



ABSTRACTS OF THE XVIII INTERNATIONAL EUROASIAN CONGRESS OF SURGERY AND HEPATOGASTROENTEROLOGY

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Devoted to the memory of academician B.A. Agayev



Azerbaijan Medical
University



Euroasian
Gastroenterological
Association



Ministry of Health
of Azerbaijan Republic



Azerbaijan Association
of Surgeons and
Gastroenterologists



Scientific Center
of Surgery after academician
M. Topchubashev

AZƏRBAYCAN RESPUBLİKASI SƏHIYYƏ NAZİRLİYİ

AVRASIYA QASTROENTEROLOJİ ASSOSİASIYASI

**AZƏRBAYCAN CƏRRAH VƏ QASTROENTEROLOQLAR
İCTİMAİ BİRLİYİ**

AZƏRBAYCAN TİBB UNİVERSİTETİ

**AKADEMIK M.A.TOPÇUBAŞOV adına
ELMİ CƏRRAHİYYƏ MƏRKƏZİ**

MINISTRY OF HEALTH OF AZERBAIJAN REPUBLIC

EUROASIAN GASTROENTEROLOGICAL ASSOCIATION

**AZERBAIJAN ASSOCIATION OF SURGEONS AND
GASTROENTEROLOGISTS**

AZERBAIJAN MEDICAL UNIVERSITY

**SCIENTIFIC CENTRE OF SURGERY named after ACADEMICIAN
M.A.TOPCHUBASHEV**

The FECM was carried out using spinal anesthesia. The main trunk of GSV was deleted by PIN-stripper and another varicose veins were excised by a miniphlebectomy after Müller with use of Varady's phlebdissector. The EVLC was carried out under local tumescence anesthesia. Using ultrasonic navigation the main venous trunk with radial light guides and "LAHTA-MILON" apparatus was coagulated. Operation was completed by aminophlebectomy after Müller. In some emergency cases a typical cross-section was carried out.

In the postoperative period the ultrasonic examination was used for the 1st and 6th days and in 2 months after operation. To analyze the results of surgical treatment we took into account the duration of patients' hospitalization and quantity of local postoperative complications.

Results: The FECM with use of new technologies was done in 255 (65.6%) patients, the EVLC – in 129 (33.2%), and cross-section – in 5 (1.2%). Another operative measures (the typical phlebectomies with use of Babcock's probe, the subfascial ligation of insufficient communicating veins) weren't carried out.

The physical activity of patients after EVLC was restored right after operation, the average duration of hospital stay was about 4 days in out-patient clinic. After FECM the physical activity restored in 12 hours and duration of hospitalization was 4-5 days in in-patient department. The local postoperative complications were a deep vein thrombosis – in 1 patient, a subcutaneous hematoma – in 4, and a few postoperative paresthesias. The greatest number of complications was observed after FECM due to traumatic manipulations.

Conclusion: The implementation of new surgical technologies in patients with diseases of lower extremities veins allows to reduce the duration of patients staying in hospital and rehabilitation with good cosmetic effect.

FIRST EXPERIENCE OF NON-THERMAL NON-TUMESCENT TREATMENT OF CHRONIC VENOUS INSUFFICIENCY

TATARIN A.E.

Vinnitsya Regional Clinical Hospital Named After M.I. Pirogov, National Pirogov Memorial Medical University, Vinnitsya, UKRAINE

Introduction. Surgical treatment, which in recent decades has become less and less traumatic, is leading in the treatment of chronic venous insufficiency. In recent years, thermal ablation of veins is replaced by non-thermal non-tumescent methods.

The aim of the study was to evaluate our experience of VenaSeal and Flebogrif systems using.

Materials and methods. Our experience included 16 patients (24 lower limbs) with chronic venous insufficiency C2-C4 (CEAP).

10 (18 lower limbs) patients were treated using VenaSeal system: 2 patients received monoprocures of VenaSeal, 2 patients – VenaSeal + miniflebectomy, 4 patients – VenaSeal + foam sclerotherapy, 1 patient – RFA of great saphenous vein + VenaSeal closure of perforator vein.

6 patients (6 lower limbs) were treated using Flebogrif system. All patients received Flebogrif for great saphenous vein and foam sclerotherapy for tributary veins.

Results. The average diameter of the treated vein area in patients of our study was 9.6 ± 2.5 mm.

