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Introduction. The prolaps of a retroperitoneal viscus can cause a sliding hernia. From 2% to 5% of all inguinal hernias are of sliding variety.
Aim of the study. Analysis of the treatment experience of patients with sliding inguinal hernia.
Materials and methods. The retrospective study of a group of patients aged between 42 and 78, diagnosed and treated in SCM "St. Archangel Michael "during the years 2015-2017.
Results. This pathology is more common for men 95% (32 cases), women 5% (2 cases). Direct hernia was found in 15% (6 cases), the oblique in 85% (28 cases). Anatomically was appreciated 30% of bladder slippage - 10 patients, 52% of sigmoid colon slippage - 18 patients and 18% of cases with caecum slippage - 6 patients, 2 of whom were associated with acute phlegmonous appendicitis. Strangulated hernia was detected in one case, incarcerated in 82% - 28 patients and simple hernia was founded in 15% - 5 cases. In 41% of cases (14), the diagnosis was established preoperatively, using EUS, R-abdomen, and irigography. In 59% of cases (20) the diagnosis was established during the surgery. Surgical treatment has been differentiated depending on the clinical form of hernia and the present complications. The reconstruction of the hernia defect was performed in: 16 cases with Liechtenstein technique, 2 cases the technique of Shouldice, 8 cases the technique of Postemski, 2 cases the technique of Kimbarovski in, one case the hernioplasty after Fabritus.
Conclusions. The proportion of sliding hernias is even higher in the elderly. Hernias of this kind are found almost exclusively in males and usually on the left side. The cleavage hernias occur more frequently at patients that suffer of obesity and inguinal hernia for many years. Surgical reconstruction is differentiated and adapted to the clinical particularities of each case.
Key words: sliding hernia, surgery, plastics

128. CLINICAL EVOLUTION AND PROGNOSIS OF BLEEDING FROM GASTRIC VERSUS ESOPHAGEAL VARICES: COMPARATIVE STUDY

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Introduction. Gastrointestinal bleeding is by far the most severe and life-threatening complication of portal hypertension in cirrhotic patients. The location of the varices is tightly bound to the management of the patient, especially as regards to the endoscopic haemostasis; hence the gastric varices have a more difficult approach than the esophageal one. Consequently the gastric variceal bleeding might have a more reserved prognosis.
Aim of the study. The comparison of evolution and prognosis of patients after an episode of upper gastrointestinal bleeding through a variceal outburst according to the site of bleeding (gastric varices *versus* esophageal varices).
Materials and methods. We conducted a retrospective study which included 214 patients and comprised 310 variceal bleeding episodes through the year 2017 (patients who were admitted to the emergency room of Bucharest Clinical Emergency Hospital "Floreasca"). For 61/310 (19.7%) observations the etiology was represented by gastric varices.
Results. Regarding the management of patients, the therapeutic mean chosen in majority of cases was the endoscopic haemostasis through ligation (89% out of 310 episodes); whilst for a smaller percentage – cyanoacrylate injections and Sengstaken-Blakemore tube were chosen. Amongst the patients with gastric varices we recorded a higher mortality in comparison with

patients with oesophageal variceal bleeding (15.8% vs. 8%). Likewise, there was a difference suggesting a slightly higher severity of gastric varices bleeding considering the mean value of hemoglobin at admission (7.3 g% vs. 8.31 g%) and duration of hospitalization (4.8 vs. 3.8 days).
Conclusion. Despite similar modalities of management for the two types of variceal outburst, gastrointestinal bleeding from gastric varices is strained by a lugubrious prognosis and evolution. Therefore these patients should undergo a more thorough and specific management and follow-up.
Key words: haemorrage, gastric varices, esophageal varices, clinical evolution, prognosis

129. TREATMENT OF PANCREATODUODENAL TRAUMA

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Introduction. Pancreatoduodenal trauma is one of the most serious and severe abdominal traumas, which comprises 1-10% of all abdominal injuries. As a result of the difficulties in diagnosis and treatment, the rate of complications and mortality are quite high.
Aim of the study. Analysis of treatment outcomes in patients with concomitant traumatic lesions of the pancreas and duodenum in dependence to the degree of pancreatic trauma.
Materials and methods. During the 1998-2007 at the Department of Surgery n.1 "Nicolae Anestiadi" 30 patients with pancreatoduodenal trauma were operated. First and II grade of the pancreatic lesion were diagnosed in 23 (76.7%) cases. Only in 4 (13.3%) patients were observed lesions of grade III and IV. Lesions of grade V were detected only in 3 (10%) patients. Segment D1 of duodenum was affected in 16.7% cases, D2 – in 50%, D3 – in 16.7% and D4 – in 6.7%. Injuries of more than 2 segments were seen in 3 patients.
Results. The duodenum was excluded from the passage in 30% of cases due to duodenal wall lesions and the presence of acute posttraumatic pancreatitis (APTP). In 21 (70%) patients the anatomic passage was maintained for duodenum. The draining of the omental bursa (OB) was performed in 23 (76.7%) patients, and the bursoomentostomy (BOS) - in 7 (23.3%). The APTP rate was 75% and 100%, respectively, both for the preservation and exclusion of the duodenum from the passage. Note that in all of these cases (7 pts) BOS has been applied in traumatic lesions of the pancreas grade III – V. The rate of APTP and mortality were 83.3% and 33.3%, respectively for lesions of grade III-V compared to the 82.3% and 23.5% in lesions grade I and II. In the first 48 hours, 7 (23.3 %) patients died due to hypovolemic shock and retroperitoneal phlegmon. The high frequency of mortality (25%) in the group of patients in whom primary duodenum suture was performed without its exclusion from the passage with the application of BOS is due to late hospitalization (> 48 hours) and the presence of APTP. Relaparotomy for pancreatic necrosis was required in 6 (20%) patients with necrectomy and application of BOS, with a mortality of 50% in the postoperative period. Causes of mortality were post-traumatic pancreatic necrosis, persistence of high-grade duodenal fistula, as well as MODS.
Conclusion. In the pancreatoduodenal trauma with lesions of the pancreas of grade I-II optimal treatment is the suturing of duodenal injury with closed drainage of OB, whereas in severe lesions it is recommended to exclude the duodenum from the passage with BOS application.
Key words: pancreatic trauma, duodenal trauma, post-traumatic pancreatitis, surgery

130. HERNIOALOPLASTY IN VENTRAL HERNIAS

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