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

number of measuring being 33. The average age of patients was 53,9. The patient's severity state was quantified by APACHE II score, the average being 15,9. The measurement of intra-abdominal pressure (IAP) was performed by indirect method – urinary bladder pressure measurement. Results: The leading causes of IAH were: intraperitoneal surgical pathology in 68% (n=15), retroperitoneal pathology in 27%(n=6) and one case of ventral hernia cure complicated by IAH. The average of IAP was 15,58 mmHg, the highest value was recorded at the patients with retroperitoneal pathology. Carrying on analysis of systemic effects of IAH was marked tachypnea at the patients whose IAP exceeded the value of 15mmHg. Signs of pulmonary shunt was found in 84,85% cases, the ratio of PaO2/PAO2 being 0,47. Comparing IAP values at the patients who had signs of pulmonary shunt and competitor group was noted a negligible difference. At the patients with IAH was noted a slight tendency to tachycardia, the average heart rate being 93.64±15.91 per min. False high values of central venous pressure (CVP) have been recorded at the patients whose IAP exceeded the value of 20mmHg. The average level of serum creatinine in the single group was 111,44 μmol/dl. Higher serum creatinine values were recorded at the patients with increased values of IAP as impairment of kidney function. Discussion and conclusions: Abdominal hypertension is a more common phenomenon in intensive care unit than seems to be at first sight. Causes leading to elevated intraabdominal pressure are diverse, but unified according to certain principles can be separated into 3 anatomical large groups: intraperitoneal, retroperitoneal pathology and those related to abdominal wall. Elevated intraabdominal pressure has systemic reflexion. Prevalence of pulmonary shunt at the patients with IAP<15 mm Hg versus those with IAP>15mmHg can be explained by other origins than intraabdominal hypertension when IAP value doesn't exceed 20mmHg. Hemodynamic effects are manifested by high false CVP value, which is a surrogate of preload and reflects indirect volemic state. Intra-abdominal pressure less than 20mmHg had minimal systemic effects while IAP exceeding 20mmHg is responsible for the compromising of at least one organ system.

Safety and Effectiveness of Ultrasound-Guided Foam Sclerotherapy for Varicose Veins

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The aim of this study is to compare NICE guidance recommendations to the outcome of a series of patients with varicose veins managed by ultrasound-guided foam sclerotherapy (UGFS), thereby assessing UGFS's safety and effectiveness. Methods: Between April 2008 and December 2009, 16 outpatients (9 males and 7 females), mean age 48.1 years, with varicose veins were treated with UGFS at the Queen Elizabeth Hospital. An audit support tool provided by NICE was used to collect data relating to three criteria: consent, safety and effectiveness. Results: Consent was sought in 100% of cases. Colour-flow Doppler ultrasound testing showed that 92% of limbs were completely occluded with no reflux at the saphenofemoral junction, whereas only 1 patient showed occlusion with reflux at the saphenopopliteal junction. None of the patients reported recurrence of varicose veins. No serious side-effects were reported. 31% had pigmentation post-procedure, 25% suffered from bruising, but only 6% reported a skin ulcer post-treatment. 75% of patients were happy and satisfied with the results, while the rest (25%) were unhappy due to persistent skin pigmentation (12.5%), pain (6%), or lack of symptom improvement (6%). The AVVQ scores show that 86% of patients have an improved quality of life post-treatment. Our results are in accordance with the NICE guidance. The outcome of the 16 patients suggests that UGFS is an efficacious and safe procedure short term. Nonetheless, a study with a larger sample size and a longer follow-up is needed to confirm our findings, yield more statistically significant results and establish long term efficacy.