polytraumatized, 19(22.6%) with HT, 42(50%) – PT, and 23(27.4%) with HPT. Bilateral TT – 2(2.3%), in one case with HPT with flail chest, the other case – HT (ISS>20). TThS upon admission was made in 64(74.4%) cases, until 24h at 12(14%) patients and over 24h at 10(11.6%) patients. TThS was performed in all cases, 53(61,6%) cases in the 5th intercostal space, 27(31,4%) for PT in the 2nd and 6(6,7%) in the 2nd and 5th. In one case, videothoracoscopy was performed 17 hours after TThS for haemostasis. TThS was required repeatedly in 3(3.5%) cases. The average length of hospitalization was 8.34±6.6days and depended directly on the associated lesions and the duration of MV. Mortality was 3.5% (n=3), the cause being hypovolemic shock and MODS.

Conclusions. The hemodynamic stability is determining the management of chest trauma and HPT. The thoracic x-ray is negative in about ¼ cases at admission. FAST in hemodynamically unstable patients with TT can appreciate the presence of HPT. Thoracic CT has the biggest sensitivity for HPT. Repeated TThS are determined by MV and the severity of TBI. Morbidity is dependent on pulmonary contusion, prolonged MV, consciousness disorders and late mobilization.

Key words: Thoracic trauma, hemopneumothorax, treatment

57. BLEEDING FROM DIEULAFOY'S LESION: DIAGNOSTIC AND THERAPEUTIC TRENDS

Author: **Ahmad Ali Khalaily**
Co-author: Malcova Tatiana
Scientific adviser: Sor Elina, PhD, University assistant, Department of Surgery, no. 1 *Nicolae Anestiadi*, *Nicolae Testemitanu* State University of Medicine and Pharmacy, Chisinau, Republic of Moldova

Introduction. Dieulafoy's lesion (DL) is a rare, potentially life-threating cause of gastrointestinal hemorrhage, which is characterized by the presence of a unusual large tortuous artery with in the submucosal layer. The lesion predominantly occurs in the proximal stomach (80%), 6cm from the gastroesophageal junction along the lesser curvature. However, it may occur in any part of the gastrointestinal (GI) tract. Extragastric localization are also described in the literature.

Aim of the study. To offer an overview of current data on available diagnostic and therapeutic tools used for patients with GI bleeding resulting from DLs.

Materials and methods. We selected the articles published during the years 2015-2020, from the PubMed database according to the following keywords:„Gastrointestinal bleeding", „Arteriovenous malformation", „Dieulafoy's lesion", „Endoscopic hemostasis" .

Results. According to the latest statistics, DL is responsible for up to 5% of acute GI bleeds. Typically, it occurs in middle-aged men, and can vary from self-limited to massive life-threatening hemorrhage. Esophagogastroduodenoscopy may significantly improve the recognition and management of this pathology. Mechanical hemostatic therapies including endo-clipping and endoscopic band ligation are considered the most effective techniques in controlling bleeding than other endoscopic methods. Pharmacological treatment can be indicated for patients in which endoscopy is contraindicated or for those who are not responding well to other treatments. Surgical resection is reserved for the cases that fail conservative interventions.

Conclusions. Due to large implementation of endoscopic investigations DLs are increasingly identified. Elaboration of standardized diagnostic and therapeutic protocols may improve the treatment quality.
Key words: Gastrointestinal bleeding, Arteriovenous malformation, Dieulafoy's lesion, Endoscopic hemostasis.

58. MECKEL'S DIVERTICULUM – CLINICAL MASKS

Author: **Cristian Nicuta**
Co-author: Corina Scerbatiuc-Condur, V.Gheorghiţa
Scientific adviser: Igor Mishin, MD, PhD, professor, Department of Surgery nr.1 *Nicolae Anestiadi, Nicolae Testemitanu* State University of Medicine and Pharmacy, Chisinau, Republic of Moldova and Laboratory of Hepato-Pancreato-Biliary Surgery, Institute of Emergency Medicine

Introduction. Meckel's diverticulum (MD) it is one of the most common abnormalities of the digestive tract, being symptomatic in about 25% of cases, however very rarely diagnosed preoperatively, especially in adults because of various abdominal pathologies it can mime.
Aim of the study. To establish the particularities of the clinical manifestations of MD and the rate of its preoperative diagnosis in adults.
Materials and methods. Retrospective study: 21 patients with MD treated in the surgery clinic "N. Anestiadi" of the Institute of Emergency Medicine, period 2012-2018. Average age - 50.2±3.9. Men - 11 (52.3%), women - 10 (47.6%), the M/W ratio 1.1:1. Diagnosis on admission: acute appendicitis - 9, intestinal obstruction - 4, colon cancer - 4, hypersplenism - 1, strangulated hernia - 1, cutaneous wound - 1, digestive hemorrhage - 1. From 100% patients undergoing surgery: McBurney access - 9 , LMM - 11, treatment of inguinal hernia - 1. Of the total group, mortality constituted 14.2% (3), for non-surgical reasons.
Results. Symptomatic patients - 14 (66.7%), ($p = 0.0629$), of which: men - 5 (35.7%) and women 9 (64.3%). In the rest of the patients, MD was accidentally diagnosed in the interventions for other pathologies. Complications detected intraoperatively in symptomatic patients: diverticulitis - 64.2% (n=9), torsion - 14.2% (n=2), hemorrhage - 7.1% (n=1), Littre hernia- 7.1% (n=1) and adhesions - 7.1% (n=1). Surgical treatment was applied in all cases of symptomatic MD. Morphology of postoperative sample: length (L) - 5.1 ± 0.6 cm (from 1.5 to 12), thickness (T) - 2.1 ± 0.2 cm (from 1 to 4), L/T ratio - 2.6±0.3. Histologically in all cases MD was covered with normal intestinal mucosa.
Conclusions. Symptomatic MD rate was 66.7%, the most common complication being diverticulitis. In no case, the diagnosis was established preoperatively. The diagnosis of complicated MD should be considered in adult patients who present with specific data of acute surgical abdominal pathology.
Key words: diverticulum, complication, asymptomatic

59. FECAL MICROBIAL MARKERS–THE ROLE IN COLORECTAL CANCER SCREENING: A REVIEW OF LITERATURE

Author: **Alexandr Ursu**
Scientific adviser: Rojnoveanu Gheorghe, MD, PhD, University Professor, Department of Surgery no.1 *Nicolae Anestiadi; Nicolae Testemitanu* State University of Medicine and Pharmacy, Chisinau, Republic of Moldova