Results: In the treatment groups indicated a direct relationship between preterm birth and a history of maternal guidance on abortion (r_{xy}=0,3), a threat to abortion (r_{xy}=0,3), intrauterine infection (r_{xy}=0,45), anemia, pregnancy (r_{xy}=0.3) ($p<0.05$). Deferred during pregnancy, maternal infections can cause miscarriages (r_{xy}=0,42); threat of termination of pregnancy has a close relationship to abortion and respiratory viral infections of the mother (r_{xy}=0,7) ($p<0.01$). We have traced the impact of adverse perinatal factors on the formation of gestational age in preterm infants. The results obtained during studying the pregnancies showed that the pathological conditions were observed in 91% (46) of the patients ($p<0.01$). In the most cases, the pregnancy of the mother proceeded in a background of aggravated obstetric history and a chronic placental insufficiency, however, the qualitative characteristics of these indices among the different periods of gestation have significant differences.

Repeated cases of spontaneous abortion were registered 2 times more often likely in the history of very preterm patients - 45% ($p<0.05$) among this category of children more often were indicated intrauterine infections (25 and 44% respectively in the third and 4th sub) ($p<0.05$).

Extragenital pathology of the mother is a substantial proportion of the causes of miscarriage in the 1st and 2nd subgroups of patients (43.2 and 30.4% respectively).Influence of different kind of bad habits during pregnancy is more frequently observed in very preterm patients - 24% ($p<0.05$).

Conclusions.

1. Risk factors of having children with I-II degree of prematurity include: the number of repeat pregnancies of up to 3 (33.3%), repeated abortion numbers up to two (10.2%), stillbirths (3.3%), spontaneous abortions (57%), toxemia (34.7%) and the threat of termination of pregnancy in the I half (10%), respiratory-viral infections (16.2%), bad habits (10%). Risk factors for delivery of very preterm children (III-IV degree) are the number of repeat pregnancies over 3 (40%), repeated abortions more than two (16%), repeated spontaneous abortions (10%), multiple pregnancy (12%), secondary infertility (3.9%) at $p<0.05$.

2. Factors contributing to the increase of severity of the ground state in preterm patients with all stages of gestations the pocket of chronic infection of mother and fetus (chronic pyelonephritis, intrauterine infection), anemia during pregnancy, the use of benefits of intrapartum period.

Keywords: Adverse factors of perinatal period, premature infants.

SELF-EXPANDING METAL STENT FOR REFRACTORY BLEEDING ESOPHAGEAL VARICES – SINGLE CENTER EXPERIENCE

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Introduction: Bleeding esophageal varices (EV) is a severe and life threatening complication of portal hypertension (PH), while endoscopic failure to control hemorrhage is even a more dramatic situation.

Aim: To assess self-expanding metal stent (SEMS) haemostatic efficacy in severe variceal hemorrhage in patients with bleeding EV and endoscopic treatment failure.

Material and Methods: A total of 12 patients, (M=8) with the mean ±SD age – 46.92±3.09 (24-62 years) and liver cirrhosis induced bleeding EV (n=8) and esophageal post-banding ulcers (n=4) were enrolled in the study. The main selection criteria was endoscopic treatment failure. A removable covered SEMS (SX-ELLA stent Danis, 135×25 mm, ELLA-CS, Hradec-Kralove, Czech Republic) was used in all cases. The mean SEMS used per patient was 1.25±0.18 (1-3). All definitions were used according to Baveno Consensus (I-V) conferences.

Results: Initial SEMS haemostatic efficacy was 100%. Partial distal stent migration was documented on X-ray and CT-scan in 5/12(41.6%) and stent reposition was achieved by second-look endoscopy. The 30-days mortality was 25% (3/12). Tanatogenesis was induced by hepatic failure (n=2) and bleeding EV distally to the stent distal end (n=1).

Conclusions: The preliminary results demonstrate that stenting is an effective life-saving hemostatic procedure in high-risk patients with severe esophageal variceal bleeding and endoscopic hemostasis failure as well as postbanding esophageal ulcers. Final conclusions will be reached after gaining experience with this new method on larger series.

Key words: esophageal varices, bleeding, stent.

MANAGEMENT OF BLEEDING ECTOPIC VARICES

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Introduction: Bleeding ectopic varices (EcV) are uncommon and a difficult conditions to manage. The clinical data of patients diagnosed and treated for bleeding EcV were reviewed to investigate the treatment strategy.

Material and Methods: Patients diagnosed with bleeding EcV over a period of 10 years were identified from the comprehensive surgical database of our institution.

Results: There were six patients (F-2, M-4) with the mean age of 46.8 ± 7.3 (20 to 76) years. The location of the EcV was: duodenal (DV, n=2), isolated gastric varices type 2 (IGV2) according Sarin classification (n=2), and rectal (RV, n=2). EcV were induced by liver cirrhosis (LC) - 2, posthrombotic portal cavernoma (PC) - 1, LC+PC – 1, hepatocelullar carcinoma (HCC) +PC-1 and left-sided portal hypertension - 1. The EcV were managed as an emergency in 4 (DV-2, IGV2-2) and elective in 2 with RV. Bleeding EcV were managed by endoscopic ligation with HX-21L-1 (Olympus®, ET, Japan) device with mini-loop MAJ-339 (n=2, DV and IGV2) and endoscopic ligation with HMBL-4 (Wilson-Cook®, Winston-Salem, NC, SUA) (n=2, RV). Haemostatic efficacy was achieved in all cases. Surgery was performed in 2 pts: for IGV2 - stapling fundectomy with splenectomy and for DV – surgical ligation of affected vessels. In-hospital lethality was – 1/6 (16.6%).

Conclusion: Bleeding EcV's are a challenging emergency, haemostatic procedures depending on the site, bleeding activity and local expertise.

Keywords: varices, ectopic, bleeding.

GALLBADDER VARICES

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Introduction: Gallbladder varices (GBV) are relatively rare ectopic varices in patients with portal hypertension (PH).