Both VenaSeal and Flebogrif systems using was associated with low pain scores. Moreover, presumably because it does not require tumescent anesthesia, treatment resulted by the absence of ecchymosis. Our patients had no postoperative burns and pigmentation at all. Also, there was no even mild paresthesia in any patient. According to ultrasonography great saphenous veins were closed in all patients both on day 3 and on day 30.

The severity and impact of venous disease on quality of life were measured with several end points in our study. Subjects treated with both systems showed significantly improving of quality of life over time. There were no statistically significant differences between the results of using both methods.

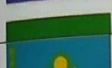
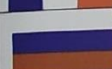
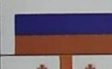
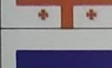
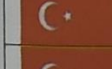
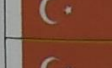
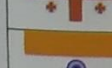
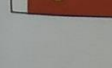
Conclusion. In our opinion using of VenaSeal and Flebogrif is a fast and effective non-thermal methods of eliminating the incompetence of the saphenous veins, without the need for tumescent anesthesia, wearing compression knitwear, not accompanied by paresthesias, postoperative burns and pigmentation.

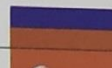
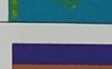
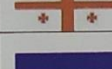
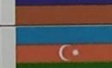
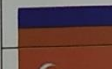
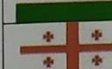
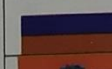
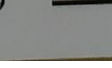
ENDOVENOUS LASER COAGULATION OF THE VEINS OF A SMALLER DIAMETER

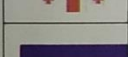
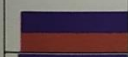
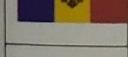
TIKHOV G.V., MUSTAFAYEV R.D.

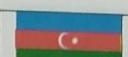
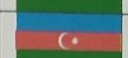
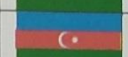
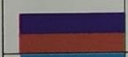
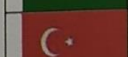
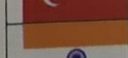
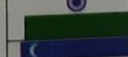
State Scientific Center for Laser Medicine named after O.K. Skobelkin, Moscow, Russia

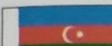
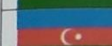
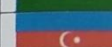
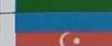
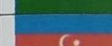
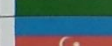
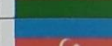
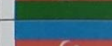
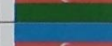
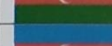
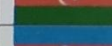
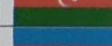
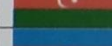
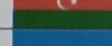
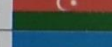
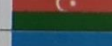
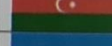
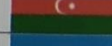
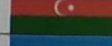
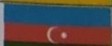
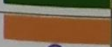
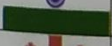
Introduction At present, the "gold standard" in endovascular laser coagulation (EVLC) is aqueous microfluoricon laser systems using radial light guides. The use of one-off radial light guides for surgical

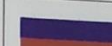
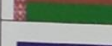
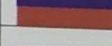
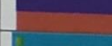
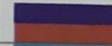
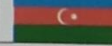
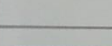
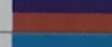
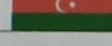
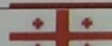
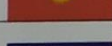
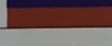
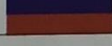
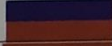
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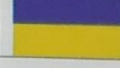
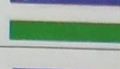
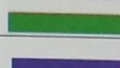
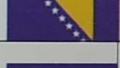
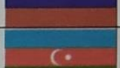
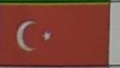
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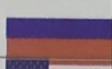
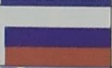
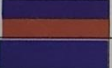
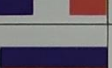
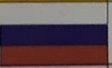
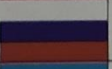
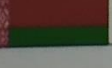
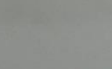
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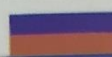
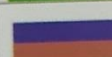
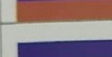
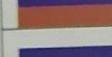
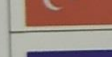
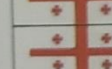
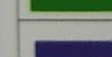
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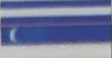
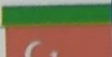
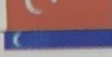
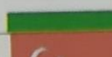
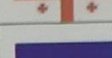
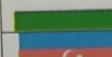
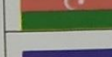
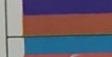
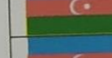
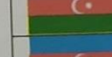
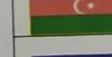
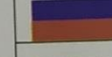
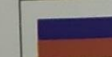
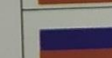
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