patients with oesophageal variceal bleeding (15.8% vs. 8%). Likewise, there was a difference suggesting a slightly higher severity of gastric varices bleeding considering the mean value of hemoglobin at admission (7.3 g% vs. 8.31 g%) and duration of hospitalization (4.8 vs. 3.8 days).
**Conclusion.** Despite similar modalities of management for the two types of variceal outburst, gastrointestinal bleeding from gastric varices is strained by a lugubrious prognosis and evolution. Therefore these patients should undergo a more thorough and specific management and follow-up.
**Key words:** haemorrage, gastric varices, esophageal varices, clinical evolution, prognosis

## 129. TREATMENT OF PANCREATODUODENAL TRAUMA

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**Introduction.** Pancreatoduodenal trauma is one of the most serious and severe abdominal traumas, which comprises 1-10% of all abdominal injuries. As a result of the difficulties in diagnosis and treatment, the rate of complications and mortality are quite high.
**Aim of the study**. Analysis of treatment outcomes in patients with concomitant traumatic lesions of the pancreas and duodenum in dependence to the degree of pancreatic trauma.
**Materials and methods.** During the 1998-2007 at the Department of Surgery n.1 "Nicolae Anestiadi" 30 patients with pancreatoduodenal trauma were operated. First and II grade of the pancreatic lesion were diagnosed in 23 (76.7%) cases. Only in 4 (13.3%) patients were observed lesions of grade III and IV. Lesions of grade V were detected only in 3 (10%) patients. Segment D1 of duodenum was affected in 16.7% cases, D2 – in 50%, D3 – in 16.7% and D4 – in 6.7%. Injuries of more than 2 segments were seen in 3 patients.
**Results.** The duodenum was excluded from the passage in 30% of cases due to duodenal wall lesions and the presence of acute posttraumatic pancreatitis (APTP). In 21 (70%) patients the anatomic passage was maintained for duodenum. The draining of the omental bursa (OB) was performed in 23 (76.7%) patients, and the bursoomentostomy (BOS) - in 7 (23.3%). The APTP rate was 75% and 100%, respectively, both for the preservation and exclusion of the duodenum from the passage. Note that in all of these cases (7 pts) BOS has been applied in traumatic lesions of the pancreas grade III – V. The rate of APTP and mortality were 83.3% and 33.3%, respectively for lesions of grade III-V compared to the 82.3% and 23.5% in lesions grade I and II. In the first 48 hours, 7 (23.3 %) patients died due to hypovolemic shock and retroperitoneal phlegmon. The high frequency of mortality (25%) in the group of patients in whom primary duodenum suture was performed without its exclusion from the passage with the application of BOS is due to late hospitalization (> 48 hours) and the presence of APTP. Relaparotomy for pancreatic necrosis was required in 6 (20%) patients with necrectomy and application of BOS, with a mortality of 50% in the postoperative period. Causes of mortality were post-traumatic pancreatic necrosis, persistence of high-grade duodenal fistula, as well as MODS.
**Conclusion.** In the pancreatoduodenal trauma with lesions of the pancreas of grade I-II optimal treatment is the suturing of duodenal injury with closed drainage of OB, whereas in severe lesions it is recommended to exclude the duodenum from the passage with BOS application.
**Key words:** pancreatic trauma, duodenal trauma, post-traumatic pancreatitis, surgery

## 130. HERNIOALOPLASTY IN VENTRAL HERNIAS

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