

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: choledocholithiasis, 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 sigmoidostoma 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