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

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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

result, with the centered anal sphincter, the elastic anal ring, without stenosis, and maintaining muscle tonus. At the same time, the child present episodes of overfill encopresis and colostasis on the background of the dysmotility, caused by the caudal osteoneurogenic defect, with affecting of spinal nerve centers. Electrosphincterometry determines the bioelectric activity of the external anal sphincter muscle of the hypotone type, without signs of denervation. The anal canal profilometry at rest denotes a decrease of anal basal pressure. Profilometry in contraction, with vectorial projection of mAES denotes a symmetrical functional result in all quadrants, which shows that reconstructive proctoplasty has reached its goal in anatomical restoration of the defect, but the restoration of its function requires rehabilitation and individually tailored specialized stimulation treatment. During the time patient needed to dilate newly formed anal hole and canal, physio-kinetotherapeutic treatment, with balloon autotraining, biofeedback therapy, ultratonotherapy, perianal and sphincterian electrostimulation.

Conclusions. High form ano-rectal atresia can be corrected by reconstructive surgery, but once the anatomical area is restored it needs to be "learned" to function according to normal physiology, this being possible through prolonged functional rehabilitation.

Key words: ano-rectal atresia, rehabilitation.

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11. RARELY COMMON TYPE IV PARAESOPHAGEAL HERNIAS IN PATIENTS WITH CONCOMITANT DISEASES: A CASE REPORT

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Background. In different literature sources paraesophageal hernias (PEH) comprises from 5% to 10% of all hiatal hernias (HH). Symptoms are wide ranging and patients with PEHs are often labeled as asymptomatic or minimally symptomatic. Higher mortality rates are related to type III or IV hernias in elder patients with concomitant diseases. Thereby diagnostic of PEH can be challenging with high risk of reduced quality of life and fatal complications due to late onset diagnosis.

Case report. A 69 years old woman was diagnosed with schizophrenia in 2006 and in the past years has not taken any prescribed medication. Due to lack of eating and talking for 2 weeks, on 5th December 2019 she was hospitalized with primary diagnose - acute cerebral ischemia. A head CT scan revealed only bilateral mastoiditis. Chest x-ray showed type IV PEH. On 6th December 2019 chest CT scan showed wide retrocardiac HH with gastric inflammation in hernial sac and compromised right lower pulmonal lobe. After a thorough evaluation and physical examination, indications for acute operative treatment were not found. Patient was stabilized and started to eat and drink, although refused to take any further diagnostic tests. After repeated consultations with different specialists, a decision was made to compensate psychiatric condition followed by elective surgical PEH treatment. Diagnostics of PEH was delayed due to complicated background of concomitant diseases.

Conclusion. Not all PEHs presents symptomatic. Asymptomatic type IV PEH diagnostics may be challenging. This case report presents rarely common type IV PEH in patient with concomitant diseases which demands multidisciplinary approach. The major issue in clinical decision-making in PEH concerns the assessment of symptoms, where late onset diagnosis may lead to reduced quality of life and fatal complications.

Key words: Hiatal hernia, paraesophageal hernia, case report