ureter is rare. The presence of continuous urinary leakage, in conjunction with regular deliberate voiding, should raise suspicion of an ectopic ureter, especially in women.

Material and methods: In this case report, we will present a 38-year-old female patient, known from personal history for recurrent urinary tract infections (UTIs) with E. Coli, complete left-sided pyeloureteral duplication. She presented to the urology department and a urethrocystoscopy was performed, revealing bilateral ectopic ureters with low implantation. The orifice of the right ureter was identified in the urethra, while the left one was found on the lateral wall of the vaginal vestibule, accompanied by stress urinary incontinence. The patient was discharged in good general condition and scheduled for surgical intervention next month.

Results: The combination of a duplicated collecting system with the distal, vestibular insertion of the ureter represents an unusual congenital anomaly and a rare cause of urinary incontinence. The identification of urinary incontinence stemming from organic factors like an ectopic ureter is crucial, given the potential for a cure through surgical correction. The best treatment in symptomatic patients is surgery, and it tries to resolve the incontinence, prevent further complications, preserve renal function and eliminate recurrent UTIs.

Conclusions: In summary, the successful diagnosis of ureteral ectopia and scheduled surgical procedure highlight the importance of a comprehensive approach, prioritizing symptom alleviation, complication prevention, and preservation of renal function.

Keywords: UTIs, ectopic ureter, pyeloureteral duplication

THE MYSTERY BEHIND MILD TRAUMATIC BRAIN INJURY: A CASE REPORT

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Background: Intracranial tumors may arise in the brain or other internal structures, including cranial nerves or meninges, and are especially prevalent in older adults. New markers for traumatic brain injuries are used in emergency settings to lower the number of computerized tomography (CT) scans performed for mild traumatic brain injuries (MTBI).

Objective: The goal of this paper is to emphasize the value of performing thorough investigations and connecting the information collected with reference to the patient's symptoms.

Material and methods: We report a case of a 36-year-old male patient who arrived at the hospital with a MTBI. The patient had a minor accident (a fall from the same level) and presented to the emergency room with headaches. The patient had a Glasgow Coma Scale of 15 points, no amnesia, and no neurological signs or symptoms. According to the new protocol, a TBI serum test was performed.

Results: Following the results of GFAP (Glial Fibrillary Protein) and UCHL1 (Ubiquitin C-terminal Hydrolase L1), the TBI score is negative, but since the mechanism of trauma was unclear and the headache continued, a CT scan is performed. The native cranial CT reveals a space-replacing process at the level of the right frontal lobe that is hypodense with a dimension of 28/21 mm, accompanied by perilesional digitiform edema and a tiny epicranial hemorrhage at the opposite frontal level without adjacent fractures at the neuro/viscerocranium.

Conclusions: UCHL1 and GFAP are useful in determining the TBI score for MTBI and lowering the number of unnecessary CT scans, but they have little predictive value for other types of lesions.

Keywords: mild traumatic brain injuries, headaches, TBI score

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DIFFERENCE BETWEEN TYPE 1 AND TYPE 2 DIABETES MELLITUS IN A PEDIATRIC PATIENT

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Background: It is well known that type 1 diabetes mellitus occurs frequently in children , but type 2 diabetes mellitus should be taken into consideration sometimes , due to a widespread increase in childhood obesity.

Objective: The aim of this case report is to highlight the difference between the two main types of diabetes mellitus in a child who has the phenotypic features of type 2 diabetes mellitus (T2DM), but the medical investigations show another diagnosis.

Material and methods: We present a 17 years and 10 months old boy who was born at term and who has no history of any complications including gestational diabetes during the pregnancy. Also, his mother declared that in their family there are no relatives with diabetes mellitus. The patient, diagnosed three days ago with hyperglycemia and dyslipidemia, presented to the hospital on 22.07.2023 due to fatigability and vomiting. He had symptoms of polyuria and polydipsia and the random blood glucose level was 511mg/dl. The boy was diagnosed with obesity, his weight was 100 kg and he had a BMI of 35.

