by the pathognomonic sign – the Rigler triad (RT): pneumobilia (P), IO signs, calculus (C) in the intestinal lumen, which may be present to varying degrees in various imaging investigations.

Aim of the study. Analysis of the rate of presence of RT elements in the imaging investigations applied in GI diagnosis.

Materials and methods. Retrospective study based on 7 cases with GI treated in the Institute of Emergency Medicine, period 2014-2018. We studied the frequency of the presence of RT: complete or incomplete (no less than two components).

Results. Men - 2 (28.5%), women - 5 (71.4%), average age - 80.1 ± 1.9 (95% CI: 75.39-84.99). M:W-1:2.5 ratio. All patients had aggravated medical history, average Charlson Comorbidity Index was 8.5 points. These data are in accordance with the data of the specialized literature. Abdominal radiography performed in 6 (85.7%) cases, showed only radiological signs of intestinal obstruction (air-fluid levels and arches) in 4 patients (66.6%), which does not indicate the absence of GI. Contrast CT examination, performed in 4 patients (57.1%), recorded complete RT and air in the gallbladder, only in one case (25%). In other 3 cases: P + C (n = 1), signs of IO and C (n = 2), P (n = 1). The presence of at least 2 radiological criteria from RT induces the diagnosis of GI. Basically, we can find the presence of RT elements in 3 CT images: 1 complete and 2 incomplete (75%)

Conclusions. The Rigler triad, according to the literature data, can be omitted in the abdominal radiological examination, being registered at CT with an accuracy of about 75%, so we can assume that CT is useful in the rational diagnosis plan in an elderly patient, presented with signs of intestinal occlusion.

Key words: gallstone ileus, imagistic, Rigler's triad

52. RETAINED ABDOMINAL TEXTILE SURGICAL MESHES: IMAGISTIC SIGNS

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Introduction. Retained textile surgical meshes (TSM) which are left unintentionally in abdominal cavity are a problem despite precautions measures. Being qualified as major medical error, they are rarely reported. The natural evolution of condition is indistinct, whereas diagnosis and treatment are difficult and not standardized.

Aim of the study. To determine typical imagistic signs of textile surgical meshes with other surgical and non-surgical pathologies.

Materials and methods. During a 17 year period nineteen patients with retained TSM were admitted in two Departments of Surgery. Males – 6, females – 13, with median age 32.8 years. Time to readmission after first surgery ranged from 5 days to 15 years. Imaging studies included abdominal radiography, ultrasound scan, and computed tomography.

Results. Transabdominal ultrasound had shown a well-defined mass with a strong posterior shadow. Computed tomography revealed a well-defined „spongiform" mass with gas bubbles inside. In one case the diagnosis was made by upper gastrointestinal endoscopy. Thirteen patients underwent repeated surgery with removing surgical meshes and drainage of

contaminated intra-abdominal collection, one – partial gastrectomy for suspected tumor, and one – endoscopic removing of surgical mesh through stomach.

Conclusions. Retained textile surgical mesh should be considered as a possible diagnosis in any postoperative patient, who presents with signs of peritoneal infection or with abdominal mass. Repeated surgery is usually required for removing surgical meshes from abdominal cavity.

Key words: Textiloma, CT, USG, X-ray

53. DIAGNOSIS AND SURGICAL TREATMENT OF ACUTE APPENDICITIS IN PREGNANCY

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Introduction. Acute appendicitis (AA) is the most common cause of acute abdomen during pregnancy. Most signs of appendicitis are not found during pregnancy and diagnosis of appendicitis during this period remains difficult.

Aim of the study. The purpose of this study was to analyze the diagnosis and surgical treatment of acute appendicitis during pregnancy according to the experience of our clinic.

Materials and methods. In this retrospective study 27 pregnant women diagnosed with AA were included, who underwent appendectomy between 2013 and 2019. Patients were evaluated according to age, clinical signs and symptoms, gestational age, laboratory and paraclinical parameters, surgical technique, operating time, morphopathology reports.

Results. The mean age of pregnant women with AA – 26.4 ± 0.9 (95% CI: 24.49-28.23) years. The mean duration of the disease evolution was 12.3 ± 2.1 (95% CI: 8.043-16.59) hours. The most common symptom was abdominal pain (95%). By gestational age: 11 (41%) pregnant women were in the first trimester, 12 (44%) pregnant women were in the second trimester and 4 (15%) pregnant women were in the third trimester. Laboratory data are of major importance in the complex examination: leukocytes on average 14.9 ± 1.5x109 / L (95% CI: 11.73-18.12), non-segmented (left deviation) 12.8 ± 2.1% (95% CI: 8.575-17.11), erythrocyte sedimentation rate – 22.9 ± 2.2 mm / h (95% CI: 18.24-27.55). A special importance is given to inflammatory scores used in the diagnosis of AA in pregnancy. The most commonly used are: Alvarado score indicated an average of 6.6 ± 0.3 (from 4 to 9), Acute Inflammatory Score - 7.9 ± 0.3 (from 6 to 11), mean RIPASA score - 8, 9 ± 0.4 (from 6 to 11) and Karaman Score - 9.1 ± 0.5 (from 6 to 12). The surgical interventions: open appendectomy 24 (89%) and 3 (11%) laparoscopic appendectomy. Histological examination revealed: phlegmonous – 23 (85.2%) case, gangrenous 3 (11.1%) case, catarrhal only 1 (3.7%) case. Average duration of hospitalization constituted 4.8 ± 0.3 (from 3 to 8) days. The maternal complication was only in 1 (3%) pregnant.

Conclusions. Diagnosis of acute appendicitis is difficult in pregnancy. Urgent surgery is the treatment of choice and prompt surgical intervention in case of AA in pregnant women is necessary to reduce the number of maternal and fetal complications.

Key words: acute appendicitis; laparoscopic appendectomy, pregnancy