THORACOSCOPY AT THE ESOPHAGUS ATRESIA WITH INSUPERABLE TO DIASTASES

(Clinical observation)

Akselrov M.A.,[1,3] Yemelyanova V.A.,[3] Sergienko T.V.,[3] Malchevsky V.A.,[1,2] Svazyan V.V.,[1] Sakharov S.P.,[1] Akselrov A.M.,[1] Evdokimov V.N.[1]

[1]*Tyumen State Medical University, Ministry of Health of the Russian Federation*

[2]*Tyumen scientific center of the Siberian Branch of the Russian Academy of Science, Tyumen, Russia*

[3]*Regional Clinical Hospital No.2, Tyumen, Russia*

The main number of complications and unsatisfactory results in the surgical treatment of esophageal atresia associated with large diastases between segments, when after complete mobilization the acute and abdominal segment of the esophagus can not be linked. In our clinic, one patient as a primary operation and delayed anastomosis of the esophagus was made thoracoscopically.

Newborn V. came to the clinic at the age of 4 hours of life with a clinical and radiological picture of esophagus atresia with a lower tracheotophageal fistula, high atresia of the anus. He was born in 35-36 weeks of gestation. Weight at birth 2156 g. After cooking the baby works. In thoracoscopy, after elimination of the lower tracheotophageal fistula and maximum isolation of the segments of the esophagus, diastases are 5 cm. Segments of the esophagus do not approach. A superposition of the transverse elongation of the esophagus on Fokera is performed. To feed the patient, laparoscopic removal of the pendulous enterostomy is performed, as well as due to the abnormality of the anorectal region-the laparoscopic formation of a double separate colostomy.

Ten days later, the patient is taken for repeated thoracoscopy. Completed thoracoscopic anastomosis of the esophago-esophagus "ends at the end". After a radiological examination with a water-soluble contrast on the 10th day, the baby begins to feed. The child developed chilothorax and chyloperitoneum. In accordance with the protocol of conservative treatment of chylothorax and choleopetonemia, the child was abolished enteral load, octreotide infusion, a full parenteral nutrition source was prescribed. Against the background of the therapy, the status stabilized, the lymph flow ceased. Enteral loading resumes after 15 days. Now the child is at home. Nutrition through the mouth in full, there is no dysphagia.. He is preparing for operative treatment of atresia of the anus.

THE CASE OF ILEOCECAL INTUSSUSCEPTION DUE TO BURKITT'S LYMPHOMA IN A CHILD

Basilayshvili Yu.V., Shtyker S.Yu.

Kharkiv National Medical University, Kharkiv, Ukraine

In the practice of a doctor, rare, casuistic diseases occur, accounting for less than 5% of all lesions of an organ. Single cases of intussusception in a child owing to Burkitt's lymphoma have been described.

The child Dmitry S., 12 years old, complained of abdominal pain, repeated vomiting, loose stools, and anorexia. He was sick for 3 days. The father accidentally discovered a tumor in in the right half of the child's abdomen. At admission, the condition is grave due to intoxication. Pronounced asymmetry of the abdomen due to the formation was revealed. Examinations: CT of the abdominal cavity - abdominal mass in the right half of 120´70´90 mm in size, enlarged mesenteric and retroperitoneal lymph nodes, ultrasound of the abdominal cavity - intussusception of 72´60´50 mm, consisting of intestinal loops and lymph nodes. Preliminary diagnosis - tumour of the abdominal cavity? Intussusception.

At laparotomy, tumor biopsy, omentum resection, terminal ileostomy and peritoneal drainage were made. The large omentum was totally affected having multiple nodular elements. The ileocecal zone was affected by the total tumorous process. Intussusception was found in the ascending colon. Disinvagination was determined to be not possible. The extensive tumor spread to the entire mesentery and walls of the small intestine. The parietal peritoneum was involved in the neoplastic process up to the diaphragm. Thrombohemorrhagic changes in the mesenteric vessels in the basin of a.ileocolica and the transitional phenomenon of the necrobiosis in the segments forming the invagination were revealed. Taking into consideration the foregoing, removal of the tumor and intussusception had been considered to be impossible. Biopsy was taken and the large omentum resected. The distal ileum was resected for examination and the terminal ileostomy applied in the proximal part. A «second look» re-exploration was planned in 48 hours. Aspiration biopsy of the bone marrow was performed.

At relaparotomy in 2 days necrosis of the intestinal loops composing the intussusception was revealed due to thrombosis of the mesentery vessels. Right-sided hemicolectomy was performed. The results of histological study: lymphoblastic lymphoma with total large omentum infiltration, lesion of the walls of the removed intestinal fragments. Atypical cells were not found in the bone marrow.

The child wss consulted in the Institute of Oncology. There was established the clinical diagnosis - Burkitt's lymphoma, stage IV, therapeutic group 2, subgroup R3, total infiltration of the omentum, lesion of the wall and mesentery of the small intestine and ileocecal angle, retroperitoneal space, parietal peritoneum. Ileo-colonic intussusception with necrosis, terminal ileostoma. For further treatment, the child was sent to the hematology department.