Results: The particularity of this case refers to the diagnostic uncertainty at first sight, because of the features of patient which rather indicate a type 2 diabetes mellitus. However, the laboratory tests indicated a reduced C-pepetide level (0.95 ng/ml), the presence of type 1 diabetes autoantibodies (GAD and ICA) and a high level of HbA1c (11,9%). Diagnosis of type 1 diabetes complicated with severe dehydration was thus confirmed.

Conclusions: While once considered an adult pathology, T2DM is increasingly prevalent in children and it is important to distinguish between Type 1 and Type 2 diabetes , especially in a overweight child, because the management, evolution and treatment are different.

Keywords: pediatric diabetes, obesity, phenotypes

CASE REPORT: LUMBAR BACK PAIN AS AN UNUSUAL SYMPTOM OF ACUTE LYMPHOBLASTIC LEUKEMIA

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Background: Acute lymphoblastic leukemia (ALL) is a severe hematological disorder characterized by uncontrolled lymphoblast growth. ALL symptoms include weakness, weight loss, dyspnea, bleeding, bruising from small trauma, fever. However, in other situations, there are also cases in which the disease starts with back pain, an unusual and rare manifestation.

Objective: The purpose of this paper is to present a rare case of ALL, which started with lumbar rheumatic back pain treated initially with anti-inflammatory drugs.

Material and methods: We discuss the case of a 16-year-old patient, who presented in November 2022 with low back pain radiating in the right lower limb for which he underwent anti-inflammatory therapy. Three months later, the patient's condition deteriorated and he was hospitalized in Hemato-Oncology Clinic complaining of nausea, loss of appetite, and weight loss (18 kg in 3 months). According to the here-do-collateral history, the patient had a brother who died at the age of 6 with ALL. Laboratory tests revealed normochromic normocytic anemia, leukopenia, lymphocytosis and positive inflammatory markers. Abdominal ultrasound indicated a slight splenomegaly. Due to the signs and symptoms, a bone marrow aspiration was indicated. The medulogram showed 79% lymphoblasts, and the immunophenotyping revealed the following antigenic profile: CD19+CD45-CD10+CD20-/+ (70% of them) CD38+ weak CD58++CD34+ which confirmed the diagnosis of L2 acute lymphoblastic leukemia with pre-B cells and the cytostatic treatment was initiated.

Results: The patient was discharged in a good condition and will return to continue the cytostatic treatment according to the ALL BFM 2009-IA protocol.

Conclusions: Although back pain is not a common symptom of the onset of leukemia, it must be considered when it comes to the differential diagnosis with other pathologies, in order to make an adequate diagnosis and to initiate the treatment as soon as possible.

Keywords: Acute Lymphoblastic Leukemia, lumbar back pain, differential diagnosis

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INTRAOCULAR UVEAL MELANOMA IN A 39-YEAR-OLD FEMALE: A CASE REPORT

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Background: Melanoma is an on-going hot topic in medical field, being one of the most aggressive cancers known. The tumor originates in the melanocytic cells, that usually produce melanin, and it can affect a variety of sites, most commonly the skin.

Uveal melanoma, an uncommon condition seen mostly in Caucasians, stands out as the primary eye tumour in adults, with an average annual incidence of 5.1 cases per million. The primary treatment options include surgery, radiation therapy (utilizing plaque brachytherapy or teletherapy), or enucleation. Despite their effectiveness in controlling localized disease, long-term survival remains uncertain, with a potential risk of liver metastasis.

Objective: This case presentation offers a systematic overview of the diagnostic process and pathological evaluation of a 39-year-old female patient who has been diagnosed with intraocular uveal melanoma in her left eye. The purpose of this presentation is to provide crucial insights into the diagnosis and characterization of intraocular uveal melanoma through a pathological case report.

