

hepatobiliare, toracice și pediatrie pentru asigurarea capacităților adecvate ale specialiștilor în acordarea asistenței medicale acestei categorii de bolnavi.

EMERGENCY GENERAL SURGERY: A TIME FOR A NEW SURGICAL SPECIALTY?

Introduction: During the recent decades, both North American and European surgical societies have advocated separation of elective and emergency general surgical specialties. These aspirations have been fueled by poor outcomes in emergency admissions, inadequate leadership, lack of literature and training, scarce allocation of resources, and high complexity of the emergency surgical disease burden.

Developments: The American Association for the Surgery of Trauma (AAST) has established a training curriculum for the Acute Care Surgery (ACS) which involves three pillars of practice: emergency surgery, trauma, and surgical critical care. Such a composition of training allows a broad base of expertise to serve the needs of critically ill surgical patients. The European Society of Trauma and Emergency Surgery (ESTES), is likewise in process of defining the training curriculum for the Emergency General Surgery (EGS), however, excluding surgical critical care for reasons adherent to training of surgeons in Europe. The Japanese Association of Acute Medicine (JAAM) has had 3 joint annual meetings with the AAST and JAAM has launched their official publication, the Journal of Acute Medicine and Surgery.

Outcome measures: There is a multitude of literature depicting major outcome benefits following establishment of the new surgical specialty. The most common emergent surgical condition such as appendicitis has experienced improved outcomes following care provided by ACS/EGS. Likewise, patients suffering emergency biliary conditions and colorectal emergencies have shown improved outcomes after establishment of dedicated emergency surgical teams.

Future perspectives: The EGS specialty will likely expand in the future as outcomes are improving through care under specialists with appropriate training. ACS/EGS fellowship programs will develop their training elements incorporating basic orthopedics, neurosurgery, resuscitation, vascular, emergency general surgery, hepatobiliary, thoracic, pediatric to ensure a adequate capability for this patient category.

TRATAMENTUL ENDOSCOPIC ȘI CHIRURGICAL AL SINDROMULUI MIRIZZI

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Introducere: Sindromul Mirizzi se caracterizează prin compresia căii biliare de către colecist sau formarea unei fistule între acestea, care corespunde tipului Mirizzi I și II (McSherry, 1984). Diagnosticul se confirmă prin ERCP. Corecția chirurgicală este complexă și adesea în cazurile de Mirizzi II este necesară aplicarea hepaticojejunostomiei.

Scop: Evaluarea oportunităților tratamentului endoscopic și chirurgical al sindromului Mirizzi pentru păstrarea pasajului bilei spre duoden.

Material și metode: Dintre 2144 pacienți cu litiază biliară, obstrucția căilor biliare a fost evidențiată la 328 (15,3%). Sindromul Mirizzi a fost diagnosticat în 21 (6,4%) cazuri: de tip I – la 6 (28,6%) pacienți, de tip II – la 15 (71,4%).

Rezultate: În două cazuri de Mirizzi I inițial a fost practicat drenajul biliar transnazal, într-un caz – stentarea ductului biliar comun. Colecistectomia laparoscopică s-a efectuat la 5 pacienți și deschisă – la unul. La 2 din 15 (13,3%) pacienți cu Mirizzi II s-a reușit litotripsia, la un bolnav a fost realizată stentarea biliară. Pentru a reduce icterul în 12 cazuri a fost aplicat drenajul biliar transnazal. Ulterior, 9 pacienți au suportat colecistectomie cu plastia defectului ductului biliar comun, la 2 bolnavi s-a efectuat colecistectomie laparoscopică cu extragerea calculilor biliari, și într-un caz s-a practicat hepaticojejunostomia. Astfel, la 14 din 15 (93,3%) bolnavi cu Mirizzi II pasajul biliar fiziologic a fost restabilit cu succes. Mortalitatea postoperatorie a constituit 0, morbiditatea – 19% (4 pacienți).

Concluzie: Aplicarea tratamentului endoscopic și chirurgical la pacienții cu Mirizzi II a permis restabilirea pasajului biliar fiziologic în 93% din cazurile noastre.

ENDOSCOPIC AND SURGICAL TREATMENT OF THE MIRIZZI SYNDROME

Introduction: The Mirizzi syndrome is characterized by compression of bile duct by gallbladder or fistula formation between them, that corresponds to the Mirizzi type I and type II (McSherry, 1984). The diagnosis confirms by ERCP. Surgical correction is complex and often needs hepaticojejunostomy in cases of Mirizzi II.

Aim: Evaluate opportunities of the endoscopic and surgical treatment of Mirizzi syndrome in the preservation of bile passage to the duodenum.

Material and methods: Among 2144 patients with cholelithiasis, biliary tract obstruction occurred in 328 (15.3%). Mirizzi syndrome was diagnosed in 21 (6.4%): type I – in 6 (28.6%) patients, type II – in 15 (71.4%).

Results: In two cases of Mirizzi I initially transnasal biliary drainage was performed and in one – the common bile duct stenting. In 5 patients laparoscopic and in one open cholecystectomy was performed. In 2 of 15 (13.3%) patients with Mirizzi II lithotripsy was successful; in one bile duct stenting was performed. To reduce jaundice in 12 cases transnasal biliary drainage was introduced. Thereafter, 9 patients underwent cholecystectomy with the common bile duct defect plasty, 2 patients underwent laparoscopic cholecystolithotomy with bile duct stones extraction, and in one case hepaticojejunostomy was formed. Thus, in 14 of 15 (93.3%) of Mirizzi II physiological bile passage was successfully restored. Postoperative mortality was 0, morbidity was 19% (4 patients).

Conclusion: The use of endoscopic and surgical treatment in cases of Mirizzi II allowed restoring the physiological bile passage in 93% of cases.