formations complicated with hemorrhage, although are casuistic, create medical-surgical management problems.
Material and methods: 61 years old man, hospitalized with recurrent postoperative SDH, after 2 surgical interventions in emergency for SDH from ulcer (GR Billroth I and reresection Balfour). He was transferred to IEM in critical condition, after 23 days from first surgery. At hopitalization: duodenal leakage and dehiscence of gastrojejunal anastomosis, eventration.
Results: CT with angiography revealed: infiltration of adipose tissue in the gastrojejunostomy region, thickened walls of D2-D3, absence of extravasation and tumor of the right kidney. At selective angiography was detected extravasation from pancreato-duodenal artery and endovsacular embolization was performed with Coil and Hydropearl, with a temporary result. The exact diagnosis was established only after 5th endoscopic examination through jejunal loop. It revealed a 3,5-4 cm duodenal tumor with a villous surface and fixed clot. A relaparatomy was performed because of vital indications (prolonged bleeding): removing of the duodenal tumor, colecistectomy with transpapilar drainage of main duct and atypically duodenoplasty. He was hospitalized again after 22 days with an recurrent bleeding. Another surgical intervention wa performed after stabilization of the pacient in the intensive care departement: Wipple procedure with Voelker drainage of the Wirsung duct and right nephrectomy. Histological results: undifferentiated duodenal carcinoma with external growth, nephrocelular carcinoma and cronic pancreatic inflamation. The duration of the treatment from the onset to the discharge: 150 days.
Conclusions: The topical diagnosis of the SDH must be established preoperatory, to avoid unjustifiably interventions. Cephalic duodenopancreatectomy remain the only safe treatment solution in case of duodenal tumors complicated with bleeding.
Keywords: superior digestive haemorrhage, embolization, cephalic duodenopancreatectomy

TACTICA CHIRURGICALĂ ÎN DOUĂ ETAPE PENTRU COLECISTITĂ LITIAZICĂ AGRAVATĂ CU ICTER ȘI COLANGITĂ ACUTĂ OBSTRUCTIVĂ

SAMOHVALOV S[1,2], DANCI A[1], ANGHELICI GH[2], SECANIA TATIANA[2]

[1]IMSP Spitalul Cancelariei de Stat, Secția endoscopie și chirurgie miniinvazivă, [2]Laboratorul Hepatochirurgie, Clinica nr. 2 Chirurgie "Constantin Țîbîrnă", Catedra nr.2 Chirurgie, Universitatea de Stat de Medicină şi Farmacie „Nicolae Testemiţanu", Chișinău, Republica Moldova

Introducere: Tratamentul chirurgical a litiazei biliare pe fondalul icterului obstructiv și colangitei acute este riscant din cauza multiplelor complicații și letalitatea înaltă postoperatorie.
Materiale și metode: Studiu a inclus 637 pacienți cu colecistită litiazică complicată cu icter și colangită obstructivă. Grup I -340 de pacienți tratați pe parcursul anilor 2011-2018, cărora la prima etapă a fost efectuată sfincterotomie endoscopică și colecistectomia laparoscopică ulterioară. Grupul II– 297 cazuri pacienți din diferite clinici chirurgicale, cărora a fost efectuată colecistectomia cu sau fără drenarea cailor biliare principale și postoperator s-a depistat obstrucție canalului biliar comun cauzată de coledocolitiază s-au stricturi. La acest grup intervenție endoscopica pentru eradicarea obstrucției distale ale coledoculuia fost efectuată ca etapa II.
Rezultatele: Evaluarea comparativă a rezultatelor tratamentului în ambele grupuri sa bazat pe prezență complicațiilor - hemoragiile din zona papilotomiei în primul grup în 2,1% (n = 7), în comparație cu 4,3% (n = 13), în al doilea grup. Frecvența pancreatitei acute după papilotomia endoscopică în ambele grupuri s-a dovedit a fi aproape identică și a constituit 4,48% (n = 15) și 4,7 % (n = 14), respectiv. Mortalitatea postoperatorie în lotul 2 a constituit 2,3% (4 cazuri), din cauza prezenței insuficienței hepatice progresante vs 0,88% (2 cazuri) în primul grup.
Concluzii: În prezența litiazei biliare complicate este preferabilă efectuarea tratamentului prin două etape, decompresie endoscopică a căilor biliare cu colecistectomia laparoscopică ulterioară. Tactica tratamentului chirurgical în două etape în Grup I a permis diminuarea evidentă traumei chirurgicale, reducerea numărului letalității și complicațiilor operatorii.
Cuvinte cheie: sfincterotomie endoscopică, colecistită litiazică, colangita obstructivă

DOUBLE-STAGE SURGICAL TACTICS FOR GALLSTONE DISEASE COMPLICATED WITH JAUNDICE AND ACUTE OBSTRUCTIVE CHOLANGITIS

Introduction: Surgical treatment of gallstone disease associated with jaundice and acute obstructive cholangitis is considered high risk because of multiple complications and high postoperative lethality.
Materials and methods: The study included 637 patients with gallstone disease complicated with jaundice and obstructive cholangitis. Group I - 340 patients treated during 2011-2018, whom in the first stage were subjected to endoscopic sphyncterotomy with later laparoscopic cholecystectomy. Group II - 297 patients from different surgical departments, that supported cholecystectomy with or without draining of main biliary ducts, but during postoperative period was observed the obstruction of the common biliary duct, caused by choledocholithiasis or constrictions. In this group, the endoscopic intervention for the irradiation of the distal obstruction of the common bile duct was performed as stage II.
Results: The comparative evaluation of treatment outcomes in both groups was based on the presence of complications - haemorrhages from the papillotomy zone in first group - 2.1% (n = 7), in comparison with 4.3% (n = 13) in the second group. The frequency of acute pancreatitis after endoscopic papillotomy in both groups proved to be almost identical and constituted 4.48% (n = 15) and 4.7% (n = 14), respectively. Postoperative mortality in group 2 was 2.3% (4 cases) due to the presence of progressive hepatic failure vs 0.88% (2 cases) in the first group.
Conclusions: In the presence of complicated ggallstone disease it is preferable to perform two-stage treatment, endoscopic decompression of the bile ducts with later laparoscopic cholecystectomy. The tactics of two-stage surgical treatment in Group I allowed an evident diminuation of surgical trauma, reduced lethality number, and operative complications.
Keywords: endoscopic sphyncterotomy, gallstone disease, obstructive cholangitis