Material and methods: We present a case of a 39-year-old female presented to the Ophthalmology department with complaints of visual discomfort in her left eye.

Results: Immunohistochemical staining confirmed the diagnosis, with positive reactions for S100, SOX10, Melan A/MART1. CD68 and CD34 were used for prognostic criteria.

Histopathological analysis revealed an intraocular uveal melanoma with a predominance of epithelioid cells, classified as G3 (melanoma with > 90% epithelioid cells). The tumour's maximum dimensions were 9x10 mm, with a maximum diameter of 10 mm and a maximum thickness of 9 mm. Importantly, the tumour did not invade the ciliary body, lens, or optic nerve, nor did it exhibit extraocular extension. However, the presence of retinal detachment was noted beside moderate macrophage infiltrate observed in some areas. The thorough clinical and histopathological assessment resulted in the identification of intraocular Uveal Melanoma in the left eye at Stage pT2a, which caused secondary retinal detachment.

Conclusions: These findings underscore the importance of enucleated eye specimens in diagnosing and characterizing ocular malignancies, enabling informed clinical decisions for optimal patient care. Uveal melanoma remains a challenge in the field, with treatment and prognostic options under constant research.

Keywords: uveal melanoma, immunohistochemistry, rare, eye cancer

LEMONY SNICKET'S – A SERIES OF UNFORTUNATE EVENTS: LANGDON-DOWN, VENTRICULAR SEPTAL DEFECT, TIME….

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Background: Pediatric cardiology focuses on diagnosing and treating congenital and acquired heart conditions in children through interventions and long-term care. Globally, ventricular septal defects (VSD) are common in congenital heart diseases, often co-occurring with Down syndrome. This syndrome is the most prevalent chromosomal aberration (1:700 - 1:1000 livebirths) and it is frequently associated with heart defects like VSD (in about 50% of cases) which may contribute to complete atrioventricular canal.

Objective: Regardless, misdiagnoses can occur, complicating surgical correction – as delaying operative timing.

Material and methods: This paper presents a 12-years-old patient with Trisomy 21, multiple digestive surgical interventions in his personal pathological history, Hashimoto's thyroiditis, adenoiditis surgically treated, neuropsychomotor developmental delay and late-diagnosed VSD. Echocardiographically, the VSD already exhibited a bilateral shunt flow. The 6-minute walk test revealed poor performance, fatigue and the oxygen saturation dropped from 97% to 92%.

The gold standard, right heart catheterization, confirmed severe pulmonary hypertension. Treatment involved medications for pulmonary hypertension, physical effort restrictions, and frequent reevaluations, with plans for re-catheterisation after several months of maximal pulmonary vasodilator combined therapy.

Results: Diagnostic investigations progress from initial physical examinations (visual observation, auscultation) to supporting imaging (echography, ECG), culminating in gold standard methods such as heart catheterization for congenital heart defects. In this case, the patient's pulmonary pressures and resistances proved an unsafe timing for surgical correction, so we decided to initiate pulmonary vasodilator combined therapy.

Conclusions: In complex pathologies with multiple disorders, thorough investigations are essential, though this increases the number of tests, hospitalization time, and resource utilization. The difficulty of this case comprises the wide spectrum of comorbidities, but also the delay of operative timing. We underline the importance of correct periodic reassessment of children with congenital heart disease, as exceeding the surgical timing carries out serious consequences for these patients, with high morbidity and mortality rate.

Keywords: pediatric cardiology, VSD, Trisomy-21, misdiagnosis

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SEBORRHEIC KERATOSIS TURNED INTO MELANOMA: A CASE REPORT

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Background: Melanomas are a type of skin cancer arising from melanocytes, representing one of the most aggressive skin cancers. Melanomas are considered rare, compared to other skin cancers, thus the fact that it can often be misdiagnosed as Seborrheic Keratosis, a benign skin growth.

