- the transcutaneous transhepatic cholangiostomy (TTCHS)
- the laparotomic choledochotomy with the external drainage of the common bile duct (EDCH)
- laparoscopic choledochostomy (LSCHS)

The second group, the seventh day after the surgery:

- the endoscopic papillosphincterotomy (EPST)
- the stenting
- the blending of choledochoainoaistomosis (CHAIA) and choledochoduodenoastamosis (CHDA)

The first group, a year after the surgery:

- TTCHS
- LSCHS.
- EDCH

The second group, a year after the surgery:

- the stenting of the choledoch
- CHAIA
- EPST
- CHDA.

Conclusions:

1. Each of the methods of the biliary decompression has clear indications and contraindications, the final choice of the method of the surgery, we believe, should be based primarily on the assessment of its impact on the quality of life in patients with the choledocholithiasis in the postoperative period with the primary usage of the sphincter-preserving invasions.

2. Using the methods of the external biliary decompression the indicators of quality of life of the patients after the sphincter miniinvasive procedures such as the transcutaneous cholangiostomy and laparoscopic transhepatic choledochostomy, reached to 97,4 ± 2,1% and 85,3 ± 2,8% (related to the healthy people).

3. Among the methods of the internal biliary decompression, the highest results reached the stenting - 94,0 ± 3,7% (related to the healthy people).

4. Despite the fact that at the present stage of development of the biliary surgery the choledochoduodenoastamosis is widely used because of its simple technique and physiology, we recommend to use the choledochoainoaistomosis, after the application of which the indicators of quality of life of the patients are higher.

Key words: choledocholithiasis, quality of life, surgical techniques and methods, long-term consequences.

THE LAPAROSCOPIC ANTIREFLUIX SURGERY FOR HIATAL HERNIAS: EARLY RESULTS

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Introduction: Hiatal hernias have been the focus of surgeons over many years. The update of this

subject is due to the increasing number in patients with these diseases as a result of diagnostic possibilities, with the advantages of laparoscopic approach. Hiatal hernia in 66% cases is associated with gastro-esophageal reflux. Surgical treatment of hiatal hernia consists of removing the hernia sac through crurorаphy and antireflux procedure.

Purpose: Review of the contemporary laparoscopic management of hiatal hernias.

Materials and methods: 35 laparoscopic antireflux surgeries were performed during 2011. Axial hiatal hernias were recorded in 30(85,5%) cases, while hiatal mixed hernias- in 5(14,5%) combined cases. All patients were examined endoscopically, X-ray, and pH-metric studies. All the patients had a preoperative period which included the drug therapy for gastroesofageal reflux.

Results: The average age of patients was 48 years. There were 21 60%) women, and 14(40%) men. In the department of general surgery were operated all the 35 patients through laparoscopy. In 31(88,6%) cases underwent previous crurorаphy with fundoplication Nissen-Rossetti, in 4(11,4%) cases – by pr. Dor. The posterior crurorаphy has been used as a standard method in all cases. The average hospitalization period was 7 days. In all 35 cases the esophago-gastrography control was administrated with barium before the discharge of patients. Intraoperative complication wasn't registered. In the postoperative period 7 (20%) patients showed clinical signs of dysphagia, this regressed after administration of the drug treatment. There were no conversions. The follow-up results were not evaluated.

Conclusions:

1. Patients with hiatal hernias may benefit from the advantages of laparoscopic antireflux surgery.
2. In most of patients the postoperative dysphagia had a transitory character.

Key words: hiatal hernia, laparoscopic surgery, antireflux procedures.

ABDOMENOPLASTY WITH ONE-STAGE BREST ENDOPROTHESIS TRANSABDOMINAL ACCESS

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Introduction: The desire of patients to receive the maximum aesthetic result with minimal injury and "invisibility" of postoperative hem creates major difficulties for the surgeon in determining access. During the detachment of a standart of abdominoplasty skin-fat flap is held up to the xiphoid process and lateral to the costal arch, extending to the anterior axillary line, which makes possible with sufficient technical equipment of the holding-stage augmentation mammoplasty.

Aim: to improve the aesthetic result of augmentation mammoplasty using transabdominal access.

Materials and Methods: The operation was performed on the patient of 34years. Estimated volume of surgery - abdominoplasty, closure of the white line of the stomach, breast endoprosthesis through the transabdominal access. Operation: endotracheal anesthesia. The total operation time is 3hrs 40 min. Previously tracing of the surgical field was made. Standard horizontal incision above the pubis with the transition to the iliac spine. Detachment of the dermal-fat flap, bluntly and sharply, up to the xiphoid process and costal margins and laterally to the anterior axillary line. Fix diastasis between the rectus abdominis, which was 5.5cm reorganization carried out the surgical field with an aqueous solution of 1% dioxidine. Next, a tunnel was formed of about 7 cm, width to 4 cm mid-clavicular line medially and 3 cm laterally from it to the inframammary fold. The lower edge of the breast was mobilized using endoscopic techniques (KarlStorz). Then the large pectoral