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 Plește**
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

angle and other inflammatory processes that deform both the duodenum and the jejunum. The most informative diagnostic method is standard abdominal radiography supplemented by contrast radiography, followed by abdominal ultrasound, digestive tract scintigraphy, MRI.
Case report. We present the case of a patient operated for duodenum malformation. Patient 7 years old, male hospitalized urgently in the emergency surgery department, presented with diffuse abdominal pain, repeated vomiting with food + ball content. According to the information given by mother, the baby is practically sick from birth. The patient repeatedly was treated at the gastrologist but without improvement of the general condition. The objective examination shows that the abdomen is painful to palpate in the epigastric region, but without muscular defense. Ultrasound-moderate abdominal meteorism. The abdominal x-ray shows the hydroaerial levels in the stomach, the left flank. Hematology shows slight anemia, leukocytes 8000, without other biochemical changes. At endoscopic examination (FEGDS), there was total duodenal-gastro-esophageal reflux, gastroduodenitis. Gastrointestinal transit with contrast substance: macrogastria, slowed discharge from the stomach at 30 minutes, 3 and 9 hours. With the diagnosis of duodenal malrotation, the patient underwent surgical treatment. Intraoperative, multiple embryonic brides have been diagnosed, in which is Ladd, Jakson, common mesh. The operative and postoperative period without any particularities, without any secondary modifications.
Conclusions. In duodenal disorders, surgical treatment must be supplemented by the complex drug, including anti-adherence to eliminate inflammatory processes and intestinal occlusive complications.
Key words: Congenital malrotation, duodenum, treatment.

10. THE FUNCTIONAL RECOVERY OF THE NEWLY FORMED ANORECTAL APPARATUS IN THE HIGH FORM OF ANAL ATRESIA IN CHILDREN

Author: **Andrei Draganel**
Co-authors: Princu Iulia, Utchina Olesea, Șavga Daniela,
Scientific advisers: Gavril Boian, MD, PhD, University Professor, Head of Department of Pediatric Surgery, Orthopedics and Anesthesiology
Nicolae Testemitanu State University of Medicine and Pharmacy, Chisinau, Republic of Moldova

Background. Physiologically, the anorectal switching device ensures the retention of the gas, liquid and solid content in different positions of the body, including during physical exertion, sneezing and coughing. The retention occurs due to the interaction of the rectum receiving apparatus, the nervous system, the smooth muscle of the locking device and the walls of the rectum. Under the influence of a number of pathological factors, the functional capacity of the unformed rectal apparatus is substantially compromised.
Case report. In the following we present the clinical case of a patient, who was diagnosed with ARM (anorectal malformation) - high form of ano-rectal atresia, without associated fistula, with sacrococcygeal agenesis. At 72 hours after birth, after a preoperative preparation, was performed descendostoma with separate ends after A. Pena. At age of 3 months, abdominoperineal plastic reconstructive operation was performed, with neo-anus and neo-rectum formation, anterior and posterior levatoroplasty (puborectal strap formation), mAES sphincteroplasty (m. External anal sphincter). At age of 7 months, stoma was closed and the intestinal continuity was restored. The stage investigations indicate a satisfactory postoperative