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6%. Conservative treatment resolves 80-84% of the complications. Operative treatment comprses: percutaneous nephrostomy – 3%, ureterostomy reinsertion – 4%, nephrectomy – 1%, colostomy correction – 1%, bowel suture 1% or resection 2%, transversostomy - 4%, re-repair of pelvic floor 2%. Survival: Radical PE: 12 months – 59; 18 months – 41; 2 years – 39; 5 years – 27 patients. Palliative PE – 18 months. Palliations – 6 months. For T4 colorectal cancers: 3-years – 78%; 5-years – 45%.

Discussion. The most common complications in the Ist group are pelvic cavity infection and in the IInd group - Urinary infection. In the second period the complications level is significantly decreased (urinary; GI and pelvic floor complications) and 5-years survival survival rates are significantly increased - from 16,5% to 22%.

Conclusions. Despite extended and exenterative surgery has high morbidity, it increases survival, being only radical treatment of extended tumors. Complications are factor determining survival. Knowing complications contributes to avoid them.

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EFFICIENCY OF MINIINVASIVE TREATMENT OF PATIENTS WITH ESOPHAGEAL VARICES BLEEDING

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Introduction. Acute variceal bleeding could be a fatal complication in patients with liver cirrhosis. Therefore, timely endoscopic hemostasis and prevention of relapse of bleeding are most important.

Aim of the work. The aim of our study was to decrease of mortality rates and improve the outcome of treatment in patients with esophageal varices bleeding.

Methods. The study is based on the prospective analysis of treatment results of 242 patients with esophageal varices bleeding, who were on inpatient treatment in the Vinnitsa regional center of the gastrointestinal bleeding in 2014–2018. Total number of men – 137 (56.61%), women – 105 (43.39%). The average age of patients was 56,8±3,6 years. The source of bleeding was established during endoscopy. All patients received drug therapy – hemostatic, antisecretory, infusion, symptomatic. In 2014–2016 patients (group 1, n=195) received just drug therapy. From the second half of 2016 we began to perform minimally invasive endoscopic surgical interventions such as ligation of bleeding esophageal varices (group 2, n=47). After endoscopic band ligation reliable hemostasis was achieved in all cases. According to protocol and in the absence of contraindications to decrease portal pressure all patients received non-selective beta-blockers. Subsequently, to reduce portal hypertension and on purpose to prevent new varices emergence the splenic artery embolization was performed.

Results. In group 1 total number of men was 105 (53.8%), women – 90 (46.2%). The average age of patients was 56.0±4.2 years. Using just drug therapy we have stopped bleeding in 152 (77.95%) cases. In all cases at the end of treatment we received improvement of clinical and laboratory indices. 43 patients (22.05%) were died. Duration of treatment was 10.2±2.1 days. In group 2 total number of men was 32 (68.09%), women – 15 (31.91%). The average age of patients was 55.1±5.4 years. Performing of endoscopic band ligation and splenic artery embolization we have stopped bleeding in 41 (87.23%) cases. In all cases at the end of treatment we received improvement of clinical and laboratory indices. 6 patients (12.77%) were died. Duration of treatment was 6.4±2.8 days.

Conclusion. Under the condition of esophageal varices bleeding treatment by performing of combination of endoscopic band ligation and splenic artery embolization in comparison with drug therapy we can see the improvement of patient's condition, decreasing of mortality and duration of treatment.

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THE ROLE OF THE GENETIC BACKGROUND IN THE SEVERITY OF ACUTE PANCREATITIS

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Introduction. Acute pancreatitis continues to be an actual problem both in surgery and in intensive medicine. Progress made in identifying the genetic susceptibility underlying acute pancreatitis could benefit the clinicians in understanding the pathogenesis of the disease in a better way. The PRSS1 gene provides instructions for making an enzyme – cationic trypsinogen. Cytogenetic location: 7q34, which is the long (q) arm of chromosome 7 at position 34. Molecular location: base pairs 142,740,235 to 142,753,076 on chromosome 7 (Homo sapiens Annotation Release 108, GRCh38.p7).

Aim of the work. The aim of our study was to determine the effect of mutation in the cationic trypsinogen gene (PRSS1) on the severity of acute pancreatitis.

