

indication of surgery timing is established upon the clinical criteria which we obtain according to Ranson Criteria and APACHE.

Conclusions: The open abdomen method has as advantage the existence of a permanent access way to the pancreatic lodge, with secretion elimination and as well as contact with O₂ which does not allow the development of anaerobic bacteria.

Keywords: acute pancreatitis, surgery, Ranson criteria, APACHE

3. POST-INFARCTION LEFT VENTRICULAR ANEURYSM. RESULTS OF SURGICAL TREATMENT

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Introduction: Even after the introduction of advanced methods in the treatment of acute myocardial infarction (MI), as early thrombolysis, percutaneous coronary intervention (PCI), *Left Ventricular Aneurysm* (LVA) remains to be a severe mechanical complication encountered in 7-35% of cases. The study is intended to evaluate results of surgical remodeling of the left ventricle.

Material and Methods: Study is performed analyzing the evolution of ventricular size and its function during the pre-, intra- and postoperative periods. Patients were operated at R.C.H. *Department of Cardiac Surgery* and „MEDPARK” International Hospital. Preferred time for the surgery is 3 months after an acute MI, allowing wall area to scar and delineate well which enables to determine the akinetic/dyskinetic zones and application of sutures after choosing the method of plasty. Plasty techniques at the moment are: aneurysmorrhaphy, resection of the aneurysm with linear suturing (*Mickleborough*), remodeling technical procedures (*Dor, Colley, Jatane*). In most of the cases was performed coronary artery bypass grafting for myocardial reperfusion. In this study were included 180 operated patients: 150 men and 30 women, with a mean age 58(41-76) years. Concomitant procedure included: papillary muscle sling (according to *Hvass technique*) – 42 cases, mitral valve annuloplasty – 51 cases. The mean preoperative LV ejection fraction (EF) was 36%, the mean LV diastolic volume 241 ml, and mean LV systolic volume was 112 ml. One of the purposes is to diagnose more efficiently the heart chambers, their vascularization. Postoperatively patients are well monitored to see their evolution by checking general clinical condition and cardiac chambers dimensions (*EchoCG*).

Results: The mortality is 6 times higher in patients who suffered MI with formation of ventricular aneurysm with or without low ejection fraction than in the patients who did not develop LVA. All operated patients have 4,9% lethality risk. The causes of death were low cardiac output syndrome, multi-organic insufficiencies and irreversible ventricular fibrillation. Five year-survival after the surgery is 87% and up to 10 years survival is in 60-65%. Heart failure III-IV (*NYHA*) was in 92%; the localization of the LVA was on the antero-apical wall, found in 92%. Intraventricular thrombus was detected in 35,2% of cases. Also was attested improvement in the ejection fraction from 36% to 50% and the average LV end diastolic volume decreased from 241 ml to 165 ml and LV end systolic volume from 112 to 81ml.

Conclusion: Surgical reconstruction of LVA, associated with a complete myocardial revascularization and concomitant procedure (papillary muscle approximation and correction of ischemic mitral regurgitations) lead to good outcomes for patients in follow up period.

Key words: acute myocardial infarction, left ventricular aneurysm, aneurysmorrhaphy, surgical treatment, aortocoronarian by-pass