

gastrointestinal hemorrhages in cirrhosis. Diagnostic and therapeutic developments have led to a significant improvement in the prognosis of this complication over the past two decades. Endoscopic treatment, mainly variceal band ligation or sclerotherapy, has proved to be effective in controlling acute variceal bleeding.

Material and methods: The study was performed within the National Scientific Practical Center of Emergency Medicine. Fifty seven consecutive alive patients admitted with variceal bleeding were included. There were 38 male and 19 female patients, mean age - 53.7 ± 12.6 (95% CI: 50.34-56.99) years. The patients were divided according to the Child Pugh score as follows: class A - 22 patients (38.6%), class B - 30 patients (52.6%), class C - 5 patients (8.8%). Haemostatic methods used were: Sengstaken Blakemore (SB) tube in 11 patients (19.3%); endoscopic rubber band ligation (EBL) in 23 patients (40.3%) and combined methods – SB probe + EBL in 11 pts (19.3%), Danis stent + EBL in 1pt (1.75%), sclerotherapy + SB probe + EBL in 1 pt (1.75%), SB probe + Danis stent + EBL in 1pt (1.75%); in nine patients only pharmacological methods of haemostasis were used.

Results: Several parameters were analyzed and compared between the groups Child Pugh A, B and C (using one way ANOVA with Bonferroni post test): length of stay, length of ICU stay, Algover shock index, number of installed rubber bands, volume of packed red blood cells and fresh frozen plasma transfusion, length of SB probe in situ and the MELD score. No statistically significant differences were found between the three groups, except the MELD score (A vs B, A vs C and B vs C; $P < 0.0001$).

Conclusion: Although our study didn't show any statistically significant difference of various parameters between the three groups, there is a general agreement that advancing through the Child classes from A to C the patients are more severely ill and have a poorer prognosis, fact proved by the highly significant difference of the MELD scores.

Keywords: cirrhosis, Child Pugh, varices, bleeding, hemostasis

40. LIVER TRANSPLANTATION

Panțiri Sergiu, Mindrila Nadejda

Academic Advister: **Gidirim Gheorghe**, M.D., Ph.D., Professor, Academician, State and pharmaceutical Universiti " Nicolae Testemițanu", Chisinau Republic of Moldova

Introduction: Liver transplant surgery is very difficult and hard to make. This surgical method allows to treat patients suffering from liver disease in advanced stages. Many scientists with continued history of liver transplantation, several surgical approaches have been proposed that liver transplantation be performed successfully and the patient's lifetime to be as high posttransplant. Developing research in immunosuppression has made disappear liver graft rejection thus increasing the life span of patients posttransplant.

Purpos end Objectives: Study of surgical techniques used in liver transplantation. Efficacy posttransplant. Study anatomical variants and biliary vessels main maintaining quality graft, surgical techniques to container, donor, back-table, graft implantation.

Materials and Methods: Gathering all the information related to the surgical and postoperative treatment. Research and publications carried out by Scientists in the field of liver transplantation.

Results: Total hepatectomy technique "piggyback". Hilar dissection should be performed as high as possible (especially blood and bile). Cystic duct is ligated and sectioned. High hilar dissection (High Hilarious Dissection, HHD). Using high hilar dissection enables us to perform venous anastomosis sector. Dissection of the bile duct. Donor operation: Skin incision. Full mobilization of the right hepatic lobe. Issuance of right hepatic lobe of the inferior vena cava. Preservation for future reinpantarea vein diameter > 5 mm. Hepato - caval ligament transection . Cholecystectomy with cholangiography subsequent cystic duct catheterization. Intraoperative ultrasound. Selective clamping the artery and portal vein straight boundary demarcation of hemificatul hemificatului left. Parenchymal transection with electrocautery. Pedicolului final clipping and bile ducts in the portal as hemificatului law. Technical Back -Table: weighing graft harvested. Wisconsin perfusion solution. Grading scale blood , bile and venous existing anatomical variants. Right hepatic artery is cannulated and dilated. Reanastomozate the manner termino-terminal venous system with

diameter greater than 5 mm. Mason venous anastomosis a 3- 5mm. Inplantation 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

Pascal Rodica

Academic adviser: **Sergiu Revencu**, D.M., Associate Professor, State Medical and Pharmaceutical University "Nicolae Testemitanu", Chisinau, Republic of Moldova

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-choledocho-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