

Introduction. Currently, bariatric surgery is the only effective therapy that leads to marked and sustained body weight loss. Although the morbidity rate after gastric bypass dropped, the postoperative complications are still a problem for the surgeons.

Aim of the study. To appreciate the evolution of the first thirty days in patients submitted to the gastric bypass.

Materials and methods. Observational retrospective study. Data of 388 patients with obesity associated or not with comorbidities submitted to the gastric bypass with 30 days follow-up starting from the date of the surgery.

Results. The age average was $40,47 \pm 10,38$ years. The mean preoperative body mass index was $43,83 \pm 8,19$ kg/m². The major complications were fistula (0,26%), gastrointestinal bleeding (3,35%), intra-abdominal bleeding (0,52%), acute gastric dilatation (1,29%), wound infection (2,83%) and deep vein thrombosis (1,55%).

Conclusions. In the period of thirty days after surgery the overall complication rate was 9,8% and death occurred in 0%. Bleeding was the main complication and the leading cause of hospitalization in intensive care unit and reoperation.

Key words: bariatric surgery, gastric bypass, complications

56. MANAGEMENT OF PATIENTS WITH BLUNT THORACIC TRAUMA AND HEMOPNEUMOTHORAX

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Introduction. Trauma is the leading cause of death worldwide. Approximately 70% of polytraumatized patients have thoracic trauma(TT) with variable severity, the pleuropulmonary complications reaching up to 30-45%, depending on the severity of the trauma.

Aim of the study. Analysis of the diagnostic and treatment outcomes in patients with blunt chest trauma and hemopneumothorax(HPT).

Materials and methods. A prospective study, performed on 86 patients with TT and HPT, hospitalized consecutively at Institute of Emergency Medicine in 2019. The epidemiology, trauma-hospitalization time, hospitalization-tube thoracostomy(TThS), ISS score, structure of associated lesions, duration of assisted ventilation, cause, the frequency of repeated of TThS were analyzed.

Results. M:F–3,5:1; mean age– $51,2 \pm 1,8$ years; In 39(45,3%) TT was caused by falling from its own height, in 27(31,4%) – physical aggression, in 14(16,3%) – motor vehicle collision, in 6(7%) – falling from the height. Chest x-ray was performed on 83(96.5%) patients, in 27(32.5%) cases HPT on hospitalization was not found, FAST – 79(91.9%), only in 10(12.7%) cases pleural collections and/or emphysema was found. CT was performed on 19(22.1%) cases, sensitivity 100% for HPT. At 21(24.4%) polytraumatized patients TT was associated with: abdominal trauma in 4(19%), traumatic brain injury(TBI) – 14(66.6%), trauma of locomotor system – 12(57.1%), vertebral trauma – 4(19%). Hemodynamic unstable patients were 3(3,5%), with ISS>25. Were hospitalized in intensive care unit 16(18.6%) patients, 2 were connected to mechanical ventilation(MV) upon admission; 4(25%) for developing ARDS; and 4(25%) for TBI (2 with GCS<10). Unilateral TT was found in 84(97.7%), of which 12(14.3%)

polytraumatized, 19(22.6%) with HT, 42(50%) – PT, and 23(27.4%) with HPT. Bilateral TT – 2(2.3%), in one case with HPT with flail chest, the other case – HT (ISS>20). TThS upon admission was made in 64(74.4%) cases, until 24h at 12(14%) patients and over 24h at 10(11.6%) patients. TThS was performed in all cases, 53(61,6%) cases in the 5th intercostal space, 27(31,4%) for PT in the 2nd and 6(6,7%) in the 2nd and 5th. In one case, videothoracoscopy was performed 17 hours after TThS for haemostasis. TThS was required repeatedly in 3(3.5%) cases. The average length of hospitalization was 8.34±6.6days and depended directly on the associated lesions and the duration of MV. Mortality was 3.5% (n=3), the cause being hypovolemic shock and MODS.

Conclusions. The hemodynamic stability is determining the management of chest trauma and HPT. The thoracic x-ray is negative in about ¼ cases at admission. FAST in hemodynamically unstable patients with TT can appreciate the presence of HPT. Thoracic CT has the biggest sensitivity for HPT. Repeated TThS are determined by MV and the severity of TBI. Morbidity is dependent on pulmonary contusion, prolonged MV, consciousness disorders and late mobilization.

Key words: Thoracic trauma, hemopneumothorax, treatment

57. BLEEDING FROM DIEULAFOY'S LESION: DIAGNOSTIC AND THERAPEUTIC TRENDS

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Introduction. Dieulafoy's lesion (DL) is a rare, potentially life-threatening cause of gastrointestinal hemorrhage, which is characterized by the presence of a unusual large tortuous artery with in the submucosal layer. The lesion predominantly occurs in the proximal stomach (80%), 6cm from the gastroesophageal junction along the lesser curvature. However, it may occur in any part of the gastrointestinal (GI) tract. Extragastric localization are also described in the literature.

Aim of the study. To offer an overview of current data on available diagnostic and therapeutic tools used for patients with GI bleeding resulting from DLs.

Materials and methods. We selected the articles published during the years 2015-2020, from the PubMed database according to the following keywords: „Gastrointestinal bleeding", „Arteriovenous malformation", „Dieulafoy's lesion", „Endoscopic hemostasis” .

Results. According to the latest statistics, DL is responsible for up to 5% of acute GI bleeds. Typically, it occurs in middle-aged men, and can vary from self-limited to massive life-threatening hemorrhage. Esophagogastroduodenoscopy may significantly improve the recognition and management of this pathology. Mechanical hemostatic therapies including endo-clipping and endoscopic band ligation are considered the most effective techniques in controlling bleeding than other endoscopic methods. Pharmacological treatment can be indicated for patients in which endoscopy is contraindicated or for those who are not responding well to other treatments. Surgical resection is reserved for the cases that fail conservative interventions.