

curative laparotomy - 8.2 ± 1.2 , ($p < 0.001$). One patient died before laparotomy. Of patients which underwent laparotomy, 3 died (11.11%).

Conclusions. Abdominal wound management is of major concern and includes patient selection for different treatment tactics. Haemodynamically stable patients without peritoneal signs require clinical examination and dynamic monitoring, and those haemodynamically unstable with hemorrhagic and peritoneal syndrome - emergency exploratory laparotomy. Differentiated therapeutic attitude leads to avoidance of non-therapeutic laparotomies, decrease of the postoperative complications rate, hospital stay and medical costs.

Key words: abdominal wounds, diagnosis, treatment

137. MANUAL VS. MECHANICAL ANASTOMOSIS IN COLON RESECTIONS – ARE THERE ANY RISK FACTORS?

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Introduction. Colonic resections with intestinal anastomosis are laborious interventions that require advanced technical skills. Modern technologies provide new equipment and mechanical devices for anastomosis which come to simplify the surgery.

Aim of the study. Analysis of the risk factors in colon resections according to the type of anastomosis.

Materials and methods. A retrospective study was made with the analysis of the patient's medical history and the operative protocols of 130 patients with colorectal resections completed with anastomosis in the PMSI IEM during 2015-2017. The postoperative evolution of patients with anastomosis was analyzed according to the time of surgery, type of anastomosis (mechanical / manual), type of continuity, location of anastomosis, duration of surgery, age of patients.

Results. The results of the analysis were as follows: ratio M:F - 4:5; average age - 61.45 ± 1.3 years. 84 (64.62%) patients underwent resections with manual anastomosis and 46 (35.38%) - mechanical anastomosis ($p < 0.001$). 74 (56.92%) patients underwent an emergency surgery, 56 (43.07%) had elective interventions, there was no significant difference between these groups. The postoperative period has evolved with anastomotic leakage in 6 (4.62%) cases: 3 (3.57%) with manual anastomosis and 3 (6.52%) with mechanical ($p > 0.05$). There were 5 (5.95%) leakage cases in the left colon resections - no significant difference compared to their incidence in the right hemicolectomy - 1 (2.22%). There were no significant differences in the location of anastomosis: of the rectum region 3 (7.69%), colo-colic 2 (4.28%), with ileum 1 (2%). According to the continuity of the anastomosis, two cases of leakage were observed: 6.67% in the termino-lateral anastomosis, 5.56% in the lateral-lateral and 3.13% in the termino-terminal, ($p > 0.05$). Age did not manifest itself as a risk factor for anastomotic fistula, 69.33 ± 4.4 years in patients with anastomotic leakage compared to 60.48 ± 1.36 in survivors ($p > 0.05$). Although the duration of the surgery with mechanical anastomosis was less (154.9 ± 9.14 min) compared to manual anastomosis (173.47 ± 8.49 min), no significant differences were observed, similar to the duration of the operation with favorable evolution compared to the cases of anastomosis dehiscence, respectively 168.53 ± 1.36 min versus 140.33 ± 8.8 min. 12 (9.2%) patients died.

Conclusions. Although the rate of manual anastomosis significantly outweighs the mechanical ones in colon resections ($p < 0.001$), there were no risk factors with significant difference regarding the incidence of anastomotic leakage according to the parameters analyzed.

Key words: Colon resections, manual and mechanical anastomosis, anastomotic leakage