taking place in intestine wall were different. Thus, in animals receiving ampicillin and hentamicin, purulent peritonitis developed in 12-24 hours. Where animals received ciphran or oframax in 24 hours bacteria on villi surface were not found, in 36 hours more than 60% of villi epithelial surface remained preserved, and in 48 hours destruction processes did not leave the limits of mucosal and submucosal layers; muscular layer remained preserved with tiny edema of intramisium. During the study of antibacterial preparations concentration from the group of penicillines, aminoglicosides, fluoroquinolones and cephalosporines in the wall of phlegmonously changed intestine it was stated that in 48 hours from the disease beginning only oframax in 13,5 mg/ l and cyphran in 10 mg/l accumulate in bactericidal concentrations. Thus, in patients with obstructive ileus phlegmonous inflammation of intestine wall located upper the place of obstacle develops which progress in disease development. The use of antibiotics from the groups of fluoroquinolones and cephalosporines in therapeutic doses in 166 patients before the beginning of the operation allowed to decrease the number of purulent-septic complication from 33,3 to 19,1 %.

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HERNIA "POST-TROCAR" DUPA OPERATII LAPAROSCOPICE GINECOLOGICE, COMPLICATA CU STRANGULAREA PARIETALA (RICHTER)

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Chirurgia laparoscopica este larg implementata in practica medicala, posedind o siguranta demonstrata. Una din complicatiile sale specifice, desi rara, este hernia "post- trocar" (HPT). Se disting 3 tipuri de HPT: (1) cu debut precoce – dehiscenta planurilor fasciale anterior si posterior si a peritoneului; (2) cu debut tardiv – doar dehiscenta planurilor fasciale si (3) tipul special – dehiscenta intregului perete abdominal si protruzia viscerelor. Noi prezentam 2 cazuri de HPT dupa laparoscopii ginecologice, complicate cu strangularea parietala a intestinului subtire. Ambele paciente, in virsta de 53 si 49 de ani, au suportat chistectomie ovariana laparoscopica programata. Bolnavele au fost externate in stare satisfacatoare, insa spre a 6-a si a 9-a zi, respectiv, a aparut durerea continua in regiunea periombilicala pentru care au fost internate in Clinica chirurgie generala. Prezenta tumefierii dolore periombilicale la examenul clinic s-a determinat doar intr-un caz. Radiografia de ansamblu a abdomenului (n=2) si evaluarea pasajului baritat (n=1) au relevat semne de ocluzie intestinala. La revizia cavitatii peritoneale prin laparotomie medio-mediana s-a depistat strangularea parietala a ansei intestinului subtire, la cca 80 si, respectiv, 110 cm de la unghiul iliocecal. Dupa eliberarea ansei, s-a observat defectul parietal subombilical, prin locul plasarii trocarului de 10 mm (HPT tip I). Ansa intestinala a fost apreciata ca viabila in ambele cazuri. Defectul abdominal parietal a fost reparat prin suturi separate pe planurile aponeurotice si peritoneu. Operatiile au fost finisate cu drenarea cavitatii peritoneale. Perioada postoperatorie a decurs fara complicatii. In diagnosticul diferential al durerii abdominale in perioada precoce dupa operatii laparoscopice trebuie sa se tina cont de posibilitatea dezvoltarii HPT. Defectul parietal in urma plasarii trocarului de 10 mm necesita a fi suturat pe straturi in vederea prevenirii HPT cu ulterioara strangulare.

TROCAR SITE HERNIA AFTER LAPAROSCOPIC GYNECOLOGIC SURGERY, COMPLICATED BY PARIETAL (RICHTER) STRANGULATION

Laparoscopic surgery is widely implemented in medical practice, possessing a proven safety. One of its specific complications, although rare, is trocar site hernia (TSH). There are three types of TSH: (1) early-onset type – dehiscence of the anterior and posterior fascial planes, and peritoneum; (2) late-onset type – dehiscence of fascial planes only and (3) special type – dehiscence of the whole abdominal wall with protrusion of viscera. We present two cases of TSH after gynecological laparoscopy, complicated by parietal strangulation of the small intestine. Both patients, aged 53 and 49 years, underwent elective laparoscopic ovarian cystectomy. Patients were discharged in satisfactory condition, but for the 6th and 9th days, respectively, were admitted to department of surgery due to continuous pain in the periumbilical region. Presence of swelling dolor periumbilicale mass was determined during physical examination in only one case. Abdominal x-ray (n=2) and evaluation of intestinal passage (n=1) revealed signs of intestinal obstruction. During the revision of peritoneal cavity through median laparotomy was found parietal strangulation of small intestine loop, localised at 80 cm and 110 cm, respectively, from the ileocecal angle. After releasing of the loop, subumbilical parietal defect was observed by 10-mm trocar site placement (TSH type I). Intestinal loop was assessed as viable in both cases. Parietal abdominal defect was repaired by separate sutures of the aponeurotic plan and peritoneum. The operations were finished with the peritoneal cavity drainage. Postoperative period were uneventful. In the differential diagnosis of abdominal pain after laparoscopic surgery it must be taken into account the possibility of developing of TSH. Parietal abdominal defect after placement of 10 mm trocar needs to be sutured in layers in order to prevent the further occurence of TSH and its strangulation.

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COMPLICAȚIE GRAVĂ ÎN APENDICITA ACUTĂ (CAZ CLINIC)

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Introducere. Tratamentul apendicitei acute la vârstnici necesită eforturi terapeutico – chirurgicale deosebite. În cazurile cu complicație severe letalitatea atinge 60-70%. Scopul. Atenționarea chirurgilor practici la evoluția drastică a apendicitei.Material și metode. Pacientul M. în vârstă de 76 ani internat în secție de chirurgie IMSP a Spitalul Raional Briceni pe 24 noiembrie 2009 la ora 9.40 cu diagnosticul de abdomen acut. S-a îmbolnăvit acum 4 zile în