Objective: This paper aims to show how easily melanomas can be overlooked, and why thorough investigation is needed even in harmless seeming cases.

Material and methods: This case report is based on a 36-year-old female patient with an initial diagnosis of seborrheic keratosis, which was later proved after surgical removal of the tumor to be a melanoma, by the Pathology Department through histopathologic screening.

Results: Microscopically, the skin fragment is covered with keratinized stratified squamous epithelium with hyperkeratosis, showing underneath a tumour proliferation consisting of epitheloid nevus cells, arranged in nests at the dermal-epidermal junction with a lentiginous appearance, and in nests and diffuse in the dermis. Tumor cells are medium to large size,with eosinophilic or pigmented cytoplasm, and enlarged, nucleolated nuclei with eosinophilic or hyperchromatic pleomorphic nucleoli. A mitotic index of 17mitoses/10 HPF. Maximum tumour thickness (Breslow index): 3.5 mm. Anatomical level (Clark): IV (infiltrative tumour to the reticular dermis), ulceration: absent, lymphovascular invasion: absent, perineural invasion: absent. The diagnosis was of acral melanoma pT3a.

Conclusions: The fact that melanomas are considered relatively rare tumors, adds to the danger of misdiagnosing them through other, less harmful diseases, even though they present a real threat. This case leads us to the conclusion that even though a lesion presents to be harmless, it should always be thoroughly analyzed and a multidisciplinary approach should be taken in all cases.

Keywords: Acral Melanoma, Seborrheic Keratosis, Breslow Index

INCIDENTAL FINDING OF VENTRICULAR SEPTAL ANEURYSM (VSA): THE IMPORTANCE OF PREOPERATIVE ASSESSMENT

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Background: The use of tailored investigations before elective, non-cardiac surgery is essential to identify patient co-morbidities that have the potential to become complications during the peri-operative and post-operative setting.

Objective: The purpose of this case report is to stress the need to follow the guidelines on cardiovascular assessment of patients undergoing non-cardiac surgery.

Material and methods: We present the case of a 68-year-old female patient previously known with a history of hypertension, hypercholesterolemia, gastric ulcer, and neuromyelitis optica (Devic's disease). She was diagnosed and scheduled for elective surgery regarding symptomatic spondylolisthesis (L5-S1). A multidisciplinary preoperative assessment is necessary to define ASA score. Regarding the cardiovascular system, electrocardiogram and echocardiography are mandatory. With no clinical and ECG signs of a classic ventricular septal defect, echocardiography revealed a thin-walled outpouching of the basal portion of the ventricular sept projecting into the right ventricular outflow tract (RVOT). There was no evidence of pulsed-wave Doppler obstructing RVOT. The cardiac MRI clarified the diagnosis: ventricular septal aneurysm. Following this, the patient revealed that three months prior to preoperative evaluation, high-risk dental procedures were performed without antibiotic prophylaxis (seven dental implants), which could be the trigger of a subclinical endocarditis that can lead to VSA. Ventricular septal aneurysms are frequently clinically silent; however, if present, they can cause serious complications such as thromboembolism, aortic valve leaflet prolapse, tricuspid regurgitation, RVOT obstruction, conduction abnormalities, or acute left-to-right shunting due to aneurysmal rupture.

Results: Given the presence of an active gastric ulcer (upper digestive hemorrhage), anticoagulant ion for the aneurysm could not be initiated. This, combined with the necessity to correct the severe anemia, postponed the surgery, as the case was assigned for conservative management.

Conclusions: Individualized, extensive preoperative assessment in non-cardiac surgery is critical in assessing the patient's general status, spotting possible risks, and adjusting the surgical strategy to improve procedure safety.

Keywords: ventricular septal aneurysm, cardiovascular guidelines

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THE IMPORTANCE OF AN EARLY DIAGNOSIS IN ACUTE CORONARY SYNDROME

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Background: Acute Coronary Syndrome is a result of reduced coronarian blood flow that progresses into the improper function or necrosis of the heart muscle. This process begins with plaque instability, resulting in ruptured, intracoronary thrombus, myocardial ischemia and necrosis or sometimes coroniarian spasms.

