rupture of the aneurysm of the AVF with external bleeding (n=2); c) pseudoaneurysm with PTFE graft infection (n=1); d) presence of calcinates in the aneurysm wall and of pain syndrome (n=1); e) aneurysm of the AVF in association with stenosis and partial thrombosis (n=3). According to location, the DTA are situated: on anastomosis line (n=2), at the puncture site (n=4), partial venous aneurysm (n=2), pseudoaneurysm of the polytetrafluoroethylene (PTFE) graft (n=1). Surgical treatment was performed in 9 (60%) from 15 patients. Following types of surgical correction were used: aneurysmectomy + AVF formation using PTFE graft (n=2), resection of the aneurysm with the reestablishment of native AVF with a segment of PTFE (n=1), resection of the aneurysm + reconstruction of the native AVF (n=4), aneurysmectomy + central venous catheter (n=1), reconstruction of synthetic AVF (PTFE) (n=1). The surgical option is made according to the size of the aneurysm, blood flow in the AVF and the patient's vascular supply. The goal of the surgical treatment is to preserve the native AVF, but in case of absence of necessary peripheral vascular reserves – synthetic PTFE graft is recommended to form a new vascular access.

Optimal Type and Timing for Cholecystectomy in Patients with Acute Biliary Pancreatitis

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Pharmacological management in patients with acute biliary pancreatitis could result in elevated number of its complications. The type of surgery, endoscopical management and timing for these procedures is controversial. For the present study 62 patients with acute biliary pancreatitis were selected. The diagnosis was confirmed by laboratory (blood and urine amylase level) and paraclinic (USG, ERCP with papillosphyncterotomy) tests. In all cases elevated level of urine amylase was detected and in 32.3% - elevated blood bilirubin level. In all patients with signs of elevated pressure in the biliary tree - ERCP with papillosphyncterotomy was performed. In 26(42%) choledocholithiasis was diagnosed while in 36(58%) – other reasons of biliary tract obstruction. In case of choledocholithiasis and patients' positive evolution, confirmed by instrumental and laboratory tests, ERCP and papillosphyncterotomy was performed within 24-48 h. form admission. These patients underwent surgery within 6-7 days, after general condition improvement – confirmed by laboratory tests. Laparoscopic cholecystectomy was performed in 60, while traditional surgery – in 2 cases. Laparoscopic cholecystectomy in patients with acute biliary pancreatitis can be performed after biliary tree decompression by means of ERCP with papillosphyncterotomy and improvement in patients' general condition. Laparoscopic cholecystectomy is considered "golden standard" for the treatment of acute biliary pancreatitis.

Surgical Management of Mesenteric Ischemia

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The aim of the research was to assess the initial results of the application of "Damage Control Surgery" (DCS) principle in the treatment of acute mesenteric ischemia (AMI). Despite the successes achieved in the surgical treatment of the AMI the lethality rate in this group of patients is still 70-