sphincterotomy was performed. Percutaneous transhepatic cholangiography and cannulation guide wire technique was used, with a modified Burhenne technique. Stones were pushed into the duodenum with Fogarty Balloon, stent inserted. Post interventional radiology revealed that CBD was cleared. Patient made good recovery.
Conclusions. Elective methods in the diagnosis of choledocholithiasis are MRCP in colangiographic regime, ERSP and percutaneous transhepatic cholangiography. Modified Burhenne technique can be used in treating choledocholithiasis.
Key words: choledocolithiasis, biliary lithiasis, surgery

11. TRAUMATIC RECTAL WOUND AND CONSEQUENCES OF DIAGNOSTIC AND MANAGEMENT ERRORS

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Background. "Hopkins Medicine" medical journal reports medical error as the third cause of patients' death. Meanwhile, WHO determined that 23% of European citizens state that they have suffered from a medical error, while 18% say that they still have complications from them. Also, WHO established that one of 20 patients got a nosocomial infection during their hospital admission. Several studies highlighted a rate of 15% to 30% of rectal postoperative infection, retrospectively linked to delayed diagnosis, fecaloid infection, inefficient primary treatment and inadequate drainage. This affects the wound's regeneration rate and leads to complications such as perirectal abscesses and fistulas, suture inconsistency, sepsis etc., which can result in prolonged hospital stay, hospital readmission, home nursing wound care needs, and the expenditure of significant medical costs.
Case report. Patient R, age 52 years, is hospitalized with a perianal wound following a 1m fall on a metal nail. Clinical and instrumental examinations showed stable hemodynamics, painless palpation of the abdomen, no pneumoperitoneum. Status localis: perianal, on the right a wound 4 cm x 8 cm depth was detected. Primary surgical wound debridement was performed under general anesthesia, and no lesions of the pelvic organs were discovered. Laparoscopy revealed a retroperitoneal hematoma, which was drained, and no penetration into the abdomen cavity was seen. The patient's condition worsened on the second day and an exploratory laparotomy was performed, where a second retroperitoneal hematoma and color changed blood in recto-sigma was detected. A terminal sigmostoma was applied for the exclusion of the extraperitoneal lesion of the rectum without succeeding in suturing the rectum wound. Subsequently, the evolution of the patient was negative and a retroperitoneal phlegmon developed. A second laparotomy followed with the suture of rectal wound and debridement of putrid retroperitoneal phlegmon. The postoperative period evolves severely but favorably with the formation of the pararectal fistula, which imposes multiple cares and readmissions over a period of 2 years with the intent of closing the fistula (rectum stenting, reconstructive surgeries for rectum extirpation and the transanal colon dissension, protection ileostoma) and, finally, a permanent terminal colostoma was applied.
Conclusions. In the presented case, the severity of rectum wound, the delayed and wrong diagnosis as well as the errors in patient approach had increased the severity of the disease, with multiple postoperative complications, high medical costs and had led to disability.
Key words: traumatic rectum wound, diagnostic and tactical errors, complications, treatment.

12. A COMPLEX CASE OF PANCREATIC CANCER COMPLICATED WITH GASTRIC VARICES AND DEEP VEIN THROMBOSIS

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Background. Pancreatic cancer is a highly lethal malignancy with few effective therapies. Pancreatic cancer is often associated with thromboembolic disease, as the malignant condition induces a prothrombotic and a hypercoagulable state.
Case report. This is a case of a 63 years old patient, diagnosed with pancreatic cancer with hepatic and splenic metastasis detected on CT, with a level of Carbohydrate antigen (CA) 19-9 of 2556 UI/ml and several associated comorbidities: a moderate form of iron deficiency anemia (Hb -7.4 g/dL, Ht - 25.2%, serum iron - 3.28 μmol/L), large gastric varices at the level of the fornix secondary to segmental portal hypertension, but with no signs of bleeding, incomplete intestinal metaplasia and Helicobacter Pylori infection at the level of the antrum and type 2 diabetes insulin dependent. The patient presented in our Medical Clinic complaining pain and functional impotence of the right inferior limb. We performed a Doppler ultrasound that revealed femoral-popliteal-tibial thrombosis of the right inferior limb and thrombosis of the internal saphenous vein. Due to the association of the thrombotic disease with the gastric varices, the initiation of antithrombotic therapy was questioned because of the high risk of variceal rupture and massive bleeding. The patient was recommended endoscopic injection sclerotherapy, but the procedure could not be performed due to the lack of compliance. A treatment the with low molecular weight heparin (Fragmin 2500 IU) and Vessel Due F was initiated. The patient condition was ameliorated during the admission and she was discharged with oncological and gastroenterological follow-up.
Conclusions. The peculiarity of this case consists in the association of the thrombotic condition with the gastric varices, both as complications of pancreatic cancer. The treatment in this case has to be carefully chosen, as the patient is at high risk of developing both gastric bleeding and thrombotic embolism.
Key words: pancreatic cancer, thromboembolism, gastric varices

DEPARTMENT OF PEDIATRICS

13. HIGH SERUM UNCONJUGATED BILIRUBIN LEVELS IN A PATIENT WITH MUTATIONS IN THE UGT1A1 GENE – CLINICAL CASE PRESENTATION

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Background. The UGT1A1 gene plays a significant role in the glucuronidation of bilirubin, and the mutations of this gene lead to limitations in the synthesis of the glucuronyltransferase enzyme, which contributes to the increase in free serum bilirubin. This clinical condition is called Gilbert's syndrome. The patient with Gilbert syndrome has no clinical manifestations until the second decade of life. Scientific studies demonstrate that free serum bilirubin in patients with Gilbert syndrome is almost entirely unconjugated. We present the case study of a 17-year-old patient with Gilbert's syndrome, confirmed by molecular genetics tests.
Case report. Patient was born from the first pregnancy with satisfactory evolution. Weight at birth was 3500g, height 52 cm, Apgar score 8/8. She was breastfed until the age of 1.5 years. Growth and development was within normal values, but after 4-5 years of age, she began to manifest periodically poor appetite, vomiting, abdominal pain, constipation. The dynamical assessment of clinical and paraclinical examinations revealed reactive pancreatitis episodes, “S”-