Material and methods: 968 patients with variceal bleeding treated using endoscopic occlusion fibrin glue were divided in two groups: the first group (n=435) achieved hemostasis – with up to 12 hours, II group (n=533) after 12 hours of the started of bleeding, divided in Child A/B/C – 119/233/83 and 131/345/57, respectively. The survival rate was analyzed according to the terms of achieving hemostasis and functional liver reserves.
Results: Control of bleeding was achieved in 957 (98.9%) patients. In controlled hemorrhage with up to 12 hours, mortality was 8.5% (n=37) and no present statistically reliable connection with functional liver reserves. In group II – hemostasis after 12 hours, mortality increased to 17.1% (n=91), we established correlation with the degree of deterioration of liver function: died in Child A/B/C – 8/58/25 patients or 6.1%, 16.8% and 43.9% respectively.
Conclusions: Hemostasis with fibrin glue is an efficient method to control cirrhotic variceal bleedings. Patients with bleeding stopped up to 12 hours demonstrated a higher survival and does not depend directly liver reserves. The mortality of patients with variceal bleedings stopped after 12 hours significantly increases and correlates directly with the level of liver function disturbances.

TRATAMENTUL HERNIILOR OMBILICALE LA BOLNAVII CIROTICI CU ASCITĂ MASIVĂ REZISTENTĂ

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Introducere: Tratamentul herniilor ombilicale la pacienţii cu ciroză hepatică şi ascită masivă rezistentă este o problemă dificilă. Strangularea herniei sau eruperea ei cu revărsarea lichidului ascitic şi dezvoltarea ascit-peritonitei sunt complicaţii severe, uneori letale, forţând efectuarea intervenţiilor de urgenţă, adesea cu rezultate nesatisfăcătoare şi mortalitate crescută.
Scopul studiului: Elaborarea tacticii de tratament chirurgical al herniilor ombilicale complicate la pacienţii cirotici cu ascită masivă rezistentă.
Material şi metode: Studiul include 102 pacienţi cirotici cu ascită masivă şi hernii ombilicale complicate. Lotul I: 48 pacienţi cirotici operaţi în mod urgent, inclusiv 36 (75%) – cu eruperea sacului herniar cu revărsarea lichidului ascitic şi 12 (25%) cu hernii strangulate. La 9 (18,8%) bolnavi simultan s-a efectuat hemostaza endoscopică pentru hemoragii variceale. Lotul II: 54 pacienţi cirotici cu ascită masivă şi risc de erupţie spontană a herniei, operaţi programat, după o pregătire minuţioasă preoperatorie, exfuzia dozată preoperatorie a ascitei. Metoda plastiei – ”tension-free”, suturi monofilament. Plombarea endoscopică profilactică a varicelor s-a efectuat la 29 (53,7%) pacienţi.
Rezultate: În lotul I au decedat postoperator 7 (14,6%) pacienţi prin insuficienţă hepatică, inclusiv 4 cu hemoragii variceale şi 3 cu ascit-peritonită. În lotul II s-a constatat 1 (1,9%) deces prin insuficienţă hepato-renală. Eventraţii postoperatorii la 3-6 luni: lot I – 10 (20,8%); lot II – 2 (3,7%). Supurarea plăgii postoperatorii: lot I – 8 (16,7%), lot II – fără complicaţii.
Concluzii: Herniile peretelui abdominal la pacienţii cirotici cu ascită vor fi operate programat. Examenul endoscopic preoperator pentru profilaxia hemoragiei variceale este o condiţie indispensabilă. Soluţia de preferinţă este hernioplastia ”tension-free” cu suturi monofilament. Drenarea abdominală postoperatorie micşorează riscul ascit-peritonitei, ameliorează cicatrizarea plăgii.

TREATMENT OF UMBILICAL HERNIAS IN CIRRHOTIC PATIENTS WITH MASSIVE REFRACTORY ASCITES

Introduction: Treatment of umbilical hernias in patients with liver cirrhosis with massive refractory ascites is a difficult problem. Strangulation of hernia or hernia sac rupture with leakage of ascites liquid and development of ascites-peritonitis are severe complications, sometimes fatal, requiring emergency surgery, often with unsatisfactory results and increased mortality.
The aim: The elaboration of tactics of surgical treatment in complicated umbilical hernias in cirrhotic patients with massive refractory ascites.
Material and methods: The study includes 102 cirrhotic patients with massive ascites and complicated umbilical hernia. Group I: 48 cirrhotic patients operated on emergency, including 36 (75%) – with hernia sac rupture with ascites fluid leakage and 12 (25%) with strangulated hernia. In nine (18.8%) patients endoscopic hemostasis was performed simultaneously for variceal bleeding. Group II: 54 cirrhotic patients with massive ascites and risk of spontaneous rupture of the hernia, operated electively after a thorough preoperative preparation and fractional preoperative exfusion of ascites. The method of hernioplasty was „tension-free” with monofilament sutures. Prophylactic endoscopic variceal sealing was performed in 29 (53.7%) patients.
Results: In the I group 7 (14.6%) patients died postoperatively due to hepatic insufficiency, including 4 with variceal bleeding and 3 – with ascites-peritonitis. In group II 1 (1.9%) death was registered, caused by hepato-renal failure. The rate of postoperative eventrations at 3-6 months was: I group – 10 (20.8%); II group – 2 (3.7%).
The rate of surgical site infection was: I group – 8 (16.7%), II group – without complications.
Conclusions: Abdominal wall hernias in cirrhotic patients with ascites should be operated electively. Preoperative endoscopic examination for prevention of variceal bleeding is an obligatory condition. The preferable technique is „tension-free” hernioplasty with monofilament sutures. Postoperative abdominal drainage reduces the risk of ascites-peritonitis, improves wound healing.

REZECȚIILE PANCREATODUODENALE ÎN TUMORILE NONCOLEDOCOPANCREATICE

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