Objective: The purpose of our presentation is to raise awareness of the importance of an early diagnosis in acute coronary syndrome.

Material and methods: We conducted a comprehensive research which included articles published on PubMed, Cambridge and Web of Science that provided adequate data on the early diagnosis of acute coronary syndrome. Moreover, we analyzed the case of a 78 year old woman who presented to the emergency room with severe precordial chest pain, dizziness and difficulty in breathing, as a result of further investigations the acute coronary syndrome diagnosis was confirmed.

Results: Precordial chest pain is a non-specific symptom that patients present with in the emergency unit. Some of them, suffer from acute coronary syndrome, however, further investigations including EKG and clinical history are insufficient. There are important markers that appear after necrosis which could indicate acute coronary syndrome, such as elevated CK-MB and troponin. Because the symptoms and anamnesis could coincide with other pathologies, a diferential diagnosis is mandatory. It is of utter importance that the diagnosis is confirmed within the first 6 hours so the pacient can be treated and not experience complications such as anevrisms.

Conclusions: The presented case and additional research highlight the importance of an early diagnosis in maximum 6 hours of the acute coronary syndrome, when coronary intervention is efficient. This, associated with other therapeutic methods, assure a favorable evolution of the patient.

Keywords: acute coronary syndrome, percutaneous coronary intervention, necrosis enzymes

NODULAR SCLEROSIS HODGKIN LYMPHOMA- A CASE REPORT

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Background: Hodgkin lymphoma(HL) is a distinct hematological tumor known with an inflammatory background combined with malignant Reed-Sternberg cells. NSHL is the most prevalent subtype of HL, mostly affects young individuals, is the only one without a male predominance and is characterized by multinucleated RS cells with an abundance of cytoplasm that resembles the atypical cells found in high-grade pleomorphic sarcomas.

Objective: The aim of our presentation is to highlight the importance of a right diagnosis in this type of hematopoietic tumor.

Material and methods: We present the case of a 30-year-old patient with the clinical diagnosis of polyadenopathy syndrome, who had the right axillary adenopathy removed.The removed specimen of size:43x30x10mm was cut and totally included for evaluation. The sectioned sample shows two nodular structures, white-yellowish color with diameter between 7 and 30mm.

Results: In the structure of the connective-adipose tissue, microscopically the two nodular formations are compatible with the lymphoid tissue, but with a histologically obliterated structure. From the level of the thickened capsule, connective bands start, fragmenting and delimiting the parenchyma into round spaces of nodular appearance, predominantly composed of reactive: lymphocytes, histiocytes, eosinophilic granulocytes and epitheloid cells. Large tumour cells are present, isolated and grouped. These cells have a single, lobulated nucleus containing small nucleoli, and are surrounded by abundant acidophilic cytoplasm and a distinctly visible cell membrane (lacunar cells), but there are also RS cells. The immunohistochemical reactions confirm the tumoral cell B-lineage origin, weakly expressing Pax5, with positive CD30 and MUM1, and negative LCA, CD20 and CD3 expression.

Conclusions: NSHL is a hematopoietic neoplasm with a great general prognosis. Patients with supradiaphragmatic lymphadenopathy, frequently accompanied by systemic B symptoms, are typically diagnosed with HL in their twenties and thirties. HL is treatable even in advanced stages of the disease with combined chemotherapy, radiation therapy, or others.

Keywords: Hodgkin Lymphoma, Reed-Sternberg cells, Hematopoietic, Sclerosis

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THE MANAGEMENT OF CLEAR CELL RENAL CELL CARCINOMA: A CASE STUDY OF PARTIAL NEPHRECTOMY IN A PATIENT WITH CO-MORBIDITIES

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Background: Renal tumors are often discovered incidentally during imaging investigations. The clear cell renal cell carcinoma is known to be the most frequent histological subtype.

