

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  $67.92 \pm 2.48$  (48-79) years, with the mean period of time before check-in of  $45.62 \pm 14.47$  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  $50.82 \pm 5.31$  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 Possibilities 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 uncinat 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