ACUTE MESENTERIAL ISCHEMIA: OPTIMAL DIAGNOSIS AND TREATMENT MODALITY

Introduction: Up to date there are no widely accepted evidence based principles for the diagnosis and treatment of acute mesenterial ischemia and the treatment outcomes are poor. The death rate in this group of patients varies between 70 and 90 %. Aim: to appreciate the initial diagnostic and treatment results of acute mesenterial ischemia. Material and methods: During January 2009 – May 2011 29 consecutive patients with mesenterial ischemia. The mean age was 70.3±2.4 (35-95) years, the mean time from onset to hospitalization was 37.1±8.1 (1-168) hours, the mean APACHE score was 24.79±1.9, ASA score – 3.32±0.1, POSSUM score was – 37.45±1.9. The diagnosis was established upon WBC, blood lactate level, procalcitonine, 3D-CT angiography and laparoscopy. The patients were treated using the "second look" principle (n=21), resection and primary anastomosis (n=2), diagnostic laparotomy (n=6). Venous and arterial mesenterial ischemia was diagnosed in 5 and 24 patients respectively.Results: The mean WBC upon admittance was 17.88±1.7x109/L, mean nonsegmented WBC was 29.0±4.2%, mean value of blood lactate level was 2.56±0.5mmol/L, In 8 patients the PCT-Q test was ≥10ng/ml, mean glucose level was 11.3±1.2 mmol/L and in 6 patients it was over 6 mmol/L. The postoperative death rate was 68.9% (n=20).Conclusions: The initial experience favors the "second look" principle and resection with primary anastomosis for the treatment of acute mesentery ischemia. Larger patients' series are necessary in order to drag definitive conclusions regarding the optimal time for anastomosis.

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APENDICOPATIILE ÎN CHIRURGIA DE URGENȚĂ - O PROBLEMĂ MAI MULT DECÎT DISCUTABILĂ

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Dacă pînă în prezent au fost atinse succese notabile în chirurgia apendicitei acute, nu ne dă posibilitatea să constatăm faptul că problema este rezolvată definitiv,au rămas probleme neclare și discutabile: 1)nu este perfectă diagnostica; 2)sunt divergențe în privința tacticii chirurgicale; 3) lipsesc intraoperator criteriile unice a modificărilor macroscopice; 4)sunt divergențe în diagnosticul clinic și rezultatele morfohistologice. Studiile din literatura franceză au constatat faptul că la 20% din cei operați s-a înlăturat apendicele neafectat. Au fost studiați 235 pacienți cu vîrsta 14-80 ani. Femei-bărbați 1,5:1. Durerea manifestată la 100% bolnavi caracterizată prin (spontană, permanentă, intermitentă, difuză, localizată, violentă, transfixiantă, iradiere topografică). Defens muscular, meteorism, pulsmetria, temperatura corpului s-au manifestat în raport variabil. Simptoamele subiective (diaree, constipație, vomă, s.Koher, grețuri) prezente la toți bolnavii. Prevalența s. obiective (Blumberg, Rowzing, triada Dieulafoy, Bartomie-Mihelson, Coop) a fost notată la bolnavii cu semne evidente de apendicită acută. La 80% - hiperleucocitoză. Polinucleoza a fost marcată variabil: normal, moderată, notabilă, excesivă și majorată enorm. USG abdominală : pneumatoză intestinală, apendice vizualizat, mobil, imobil, îngroșat, lichid în cavitatea abdominală notate variabil. Intraoperator s-a înregistrat lichid seros, serohemoragic, seropurulent, purulent cu variații. S-a constatat faptul că 22% nu au modificări patomorfologice în apendice. Coeficientul identificării diagnosticului clinic cu cel patomorfologic este în raport 4,5:1. Acestea sunt cazurile apendicopatiilor cu manifestări clinice evidente și cu lipsă de substrat patomorfologic, mai bine spus, apendice neafectat.

Concluzii:

1. Apendicopatiile diferă radical de apendicita acută prin faptul că ele se manifestă clinic printr-un complex simptomatologic evident de apendicită acută și cu lipsa totală a substratului patomorfologic.
2. Pentru a clarifica aceste probleme definitiv, va fi necesar un studiu clinic mai profund si identificarea mai sigură a modificărilor patologomorfologice.
3. Extirparea apendicelui alterat în apendicopatie, cauză a fenomenelor dureroase sau a crizelor repetate, se impune ca singura măsură de a vindeca răul prezent și de a evita pericolele viitorului.

APPENDICOPATHIES IN EMERGENCY SURGERY - A SUBSTANTIAN PROBLEM

The fact that until now has been achieved notable success in the surgery of acute appendicitis doesn't give us the possibility to say that the problem is entirely solved; there still are many confusing and contestable problems:

1) the diagnosis is not perfect.
2) there are many divergences about the surgical tactics.
3) there are no unique criteriafor macroscopical changes during the operation.
4) there are different opinionsamong surgeons as for clinical diagnosis and morphological characteristics.

The study of French literature have concluded that in the case of 20% of operations unaffected appendix has been removed. 235 patients aged 14-80 years in rapport of 1,5:1 women and men have been examined.

The pain manifested at 100% of patients was characterized as spontaneous, continuous, intermittent, diffuse, localized, violent, topographical radiation. The muscle defense, flatulence, pulsation, high temperature occurred in several cases. Subjective symptoms (diarrhea, constipation, vomiting, Koher's sign and nausea) have been noticed at all the patients. The prevalence of objective symptoms (Blumberg, Rowzing, Dieulafoy triad, Bartomie-Mihelson, Coop) has been noticed at the patients with obvious signs of acute appendicitis. 80% manifested hyperleukocytosis. The mark of polynucleosys was variable: normal, moderate, noticeable, excessive and increased enormously. The ultrasound check of abdomen showed intestinal pneumatosis, visible, mobile, immobile, thickened, fluid appendix in the abdominal cavity has been detected in several cases. Intraoperative serous, sero-hemorrhagic, seropurulent and purulentliquid was noticed 22% of patients had no pathomorphologicchanges coefficient was 4,5:1. These are the appendicopathy cases with clinicalmanifestations and lack of pathomorphological base, batter said: normal, unaffected appendix.

Conclusions:

1. Appendicopathies differ radically from acute appendicitis in that they manifest clinically evident symptomatic complex of acute appendicitis and total lack of pathomorphological substrate.
2. To clarify these issues ultimately a deeper clinical study and a more reliable identification of pathomorphological changes would be necessary.
3. The removal of altered appendix in appendicitis, cause of pain phenomena or repeated crisis imposes itself as the only measure to cure the present disease and to avoid future dangers.