Objective: The primary goal was to provide medical assistance to the patient, with the idealistic objective of attaining complete remission of the pathology.

Material and methods: We present the case of a 67-year-old woman admitted to the Urology department with gross hematuria and right lumbar pain. She presented with a positive Giordano sign and had a known history of a left mediorenal cyst, along with other co-morbidities, such as type 2 diabetes, essential hypertension, and dyslipidemia. The ultrasound examination revealed two tumoral masses, measuring 5x5 cm and 3x3 cm, in the right kidney. These masses were situated on opposite sides of the organ, one on the superior pole and the other on the inferior pole. Due to their favorable position, a partial nephrectomy was performed. Biological samples were analyzed, and the results indicated a clear cell renal carcinoma WHO/ISUP grade 2, stage T1bN0M0, with no infiltration of the resection margins. Following the excision, the patient exhibited a slow but steady recovery with physiological micturitions, a good general state, clear urine, and no signs of aggravation or febrile state.

Results: Prompt evaluation and intervention facilitated the complete excision of the tumor and resulted in a favorable recovery. Partial nephrectomy, when combined with low-grade tumors, yields very good prognostics.

Conclusions: Localized renal cell carcinoma is typically asymptomatic, and clinical examination often results in a late diagnosis due to the infrequency of the ‘classical triad’ of symptoms, including flank pain, gross hematuria, and palpable abdominal masses. Considering the preservation of renal function, nephron sparing surgery offers significant advantages, especially in patients with associated co-morbidities. Early diagnosis and prompt intervention can avoid a fatal outcome.

Keywords: partial nephrectomy, renal cell carcinoma, clear cell, asymptomatic

FROM INTERVENTION SITE TO CATH LAB: THE SIGNIFICANCE OF PREHOSPITAL MANAGEMENT IN MINIMISING DOOR-TO-BALLOON TIME FOR STEMI PATIENTS

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Background: The prehospital management of ST elevation Myocardial Infarction is essential in achieving a shorter Door-To-Ballon Time(D-2B),known as the time between the FMC(First Medical Contact) and the PCI(Primary Percutaneous Coronary Intervention).When"time is myocardium"the emergency physician's competence can play a crucial role in minimising the bedside to Cath Lab timeframe

Objective: Highlighting the importance of prehospital management of STEMIs in order to obtain shorter times to reperfusion

Material and methods: We present the case of a 75 years old man who called the EMS for epigastric pain.At the team arrival he was severely diaphoretic with cold extremities.The initial monitoring revealed: BP:89/60mmmHg HR:40 bpm.A 18-lead ECG revealed ST elevation in the inferior,right,posterior leads and third degree AV block.The initial diagnosis was STEMI involving the inferior,posterior and right ventricular territories,Killip class 4.Dual antiplatelet therapy was initiated,alongside inotropic and vasopressor support.Subsequently,the clinical status remarkably improved and the team prepared for transportation to the Emergency Department.Concurrently,the Cath Lab was notified,hence the timeframe between entering the ED and proceeding to CathLab was minimal.An emergency PCI was performed and three drug-eluting stents were implanted

Results: The prehospital phase can heavily impact the patient's outcome.At the point of FMC a diagnosis should be promptly made alongside early institution of antithrombotic therapy.Since rapid arrival to a regional STEMI center is crucial,the emergency physician decides if that is logistically possible and the transfer will not overrun the maximum D2B time.Notifying the CathLab during transportation minimises total ischaemic time.Hemodynamic stabilisation at the intervention site accelerates the prehospital-CathLab transition,bypassing the ED

Conclusions: It is mandatory to emphasise the importance of prehospital proceedings and the EMS-hospital coordination in order to significantly reduce D2B times

Keywords: prehospital,STEMI,D2B

INTRAPERITONEAL HEMATOMA UNVEILED DURING ANEMIA EVALUATION: CONSERVATIVE MANAGEMENT AND COMPLICATIONS

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Background: When blunt abdominal trauma occurs, the most frequently affected organ is the spleen. Unstable patients usually have an indication of total splenectomy or laparotomy. Yet, if patients are stable they can benefit from a more conservative treatment such as the endovascular splenic artery embolization, without the risk of lifelong functional asplenia.

