

diameter greater than 5 mm. Mason venous anastomosis a 3- 5mm. Implantation graft technique: end-to-end portal anastomosis. Reperfusion of a PVC 5 -9mm Hg, assess graft quality, complete hemostasis and bilistaza. Making Doppler ultrasound. Portosystemic shunts, splenic artery ligation, splenectomy. End-to-end anastomosis of the right hepatic artery. Bile duct reconstruction and prosthesis on stend transcoledocian externalized. Harvesting hemostasis and assessment of liver surface. One important thing ese posttransplant administration of immunosuppressants for graft rejection does not occur.

Conclusion: Knowledge anatomical variants of the arteries, veins and biliary enables us to intervene surgically prepared as well as possible and post surgical complicatiilr less. Knowledge of surgical techniques allow us to perform surgery and how quickly how much less damage to both the donor as well as recipient. And immunosuppressive therapy increases the life of the patient.

Keywords: Surgical technique donor, recipient, Back-Table

41. BENIGN JAUNDICE CHOLEDOCHOLITIASIS - SURGICAL EMERGENCY

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Introduction: Jaundice is due to failure of route intrahepatic bile- biliary duct -digestive tract, incriminated mostly of choledocholithiasis. Often the icteric manifestation of choledocholithiasis is established with a delay, which can reach a few months, which significantly increases the operative risk due to development of hepato -renal failure and to the installation of the suppurative angiocolitis, with high rate of postoperative mortality . In the last decades technological progress has led to the creation of a successive generations of improved equipment, which enables efficient exploration of the entire biliary system. So surgical act could become more complex, being made safe interventions previously considered impossible. Surgical operations wich are performed to emergency patients are accompanied by complications and lethality reaches 15-30%, 3 times more than mechanical jaundice approached as if the emergency postponed.

Purpose and objectives: Highlighting the informational value of the contemporary diagnostic methods pre- and intraoperative in the benign mechanical jaundice made by choledocholithiasis and effectiveness of surgical treatment depending on clinical and anatomical form and the moment of its establishment.

Materials and methods: The study is based on retrospective analysis of 83 clinical observation sheets of patients with final diagnosis of choledocholithiasis, recorded the clinical and laboratory manifestations, under which were later established indications for surgery and operative time.

Results: Patients with benign jaundice refer to a subset of surgical pathology addressed as a delayed emergency, within 3-5 days, even when their etiology is not understood, if not progressing diagnostic approach. Indications for surgical treatment are choledocholithiasis diagnosed preoperatively, where the condition itself is an indication of surgical, and the suspected choledocholithiasis with subsequent intraoperative diagnosis, where the main indication for surgery is mechanical jaundice syndrome. Surgery was undertaken in all cases , in the vast majority, the nature of interventions aimed at solving both jaundice by choledocholithotomy, endoscopic papillo-sphincterotomy and drainage, as well as the progressive diseases associated, by cholecystectomy and endoscopic papillo-sphincterotomy (in the cases of dysfunction of the Oddi sphincter). Drainage method was determined by CBP diameter , so the diameter < 1.5 cm was chosen to install an external drain type (Kehr), for a diameter > 1.5 cm to perform latero-lateral choledochoduodenostomy. Postoperatively, incorporating all the data, we obtained the diagnosis of choledocholithiasis associated with comorbidities in 59 % of other adjacent structures: chronic calculous cholecystitis, stenosis of Oddi sphincter, cholecysto-cholecho-duodenal fistulas. Postoperative complications were recorded mostly at decompensated patients. Postoperative mortality was 8.4 % .

Conclusion: jaundice presents indications for emergency surgical treatment delayed if diagnostic approach is not progressing (3-5 days), especially when the adjacent structures overlapping with pathological disorders.

Keywords: choledocholithiasis, pre-/intraoperator diagnosis, contemporary surgery