

PRINCIPLES OF DIAGNOSIS AND TREATMENT IN CHOLANGIOCARCINOMA

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Background. Cholangiocarcinoma (CCA) is an aggressive biliary tract malignancy with a high incidence globally, accounting for 15% of all liver cancers. CCA is a clinically silent disease, that manifests itself in advanced stages. Mortality rises to 20%. **Objective of the study.** Analysis and evaluation of the efficacy and limitations of current diagnostic modalities and therapeutic approaches for CCA. **Material and methods.** This study is a review of 32 literature sources about CCA, found in the PubMed, Medline, Google Scholar and clinical guidelines with a focus on evaluating imaging techniques, tumor markers, biopsy methods, systemic, targeted and surgical treatment. **Results.** Risk factors for CCA - cirrhosis, sclerosing cholangitis, and trematode infection. Diagnosis is based on clinical symptoms, laboratory and paraclinical investigation. Tumor biomarkers- CA 19-9, CEA and α -fetoprotein are > in CCA. Best methods of investigation are CT- identify and evaluate locoregional or metastatic dis-

ease, MRCP- provides the best noninvasive imaging of CBD, EUS visualizes the portal structures, lymph nodes and guided biopsies with a higher sensitivity. The overall prognosis for CCA is poor. A multidisciplinary team must be involved in the patient's care from the time of diagnosis. Only 1/4 of patients have resectable tumors. Treatment strategies differ among CCA locations: hepaticojejunostomy in upper CBD tumor, Whipple surgery in tumor of distal CBD, liver transplantation being an option for highly selected patients with hilar CCA or intrahepatic CCA. In unresectable disease is used systemic and targeted therapies. **Conclusion.** Early detection is crucial due to poor survival rates. Initial diagnosis typically involves imaging along with elevated CA19-9 levels, while a confirmatory biopsy. Treatment primarily depends on the resectability of the CCA. Liver transplantation is the option that decreased poor prognoses for CCA. **Keywords:** cholangiocarcinoma, bile duct malignancy.

USE OF DISTAL VENOUS PATCH IN INFRAINGUINAL BYPASS REVASCULARIZATION WITH SYNTHETIC GRAFT

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Background. Infrainguinal revascularization procedures are often the main in treating peripheral artery disease (PAD) and restoring vital blood flow to the lower extremities. Synthetic grafts such as PTFE or Dacron are considered when autogenous vein grafts are not available. Distal venous patches, strategically attached to these grafts, improve vascular dynamics, foster optimal healing, and augment vessel compliance. This reduces complications, prolongs graft viability, and improves results for limb preservation. **Objective of the study.** to meticulously evaluate venous patch efficacy in infrainguinal bypass revascularization with synthetic grafts. Aims include assessing their influence on graft patency optimization, complications mitigation, and long-term limb salvage rate augmentation. **Material and methods.** Systematic searches of PubMed and Google Scholar using keywords like „infrainguinal bypass”, „venous patch” and „synthetic graft”. Inclusion criteria focused on

English-language peer-reviewed articles from the last two decades. **Results.** Studies reveal significant advantages of venous patches in infrainguinal bypass revascularization with synthetic grafts. Venous patches increase graft patency rates and decrease thrombosis and infections. Autogenous vein segments are preferred, with different dimensions and configurations observed. Subgroup examinations indicated benefits for older patients with vascular comorbidities. Limitations include surgical methodology disparities and potential biases in retrospective analyses. **Conclusion.** Distal venous patches have remarkable clinical effectiveness in infrainguinal bypass revascularization, improving graft patency and reducing complications. Despite limitations, they are key adjunctive strategies for enhancing the results of this procedure. **Keywords:** Distal venous patches, infrainguinal bypass, synthetic grafts, graft patency.