Objective: We present the case of a 68-year-old male patient, with a known history of chronic atrial fibrillation under treatment with anticoagulants. He was brought to the Emergency room for repeated falls, attributed to post-traumatic epilepsy following a car crash he was involved in 45 years prior.

Material and methods: Laboratory test results showed severe anaemia, with a haemoglobin of 7 g/dL, therefore the patient was transfused with four units of packed red blood cells and the anticoagulant was preventively discontinued. Abdominal ultrasound revealed the presence of a morphological anomaly of the spleen suggestive of a subcapsular hematoma. CT scan was performed and confirmed the diagnosis of splenic and perihepatic hematoma with capsular effraction, as well as extended intraperitoneal haemorrhage.

Results: Considering the haemodynamically stable state of the patient, it was opted for transcatheter arterial embolisation of the splenic artery. Meanwhile, anticoagulation treatment was resumed with a prophylaxis Enoxaparin dose on the first day after the intervention. However, the next day his respiratory condition destabilised, raising the suspicion of acute pulmonary embolism, which was confirmed by emergency AngioCT. Given the hematoma was kept stable, the Enoxaparin was increased to therapeutic doses, and he was put on high-flow oxygen therapy.

Conclusions: The efficacy of the intervention was checked by control CT scan 5 days later, showing the hematoma had begun to resolve and was stable. The evolution was favourable under anticoagulation treatment, and he was discharged.

Keywords: splenic artery embolisation, functional asplenia, hematoma

FROM ANEMIA TO NORMAL RBC, JUST A WARM-UP!

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Background: Cold agglutinin disease (CAD) is a rare autoimmune hemolytic anemia, that occurs when IgM antibodies, tag erythrocytes, leading to their agglutination and subsequent destruction. Only 15% of hemolytic anemia cases are CAD and the pathology affects mostly women, being diagnosed around the seventh decade of life.

Objective: The current paper aims to raise awareness around the possible analitical errors associated with this pathology.

Material and methods: We introduce the case of a 77 year old female patient, previously diagnosed with type II diabetes mellitus, bronchial asthma and total hysterectomy that presents to the hematology department with the following symptoms: fatigue, lightheadedness, pale complexion and acrocyanosis.A hemoleucogram is performed. The blood sample, collected into EDTA 2 ml containig tubes is processed by two hematology devices: ALINITY HQ and SYSMEX XN 1000. Red blood cell (RBC) proved to be suspiciously low, measuring only 0.09 × 106/µl, hemoglobin was also deficient 8.00 g/dl and following further questioning, the patient reported that her condition improves when exposed to warmer temperatures. Retesting was requested, obtaining similar numbers. CAD suspicion arose, leading to the idea of placing the blood sample in a warmer temperature environment (37°C) and repeating the hemoleucogram afterwards.

Results: After comparing the hemoleucograms pre- and post- blood warm-up, the following have been observed: important increase in RBC, from 0.09 to 2.94 × 106/µl, hemoglobin levels rose from 8.00 g/dl to 9.40 and a major increase of the hematocrit – from 1.2% to 27.9%. A Coombs test was also performed, concluded with a positive result and finally, the suspicion of CAD was confirmed.

Conclusions: For this pathology, initial hemoleucogram results can be deceiving and more appropriate clinical decisions, along with a swifter CAD diagnosis can be made just by taking into consideration one simple factor: the blood sample temperature when examined.