Methods. The study included 54 patients with confirmed diagnosis of necrotising pancreatitis (n=34; 62.9%) and interstitial oedematous pancreatitis (n=20; 37.1%). The mean age in the investigated contingent was 41.8 ± 12.9 years. Genomic DNA was extracted from peripheral blood mononuclear cells using the GeneJet Whole Blood Genomic DNA Purification Mini Kit (ThermoScientific, USA). For

identification of Arg122Hi polymorphic alleles of the PRSS1 gene amplification of the corresponding gene site on the iCycler IQ5 device (BioRad, USA) was performed. Amplification mode: 93ºC, 1 min; 35 cycles: 93ºC, 10 seconds; 64ºC, 10 seconds; 72ºC, 20 seconds.

Results. Polymorphic allele Arg122His of the PRSS1 gene was detected in 46.3% of patients with necrotising pancreatitis. There was a strong statistically significant association between the mutation in the PRSS1 gene and the formation of pancreatic necrosis (r=0.651). The chance of pancreatic necrosis in patients with mutations in the PRSS1 gene was 11.11 times higher than in patients without this mutation [95%, 2.93-42.2]. The relative risk indicator demonstrated that there was a direct relationship between the mutation of the PRSS1 gene and the pancreatic necrosis. In patients with mutation in the PRSS1 gene, the pancreatic necrosis was observed 2.4 times more often than without it [95%, 1.4-4.12].

Conclusion. The presence of mutation in the gene of cationic trypsinogen (PRSS1) significantly increases the risk of severe forms of acute pancreatitis.

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THORACOSCOPIC TRANSDIAFRAGMAL ACCESS FOR UPPER-POSTERIOR SEGMENTS OF SOLITARY LIVER METASTASIS

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Introduction. Introduction of new access in surgery of upper-posterior segments for solitary liver metastasis. Evaluation of the necessity of application of thoracoscopic transdiaphragmatic access with solitary metastases of the upper-posterior segments of the liver.

Materials and methods. In 2017, the technique was applied in two patients who underwent resection of segment VIII of liver, one of them for solitary metastasis of laryngeal cancer, the other – solitary metastasis of colorectal cancer, 3 sm in size. Patient is positioned on the left side, a video telescope is installed in VI intercostal space of middle armpit line, working thoracoport is installed in the VI intercostal space at the anterior axillary line in the seventh and eighth intercostal space along the back axillary line. The right pulmonary ligament is dissected. The diaphragm is cut by the Harmonic device. Step by step, according to the planned line of resection, the intersection of the liver parenchyma is performed, the vessels and bile ducts are subject to clipping. Resection of the VIII segment of liver is performed. The abdominal cavity is drained by silicone tube installed in resected area of liver under control of videothoracoscopy and taken through counterincision in the right hypochondrium. The defect of the diaphragm is sutured. Right pleural sinus is drained by silicone tube and taken through counterincision. Port aperture is sutured.

Results. The duration of the operation in 1 case was 125 minutes, in the second – 140 minutes. Intraoperative blood loss in 1 case-1900 ml, in the second – 850 ml. Postoperative complications were not observed. The length of stay of patients in hospital after surgery-5 days.

Conclusions. Based on our experience in the application of this technique of operating on patients with tumor localization of no more than 3 cm in the upper-posterior segments of liver, we see advantages compared to open surgery.

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EXTENSIVE LIVER RESECTION IN TERMS OF INTRA-OPERATIVE INFUSION CONTRAST OF THE BILE DUCTS

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Relevance. At performance of extensive resections of a liver a considerable quantity of biliary complications remains

Purposes of research. To study the frequency and severity of bile leakage after extensive liver resection in the postoperative period. To find the optimal way of preventing bile leakage.

Material and methods. For the period since 2006 to 2017 183 extensive liver resections (ELR) were performed. There were 92(53%) women and 81(47%) men. Average age of patients was 49±13.9 years old. Exclusionary criteria from the study were emergency and simultaneous surgical interventions, surgeries with angioplasty and biliary ducts reconstruction. As a result, 122 patients were selected for the analysis; all of them were divided into 4 groups. In the first group (n=32), infusion contrast of bile ducts (ICBD) was performed. The essence of the method consisted in putting a thin catheter into the choledoch through the stump of the cystic duct and constant infusion of the original coloring solution into the bile duct system throughout the entire liver resection. In the 2 group (n=31) "White test" was performed. In the 3 group (n=29) external drainage of the bile ducts was performed proactively. In the 4 group (n = 30, control) there was no prophylaxis at all. Assessment was conducted according to the classifications Nagano 2003 and ISGLS. For data processing program Statistica 8.0 was used. The minimum number of patients allowed for the study was calculated by the formula Lopez-Jimenez. Reliability was assessed using Students test with accurate Yates correction, Manna-Whitney criterion.

Results. In group 1 only single bile leakage of D type was