(CSA), and a combination of the two called mixed. OSA affects 1 to 6% of adults and 2% of children, but CSA affects less than 1% of people.

Case report. Patient X, 58 years old, of female, was admitted at the Institute of Cardiology with mixed (inspiratory and expiratory) dyspnea at minimal effort, ankle swelling, general weakness, dizziness. The patient suffers from arterial hypertension during 14-year with maximum levels 180/90 mmHg, working blood pressure being - 130/80 mmHg. At home regular treatment with tab. Bisoprolol 2.5 mg in the morning, tab. Aspirin 75 mg/day, tab. Losartan 50 mg in the evening, tab. Torasemidi 10 mg in the morning, over a day. The general condition worsened the last month when signs of congestive heart failure progressed. The echocardiographical examination revealed severe cardiomegaly (LA - 50 mm, LV - 60 mm, RA - 51 mm, RV - 40 mm), preserved left ventricular function (EF - 58%), reduced right ventricular function (TAPSE - 16 mm), severe pulmonary hypertension (PASP - 140 mmHg). To determine the cause of the pulmonary hypertension, a number of investigations were performed. Pulmonary artery angiography by computed tomography revealed pulmonary artery enlargement (40 mm) and dilated intrapulmonary arteries, but no data on thrombosis. Spirography has revealed severe changes in the function of external respiratory organs, being restrictive. Laboratory analyzes excluded the systemic sclerodermia (ANA-negative, Anti Scl-70 antibodies – 1.5 U/ml, Anti Centromer B antibodies – 0.3 U/ml) and normal values of D-dimers (0.24 ng/ml) excluded the presence of venous thrombosis. To exclude the presence of Sleep Apnea Syndrome, cardio-respiratory polygraphy was performed. A severe form of Sleep Apnea-Hypopnea Syndrome was recorded, with the Apnea-Hypopnea Index (AHI) – 84.3/hour, with severe intermittent and continue nocturnal hypoxemia in close correlation with respiratory events, having a Desaturation Index (DI) – 82 6/hour. Average SaO2 – 69.6%, SaO2 minimum – 42%, SaO2 <90% = 07 hours 50 min 48 sec.

Conclusions. After 10 days of complex treatment with diuretics, direct and indirect anticoagulants, nitrates, angiotensin II receptor blockers, beta-adrenoblockers, continuous oxygen therapy, and CPAP + Oxygen therapy, the general condition improved: the mixed dyspnoea at minimal effort was reduced, general weakness , dizziness disappeared as well as the ankle swelling, and pulmonary artery systolic pressure decreased from 140 mmHg to 100 mmHg.

Key words: sleep apnea-hypopnea syndrome, pulmonary hypertension

DEPARTMENT OF SURGERY no.1 *NICOLAE ANESTIADI*

10. CHOLEDOCHOLITHIASIS – DIAGNOSTIC AND TREATMENT OPPORTUNITIES

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Background. Choledocolithiasis is a late complication in the evolution of biliary lithiasis. More frequently, the main bile duct approach is performed by new miniinvasive methods.

Case report. A 38 y/o female was diagnosed and treated in SOROKA Medical Center Beersheba in 2016**.** The patient was afebrile, haemodynamically stable, yet presented jaundice. The abdomen was soft, mildly tender at palpation, with a negative Murphy's sign. Blood tests identified: WBC 4.6 x 109/L, AST 258 IU/L, ALT 352 IU/L, billirubin 77 umol/L, alkaline phosphatase 258 IU/L. The ultrasound investigation detected a dilated CBD (14 mm) containing two stones. MRCP confirms two ductal stones of 8 and 10 mm, and a dilated duct. ERCP identified two stones of 8 and 10 mm that couldn't be removed, so a stent was placed and a

sphincterotomy was performed. Percutaneous transhepatic cholangiography and cannulation guide wire technique was used, with a modified Burhenne technique. Stones were pushed into the duodenum with Fogarty Balloon, stent inserted. Post interventional radiology revealed that CBD was cleared. Patient made good recovery.
Conclusions. Elective methods in the diagnosis of choledocholithiasis are MRCP in colangiographic regime, ERSP and percutaneous transhepatic cholangiography. Modified Burhenne technique can be used in treating choledocholithiasis.
Key words: choledocolithiasis, biliary lithiasis, surgery

11. TRAUMATIC RECTAL WOUND AND CONSEQUENCES OF DIAGNOSTIC AND MANAGEMENT ERRORS

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Background. "Hopkins Medicine" medical journal reports medical error as the third cause of patients' death. Meanwhile, WHO determined that 23% of European citizens state that they have suffered from a medical error, while 18% say that they still have complications from them. Also, WHO established that one of 20 patients got a nosocomial infection during their hospital admission. Several studies highlighted a rate of 15% to 30% of rectal postoperative infection, retrospectively linked to delayed diagnosis, fecaloid infection, inefficient primary treatment and inadequate drainage. This affects the wound's regeneration rate and leads to complications such as perirectal abscesses and fistulas, suture inconsistency, sepsis etc., which can result in prolonged hospital stay, hospital readmission, home nursing wound care needs, and the expenditure of significant medical costs.
Case report. Patient R, age 52 years, is hospitalized with a perianal wound following a 1m fall on a metal nail. Clinical and instrumental examinations showed stable hemodynamics, painless palpation of the abdomen, no pneumoperitoneum. Status localis: perianal, on the right a wound 4 cm x 8 cm depth was detected. Primary surgical wound debridement was performed under general anesthesia, and no lesions of the pelvic organs were discovered. Laparoscopy revealed a retroperitoneal hematoma, which was drained, and no penetration into the abdomen cavity was seen. The patient's condition worsened on the second day and an exploratory laparotomy was performed, where a second retroperitoneal hematoma and color changed blood in recto-sigma was detected. A terminal sigmostoma was applied for the exclusion of the extraperitoneal lesion of the rectum without succeeding in suturing the rectum wound. Subsequently, the evolution of the patient was negative and a retroperitoneal phlegmon developed. A second laparotomy followed with the suture of rectal wound and debridement of putrid retroperitoneal phlegmon. The postoperative period evolves severely but favorably with the formation of the pararectal fistula, which imposes multiple cares and readmissions over a period of 2 years with the intent of closing the fistula (rectum stenting, reconstructive surgeries for rectum extirpation and the transanal colon dissension, protection ileostoma) and, finally, a permanent terminal colostoma was applied.
Conclusions. In the presented case, the severity of rectum wound, the delayed and wrong diagnosis as well as the errors in patient approach had increased the severity of the disease, with multiple postoperative complications, high medical costs and had led to disability.
Key words: traumatic rectum wound, diagnostic and tactical errors, complications, treatment.

12. A COMPLEX CASE OF PANCREATIC CANCER COMPLICATED WITH GASTRIC VARICES AND DEEP VEIN THROMBOSIS