Keywords: CAD, temperature, analitical errors

COMPLEX MANAGEMENT OF PULMONARY THROMBOEMBOLISM IN THE PARANEOPLASTIC CONTEXT

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Background: Pulmonary Thromboembolism (PTE) is a potentially fatal medical emergency, whose management is complicated by associated comorbidities. These conditions can mask PTE symptoms and impact the treatment, as pneumonia can amplify the procoagulant state, and asthma can disrupt ventilation and increase the risk of thrombosis. The clinical and therapeutic approach to PTE must be tailored to each case.

Objective: The main objective of this presentation is to describe the management of pulmonary thromboembolism in a paraneoplastic context and to clarify the etiology of the pleural collection.

Material and methods: We present the case of a 72-year-old patient with a history of asthma, trenant pneumonia, hypertension, allergic rhinitis, chronic ischemic heart disease, and moderate obstructive ventilatory dysfunction. The patient arrives at the emergency room with a productive cough,hemoptoic expectoration and suddenly installed dyspnea. To establish the diagnosis, several tests were carried out, including laboratory tests, thoracic CT angiography, cardiology, and gastroenterology investigations.

Results: Radiological examinations highlight the presence of a thrombus in the right pulmonary artery and left basal lung consolidations suggesting pneumonia, as well as bilateral pleural effusions. Following the results, the pacient was treated with antibiotics, anticoagulants, and symptomatically, in addition to the treatment received for his associated diseases. Subsequently, the patient's condition worsens with an increase in bilirubin and transaminase levels, raising the suspicion of mechanical jaundice in the context of pancreatic damage. The patient is referred to the surgical service for confirmation of a pancreatic tumor after abdominal-pelvic CT shows intrahepatic biliary tract dilation. Histopathological and immunohistochemical examination of pleural fluid supports the metastatic origin of the pleural collection.

Conclusions: This case emphasizes the need for a multidisciplinary assessment and a thorough approach to establish a definitive etiological diagnosis, to ensure correct case management and effective therapeutic conduct.

Keywords: pulmonary thromboembolism, trenant pneumonia, mechanical jaundice, pancreatic neoplasm.

MULTIPLE MYELOMA IGA SUBTYPE – CASE REPORT

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Background: Multiple myeloma (MM) is a malignant proliferation of the plasma cells. Most patients with MM have osteolytic lesions in the bones. Although plasma contains a high number of immunoglobulins, they are not functional, and the risk of infection increases.

Objective: To present a rare case of rapid progressive MM with IgA-type paraproteins and the evolution of laboratory parameters.

Material and methods: An 83-year-old woman, previously diagnosed with ischemic cardiopathy, mitral and tricuspid regurgitation, Parkinson's disease, and chronic renal disease, is admitted for asthenia, marked fatigability, loss of appetite, and a cough for about 3 days. She has osteolytic lesions in the skull cap and left iliac bone.

Results: At first admission, she had anemia, high creatinine, and total serum proteins (11.38 g/dl). An M-type gradient was found in serum electrophoresis. The value of IgA was very high (8184 mg/dl). A bone marrow aspiration was performed, and 57% of plasmocytic cells were found. In immunophenotyping, the subtypes CD38+, CD138+, CD56+, CD45-, and CD19- were found. Lenalidomid (10 mg) treatment is initiated. After the second cycle, the clinical status, anemia, and renal function improved. In the third cycle of treatment, the patient has a stationary clinical status and an increased ESR and M-type gradient of 21.1%. At cycle 4, improved clinical status is noted with lower IgA, but ESR remains high. IgA levels continue to increase after cycles 5 and 6. In cycle 6, after an infection with S. aureus MRSA, the patient dies.

Conclusions: Despite the treatment, multisystemic organ impairment caused by MM has led to a negative prognosis in our patient. The IgA subtype is fairly rare and appears in only 20–25% of MM. In our case, the IgA values remained high throughout the treatment cycles.

Keywords: Multiple Myeloma, IgA subtype, laboratory tests

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