SELECTION OF OPTIMAL SURGICAL TREATMENT FOR ESOPHAGEAL DIVERTICULA

Background. The appearance of esophageal diverticula is caused by several factors: intraesophageal hypertension, disturbance of esophageal motility, paraesophageal inflammation -all acting on the anatomic zones with weak parietal resistance. Some patients with specific clinical signs need surgical correction of this condition. Material and methods. In the period 2000-2010 in the department of thoracic surgery, Clinical Republican Hospital 41 patients were diagnosticated with esophageal diverticulum. Repartition of the patients according to diverticula topography as follows: cervical – 27 (66%), mid-esophageal – 10 (24%) and epiphrenic – 4 patients (10%) – this corresponds to observations from other studies. In 34 patients a surgical intervention was performed. In majority of cases (31 cases – 91.2%) a traditional diverticulectomy was used with cervical or thoracic approach depending on the topography of the diverticular pouch. In 3 cases (8,8%) of mid-esophageal diverticulum a video-assisted thoracoscopic surgery was performed.Results. No postoperative lethality was registered. Among early postoperative complications 2 cases of exudative pleurisy were observed and solved by thoracocentesis. Other 2 patients had temporary dysphagia treated conservatively. During the mean follow-up of 5 years late complications or recurrences were not registered.Conclusions. Surgery is elective treatment of esophageal diverticula, which needs specific and complex operative procedures. The main element of the intervention is proper dissection of the diverticular neck. Video-assisted thoracoscopic diverticulectomy opens new perspectives in the treatment esophageal diverticula.

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UNELE METODE DE PROFILAXIE A HEMORAGIILOR DIN VARICELE ESOFAGIENE LA BOLNAVII CU HIPERTENSIUNE PORTALĂ

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Introducere. Hemoragia din varicele esofagiene (VE) este cea mai frecventă și gravă complicație a hipertensiunii portale (HP), ea are loc la o treime de pacienți cu ciroză hepatică (CH) și provoacă decesul la 30-50% paienți timp de 6 luni. Riscul apariției hemoragiei esofagiene sunt varicele esofagiene de gr.II-III și esofagita erozivă.Material și metode: În perioada 2000-2009 în secțiile de chirurgie ale Spitalului Clinic Militar Central și Spitalul Clinic Central st.Chișinău s-au aflat la tratament 112 pacienți cu CH și HP. Vîrsta pacienților varia de la 8-68 ani, de CH virală sufereau 94 pacienți, iar la 8 a fost depistată CH alcoolică. HP intrahepatică a fost depistată la 107 pacienți (din ei 43 aveau CH Child „B" și 64 - Child „C"), iar HP extrahepatică – 5 cazuri. La FGDS la 86 pacienți s-a depistat esofagită erozivă, iar la 21- esofagită catarală; VE de gr.II-III la 96 pacienți și în 11 cazuri VE cu d ≈ 7-10 mm, ceea ce reprezintă risc pentru apariția hemoragiei. Cu scop de profilaxie a apariției hemoragiei la 30 pacienți s-a efectuat SE paravazală cu sol.Aethoxysklerol 1% cu dezvoltarea complicațiilor eroziv – nercrotice în 16,7% cazuri, la 66 pacienți s-a efectuat SE paravazală cu sol. Aethoxysklerol 0,5% fără complicații postSE, indicele supraviețuirii fiind 48,6%. La 11 pacienți cu VE d ≈ 7-10 mm s-a efectuat SE intravazal cu sol.Trombovar 3%, iar după diminuarea VE la gr.II-III s-a efectuat SE paravazal cu sol.Aethoxysklerol 0,5%, complicațiile postSE 45,5%. La toți pacienții postSE s-a administrat Obzidan 40 mg/ 24 ore. La 5 pacienți cu HP extrahepatică s-au aplicat anastomoze porto-cavale (mezo-cavală -1 și spleno-renală - 3) și stentarea venei hepatice drepte – 1 caz.Concluzii: SE cu sol. Aethoxysklerol 0,5% în combinare cu β – blocatori reprezintă o metodă mininvazivă, accesibilă și eficientă pentru profilaxia hemoragiilor din VE. Anastomozele porto-sistemice reprezintă modalități de elecție în tratamentul chirurgical al HP extrahepatice.

CERTAIN HAEMORRHAGE PROPHYLAXIS METHODS OF ESOPHAGEAL VARICES

Introduction. Haemorrhage from esophagean varices(EV) is the most frequent and serious complication of portal hypertension(PH),it can be observed in 1/3 of patients with liver cirrhosis(LC) and causes death in 30-50% patients during a 6 months period.The risk of esophagean haemorrhage is due to esophagean varices of the 2nd and 3rd degree and due to erosive esophagitis.Methods and material: One hundred twelve patients with LC and PH were being followed up in the surgery departments from Central Clinical Military and Railway Hospitals in 2000-2009.The average age was from 8-68 ,94 patients were suffering from viral LC, while 8 patients had alcoholic LC. Intrahepatic PH was observed in 107 patients (43 had LC Child"B" and 64 –Child "C"), but extrahepatic PH – 5 cases. Due to fibroscopy erosive esophagitis was noted in 86 patients, but catarrhal esophagitis in 21; EV of the 2nd and 3rd degree in 96 cases and in 11 cases EV with d~7-10 mm, which represents the risk for haemorrhage.As a haemorrhage prophylaxis, paravasal SE with Aethoxysklerol sol of 1% was done in 30 patients, after what 16,7 % had necrotic erosive complications, in 66 patients paravasal SE was done with 0.5% of Aethoxysklerol without no complications post SE, survival index was of 48.6%. Intravasal SE was administered with Trombovar sol of 3% in 11 patients with EV d ~ 7-10 mm, but after EV decrease to the 2nd and 3rd degree paravasal SE was done with 0.5 % Aethoxysklerol sol, Se complications were noted in 45.5 cases. All the Se patients were administered Obzidan 40 mg /24 h. Porto-caval anastomosis (meso-caval-1 and spleeno-caval-3) and right vein hepatic stentation –1 case, were applied to 5 patients with extrahepatic PH.Conclusions: Se with Aethoxysklerol sol of 0.5% in combination with beta blockers represent a miniinvasive, accessible and efficient method for EV haemorrhage prophylaxis. Portosystemical anastomosis represents election modalities in surgical treatment of extrahepatic PH.