

**Conclusion:** This meta-analysis study provides evidence that translocation (especially of endotoxin) occurs into the thoracic duct. These data do support the concept that the thoracic duct is a major route of bacterial translocation in patients with MOF

### 38. NEGATIVE PRESSURE THERAPY IN THE TREATMENT OF SUPPURATED EVENTRATED LAPAROTOMIC WOUND

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**Introduction:** The laparotomic suppurated eventrated wound is a postoperative complication caused by contamination, suppuration and necrosis of the abdominal wall anatomical layers (subcutaneous fat, ventral aponeurosis, peritoneum) with eventration of abdominal organs. The use of negative pressure therapy in the treatment of laparotomic suppurated eventrated wound is described worldwide in the specialty literature, but its efficiency depending on the etiology of the intraabdominal infection remains insufficiently studied.

**Purpose and Objectives:** Reporting the results of the treatment with negative pressure of the patients with laparotomic suppurated eventrated wounds.

**Materials and Methods:** From October 2012 until March 2014, negative pressure therapy was used in the treatment of laparotomic suppurated eventrated wounds in 22 patients with the mean age of 64.2 and sex ratio M:F being 15:7. The study included patients with laparotomic suppurated eventrated wounds due to diffuse peritonitis in the following nosologies: inguinal hernia with small bowel necrosis (1), postoperative ventral hernia (1), gastric adenocarcinoma with perforation (1), gangrenous cholecystic perforation (1), closed abdominal trauma with bowel (1) and small intestine injury (1), fistular Crohn's disease (1), gangrenous perforative appendicitis (3), colon ischemia and necrosis with perforation (2), nonspecific ulcerative colitis with intestinal obstruction (1), colon diverticulum perforation (2), benign tumor of the colon with mechanic obstruction (1), colon adenocarcinoma with mechanic obstruction (3), colon adenocarcinoma with perforation (3).

**Results:** The negative pressure therapy set at 75-105 mmHg was applied after necrectomy, with a mean duration of the sessions of 48-72 hours. The number of sessions was determined by the type of intraabdominal infection. Wound closure criteria were: the presence of mature granulation tissue, the type of inflammatory-regenerative cytological imprints and the decrease of the amounts of wound microflora from  $10^{6-7}$  to  $10^{2-3}$ . The treatment was carried out in two stages: the first stage - negative pressure therapy with suturing of the ventral aponeurosis, the second stage - continuing negative pressure therapy with complete closure of the laparotomic wound. Definitive closure of the abdominal wall was possible in 19 patients. 3 patients died, the mortality rate constituting 13.6%.

**Conclusions:** The use of negative pressure therapy in the treatment of the laparotomic suppurated eventrated wounds allows to: eliminate the septic source, decrease the frequency of dressings changes- one at 48-72 hours with a fascial closure rate of 86.4%.

**Keywords:** negative pressure therapy, laparotomic suppurated eventrated wounds, fascial closure

### 39. HAEMOSTASIS FOR VARICEAL BLEEDING IN PATIENTS WITH LIVER CIRRHOSIS

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**Introduction:** Variceal bleeding is a severe complication of cirrhosis leading to significant morbidity and mortality. Ruptured esophageal varices cause approximately 70% of all upper

gastrointestinal hemorrhages in cirrhosis. Diagnostic and therapeutic developments have led to a significant improvement in the prognosis of this complication over the past two decades. Endoscopic treatment, mainly variceal band ligation or sclerotherapy, has proved to be effective in controlling acute variceal bleeding.

**Material and methods:** The study was performed within the National Scientific Practical Center of Emergency Medicine. Fifty seven consecutive alive patients admitted with variceal bleeding were included. There were 38 male and 19 female patients, mean age -  $53.7 \pm 12.6$  (95% CI: 50.34-56.99) years. The patients were divided according to the Child Pugh score as follows: class A - 22 patients (38.6%), class B - 30 patients (52.6%), class C - 5 patients (8.8%). Haemostatic methods used were: Sengstaken Blakemore (SB) tube in 11 patients (19.3%); endoscopic rubber band ligation (EBL) in 23 patients (40.3%) and combined methods – SB probe + EBL in 11 pts (19.3%), Danis stent + EBL in 1pt (1.75%), sclerotherapy + SB probe + EBL in 1 pt (1.75%), SB probe + Danis stent + EBL in 1pt (1.75%); in nine patients only pharmacological methods of haemostasis were used.

**Results:** Several parameters were analyzed and compared between the groups Child Pugh A, B and C (using one way ANOVA with Bonferroni post test): length of stay, length of ICU stay, Algover shock index, number of installed rubber bands, volume of packed red blood cells and fresh frozen plasma transfusion, length of SB probe in situ and the MELD score. No statistically significant differences were found between the three groups, except the MELD score (A vs B, A vs C and B vs C;  $P < 0.0001$ ).

**Conclusion:** Although our study didn't show any statistically significant difference of various parameters between the three groups, there is a general agreement that advancing through the Child classes from A to C the patients are more severely ill and have a poorer prognosis, fact proved by the highly significant difference of the MELD scores.

**Keywords:** cirrhosis, Child Pugh, varices, bleeding, hemostasis

#### 40. LIVER TRANSPLANTATION

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**Introduction:** Liver transplant surgery is very difficult and hard to make. This surgical method allows to treat patients suffering from liver disease in advanced stages. Many scientists with continued history of liver transplantation, several surgical approaches have been proposed that liver transplantation be performed successfully and the patient's lifetime to be as high posttransplant. Developing research in immunosuppression has made disappear liver graft rejection thus increasing the life span of patients posttransplant.

**Purpos end Objectives:** Study of surgical techniques used in liver transplantation. Efficacy posttransplant. Study anatomical variants and biliary vessels main maintaining quality graft, surgical techniques to container, donor, back-table, graft implantation.

**Materials and Methods:** Gathering all the information related to the surgical and postoperative treatment. Research and publications carried out by Scientists in the field of liver transplantation.

**Results:** Total hepatectomy technique "piggyback". Hilar dissection should be performed as high as possible (especially blood and bile). Cystic duct is ligated and sectioned. High hilar dissection (High Hilarious Dissection, HHD). Using high hilar dissection enables us to perform venous anastomosis sector. Dissection of the bile duct. Donor operation: Skin incision. Full mobilization of the right hepatic lobe. Issuance of right hepatic lobe of the inferior vena cava. Preservation for future reinpantarea vein diameter  $> 5\text{mm}$ . Hepato - caval ligament transection . Cholecystectomy with cholangiography subsequent cystic duct catheterization. Intraoperative ultrasound. Selective clamping the artery and portal vein straight boundary demarcation of hemificatul hemificatului left. Parenchymal transection with electrocautery. Pedicolului final clipping and bile ducts in the portal as hemificatului law. Technical Back -Table: weighing graft harvested. Wisconsin perfusion solution. Grading scale blood , bile and venous existing anatomical variants. Right hepatic artery is cannulated and dilated. Reanastomozate the manner termino-terminal venous system with