

Background. Traumatic diaphragmatic hernia in children is rarely reported, with an incidence ranging from 0.08% to 8%, and the death rate ranges from 16.6% to 33.3%. Diagnostic difficulties are found in 50-70% of cases. Late manifestation of traumatic lesions of the diaphragm is well studied in adults, as opposed to children. In this context we present the following clinical case.

Case report. Patient S., 4 years old, was transferred to our institution from a district hospital with suspicion to a paraesophageal hiatal hernia, but a destructive pulmonary process with pulmonary abscess formation was not excluded. The anamnesis allowed to specify that two weeks before hospitalization the child fell, hitting the chair, the accident was overlooked by the mother. The clinical examination revealed the serious general condition, conditioned by the presence of signs of exicosis, stable hemodynamics. Palpator - painful abdomen all over the surface, predominantly in the epigastric region and in the left hypochondriac region. Laboratory examination revealed anemia and neutrophil leukocytosis. The thoracic and abdominal radiography, performed by emergency in the clinic, showed the transdiaphragmatic positioning of the intestinal handles in the left hemithorax, the diaphragmatic hernia having comparatively larger dimensions. The diagnostic of certainty was established with the help of thoracic CT with dynamic contrast in angiographic regime. Surgery was performed, intraoperatively, a defect of the left hemidiaphragm was detected at the level of fusion of the anterior part of the tendon with the muscular part, through which the intrathoracic hernia omentum, the colon and the small intestine handles. After the organs were repositioned, the integrity of the diaphragm was restored with non-absorbable interrupted sutures and consolidation with a biodegradable acellular biological graft fragment by equine pericardium (Bioteck Heart).

Conclusions. The results of the histological examination indicate that the mechanism of development of the diaphragmatic defect in children may occur as a result of a contusional tissue injury and the subsequent disjunction of the resident hemidiaphragmatic tissue. Therefore, preoperative diagnosis of HDT in young children is quite difficult, with chest angiographic CT with dynamic contrast being an effective method in establishing the diagnosis with certainty. The primary repair, with the application of non-absorbable sutures and the concomitant use of the acellular pericardial graft for consolidation, represents an effective option in the surgical reconstruction of traumatic diaphragmatic defects.

Key words: biologic graft, traumatic diaphragmatic hernia.

8. MEDICAL TREATMENT IN ACUTE MEDIASTINITIS BY PERFORATION OF THE ESOPHAGUS: CLINICAL CASE

Author: **Valentina Ciolac**

Scientific adviser: Eva Gudumac, Academician of the Academy of Sciences of the Republic of Moldova, MD, PhD, Professor, Pediatric Surgery, Orthopedics and Anesthesiology Department *Nicolae Testemitanu* State University of Medicine and Pharmacy of the Republic of Moldova

Background. Mediastinitis is the inflammation of the soft tissues of mediastinum. The main causes of mediastinitis are infections caused by heart surgery. Within the iatrogenic etiology the perforation of the esophagus predominates - 85% of cases. The incidence of esophageal perforation is most often due to the inflammatory response of mediators from the stomach, pleura and adjacent tissues. Mortality is due to acute mediastinitis, pneumonia, empyema, polymicrobial sepsis and MODS (Multiple Organ Dysfunction Syndrome). The treatment of

acute mediastinitis by perforation of the esophagus imposes the diagnostic problem and still arouses numerous discussions regarding the treatment.

Case report. Case report: The patient, aged 1.5 months, with no pathological history, presents within the framework of the National Scientific-Practical Center Pediatric Surgery 'Natalia Gheorgiu' with accusations of dysphagia, with temperature 39 °C. Objectively observed symptoms: dyspnea, pallor, tachycardia, slight bulging in the cervical, suprasternal and supraclavicular pits. The presence of subcutaneous emphysema was a determining factor for the chest radiograph, in which there was an enlargement of the shadow of the upper mediastinum. Based on the clinical examination, the etiological factor was not confirmed, but ingestion of a foreign body was not excluded, and based on the imaging examination the suspicion of acute mediastinitis by esophageal perforation was determined. Esophagoscopy indicated the presence in the upper third of the esophagus of an ulceration surrounded by edema and hyperemia. The first therapeutic gesture was the introduction of a naso-gastric feeding probe, the introduction of broad-spectrum antibiotic therapy, hydro-electrolyte rebalancing, and analgesic therapy. Computer tomography with angiography confirmed the presence of esophageal perforation and mediastinal infiltration. The second medical gesture was the opening and the suprasternal drainage of the anterior mediastinum, the drainage with sleeve blade. Therapeutic attitude was conservative and antibiotic therapy was continued. Patient monitoring during treatment was favorable with the relapse of fever, pain, dyspnea and improvement of the general condition. After 1 month of conservative treatment was performed the esogastric transit control with radiopaque substance (Gastrofarm). This procedure does not highlight the contrast substance outside the esophagus. In this clinical case, we combined a conservative treatment and a surgical treatment with the opening of the previous mediastinum. There was no major surgery despite the fact that the mediastinal syndrome was manifest. The patient presented good results as well as at a distance.

Conclusions. Conclusions. Suspicion of perforation of the esophagus requires emergency hospitalization and complete investigation of the esophagus and mediastinum under strict supervision. Indication for drug or surgical therapy will be required on a case-by-case basis, depending on the size of the efficacy, the short time from perforation, the association of neighborhood lesions and the presence of sepsis.

Key words: Esophagus. Mediastinitis. Diagnostics. Treatment. MODS Syndrome.

9. CONGENITAL DUODENAL DISORDERS IN CHILDREN

Author: **Alina Pleșca**

Scientific adviser: Eva Gudumac, Academician of the Academy of Sciences of the Republic of Moldova, MD, PhD, Professor, Pediatric Surgery, Orthopedics and Anesthesiology Department *Nicolae Testemitanu* State University of Medicine and Pharmacy of the Republic of Moldova

Background. Congenital duodenal disorders are relatively common diseases for children. There are 1: 500; 1: 1000 cases of live newborns. They represent a congenital defect of rotation and fixation of the duodenum produced at the moment of rotation of the primitive intestine. The most common pathology is diagnosed in older children or adults. Most of these disorders do not have a clear etiology and pathogenesis. The lack of specific clinical signs and symptoms at early clinical-evolutionary stages presents a difficulty in establishing a diagnosis. Treatment is controversial, especially for congenital forms. Evolutionarily the first signs are repeated vomiting, abdominal pain conditioned by the evacuatory disorders of the stomach and duodenum as a result of arterio-mesenteric compression of the duodenum, duodenal-jejunal