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-

90%. Several surgical options have been reflected until now in literature, but there are few articles on the application of DCS principle in the surgical management of AMI. We present the results of the surgical management of 13 consecutive cases of AMI treated according to the DCS management option (immediate resection of nonviable bowel without the reconstruction of the digestive tract, laparostoma, including VAC-system, stabilizing the patient in the Intensive Care department and eventual elective reconstructive surgery later) between January 2009 and march 2010. Mean age was 67.92±2.48 (48-79) years, with the mean period of time before check-in of 45.62±14.47 hours. Diagnosis was set using the results of D-dimers test, 3D-CT with angiography and laparoscopy. 11 cases of arterial AMI and 2 cases of venous AMI were identified. The primary surgery included resection of the nonviable portion of the intestine: ileum (n=2), jejunum+ileum (n=3), jejunum+ileum+right hemicolonectomy (n=8). The final reconstructive surgery was performed after 50.82± 5.31 hours. The postoperative mortality was 61.53% (died 8 patients). The initial experience demonstrates that the Damage Control Surgery principle can be considered the only surgical option for the treatment of patients with AMI. The final conclusions will be defined after the analysis of a bigger group of patients.

Anatomical Embryological Posibilities for Ventral and Dorsal Pancreatic Resections

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Recently, ventral and dorsal pancreatic resections are considered the procedures of choice for low-grade malignant neoplasms. The anatomical structure of the head of the pancreas is currently controversial. The anatomy of the head of the pancreas was studied on 10 fresh and 10 fixed in formaline specimens, collected from cadavers with age between 18-85 years, without pancreatic injuries. Anatomical macropreparation, morphometry, histotoporaphy were performed as methods of the study. The apex of the uncinate process was considered as orientation for separation and penetration into the interpancreatic fissure. The presence of a loose fissure between this two pancreatic structures facilitates their separation. The ventral portion is adhered to the dorsal portion by means of perforating vessels only. The ventral portion is connected to the dorsal portion by loose tissue. After separation, the dorsal and ventral pancreatic surfaces are smooth and shiny. The ventral portion can be removed without affection for the duodenal blood circulation. A complete fusion between the ventral and dorsal pancreas is determined only in the 1/3 superior part of the head of the pancreas. The main blood source for the ventral portion of the pancreas is presented by anterior pancreatoduodenal arcade. The ventral and dorsal pancreatic resections are argumentated anatomically and embryologically.

Intra-Abdominal Hypertension in the Intensive Care Unit

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Intra-abdominal hypertension (IAH) and abdominal compartment syndrome (ACS) have been increasingly recognized in the critically ill over the past decade. The wide variety of definitions leads to confusion and difficulty in daily activity. Goal of study: Elucidate the leading causes of IAH in intensive care unit and the systemic effects of elevated intraabdominal pressure. Materials and methods: The study included 22 patients who had monitored intraabdominal pressure, the total