

Materials and methods. The English literature search was conducted in PubMed database, using the following MeSH-terms: “gastrointestinal lipoma”, “duodenum”, “giant lipoma”, “complications”, “endoscopic excision”, and “surgical excision”, time period 2010–2022.

Results. Gastrointestinal (GI) lipomas account 4% of all benign GI tumors, most of them are seen in colon (64%) or small intestine (26%), rare localizations, as duodenum (4%), stomach (3%) and oesophagus (2%), are also described. Literature on duodenal lipomas (DLs) is scarce, only 7 relevant publications were identified. They are slow-growing, most of them asymptomatic, incidentally discovered, most frequently localized in D2 (n=6;85.7%), but may cause a set of specific or non-specific upper GI complaints, including early satiety, abdominal discomfort, pain, and fullness (n=4;57.1%). Severe complications are registered in case of giant lipomas (>4,0 cm), as anemia because of ulceration and bleeding (n=3;42.8%), intestinal obstruction due to intussusception (n=1;14.3%). Clinical investigations necessary for diagnosis include esophagogastroduodenoscopy (n=6;85.7%), CT (n=3;42.8%), and endoscopic ultrasound (n=4;57.1%). No standard of care to treat symptomatic lesions is accepted; the existing recommendations are controversial. For the larger lesions endoscopic removal may be associated with high risk of hemorrhage and perforation; it is difficult to be applied in case the lesion is localized in D2 which is narrow and curved, surgical excision being preferred (n=3;42.8%).

Conclusions. Giant DLs are extremely rare. The symptoms are nonspecific and imaging tools are useful for diagnosis. The treatment depends on the size and position of the lesion.

Keywords. Gastrointestinal lipoma, duodenum, giant lipoma, complications, endoscopic excision, surgical excision

STRATEGIA MODERNĂ A RECONSTRUCȚIEI PERETELUI ABDOMINAL ÎN TRATAMENTUL HERNIILOR INCIZIONALE GIGANTE



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Scopul lucrării. Tratamentul chirurgical al herniei incizionale gigante cu “pierdere dreptului la domiciliu” reprezintă o provocare pentru echipa chirurgicală grație riscurilor și complicațiilor perioperatorii asociate manevrei chirurgicale. Scopul studiului este optimizarea rezultatelor tratamentului chirurgical al herniilor incizionale gigante prin implementarea tehnicii novaționale de reconstrucție peretelui abdominal.

Materiale și metode. În perioada 2019-2023 am utilizat tehnica de separare posterioară a componentelor cu eliberarea mușchiului transvers abdominal (TAR) la 12 pacienți cu hernii incizionale gigante. Repartiția defectelor parietale conform clasificării EHS (2009): M1W3 (n=1), M2W3 (n=2), M3W3 (n=4), M4W3 (n=2), M5W3 (n=1) și L2W3 (n=2). Dimensiunea medie a lățimii defectului parietal a constituit 15,5 cm (interval 12,5-24,5 cm). Tehnica chirurgicală prevede deschiderea tecilor mușchilor dreپți abdominali, disecția retromusculară tip Rives-Stoppa, eliberarea componentului fascial transvers medial de la linia semilunară și crearea unui spațiu preperitoneal avascular extins cranial pînă la tendonul central al diafragmului, inferior în spațiul Retzius și în plan lateral pînă la psoas. Augmentația protetică prevede crearea planului de rezistență prin montarea plasei chirurgicale de mari dimensiuni în poziție preperitoneală.

Rezultate. Durata medie a intervenției 140,8±20.1 min (interval 130-187 min). Mediana spitalizării 10 zile (interval 6-22 zile). Complicații parietale au fost instalate la 4 pacienți. Timpul mediu de urmărire a fost 12 luni fără recurență.

Concluzii. Tehnica de separare posterioară a componentelor completată cu augmentația protetică și restaurarea liniei albe reprezintă o direcție inovatoare de reconstrucție a peretelui abdominal. TAR oferă soluția eficientă în tratamentul evențrațiilor voluminoase și asigură restabilirea structurală și funcțională a peretelui abdominal.

Cuvinte cheie. Hernia incizională, separarea posterioară a componentelor, plasa chirurgicală

A NEW ABDOMINAL WALL RECONSTRUCTION STRATEGY FOR GIANT INCISIONAL HERNIA

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Aim of study. Giant incisional hernia repair is a complex and challenging issue due to preoperative risks and high complication rate. The aim of the study is to improve the results of giant incisional hernia repair by implementing an innovative technique of abdominal wall reconstruction.

Materials and methods. During the period from 2019 to 2022 we used the posterior component separation technique with transverse abdominis muscle release (TAR) in 12 patients with giant ventral incisional hernias. According to EHS (2009) classification, the hernias were classified as type EHS (2009): M1W3 (n=1), M2W3 (n=2), M3W3 (n=4), M4W3 (n=2), M5W3 (n=1) și L2W3 (n=2). The average width of the defect was 15.5 cm (range 12.5-24.5 cm). The procedure includes a Rives-Stoppa retro-rectus dissection followed by the transversus abdominis release medial to the linea semilunaris and wide plane of pre-peritoneal dissection extended from the subxiphoid area towards the space of Retzius. The prosthetic augmentation of abdominal wall is done by placement of a large surgical mesh in preperitoneal fashion.

Results. The mean operating time was 140.8±20.1 min (range 130-187 min). The average length of hospital stay was 10 days (range 6-22 days). We observed 4 cases of various types of wound complications. Patients were evaluated at a median follow up of 12 months without recurrence.

Conclusions. Posterior component separation technique with transverse abdominis muscle release augmented by surgical mesh represents a novel approach to ventral hernia. TAR is a versatile technique that provides high-level functionality of the abdominal wall and offers a reliable solution for complex incisional hernias.

Keywords. Incisional hernia, posterior component separation, surgical mesh