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SURGICAL TREATMENT OF RUPTURE OF ABDOMINAL AORTA ANEURYSM

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The rupture is frequent and lethal complication of abdominal aorta aneurysm (AAA). Despite development of anesthesiology, surgery and intensive care units, mortality is still high. By our experiences mortality is in direct relation with time from the rupture to the beginning of operation. In period 2003-2005 we operated 23 patients for rupture of AAA, 17(73,9%) male and 6(26,1%) female in age 54-81 year. Two male and one female had previously verified AAA, 2 patients had verified aneurism of thoracic part of aorta, and 19(78,3%) had no data on AAA. With 3 patients general surgeon indicated laparotomy due to acute abdomen, and on one patient due to ileus. Other patients were diagnosed by clinical examination, abdominal US and CT scan. All patients had rupture below renal arteries junction. Leading symptoms were abdominal pain 73,9%, back pain 34,7%, pulsing abdominal tumor was present in 52,1%, hypotension in 20(76,9%) and cardiac arrest in 13%. Prior to surgery we reanimated 93,1% patients; inserting CVC and raising the BP to 100 mmHg. In 11(7,7%) we implanted «Tube» prosthesis, in other 12(52,1%) aortic-iliacal bypass and in 6(26,0%) aorto-femoral bypass. We had no surgical complications, we register acute renal failure (39,1%), CVI (13%), respiratory insuffitiention (13%). The survival rate in patients with rupture of AAA we operated is 39,1% (9 patients).

RETROPERITONEAL APPROACH FOR TREATMENT OF INFRARENAL AORTIC ANEURYSM

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Introduction: This report will summarize our initial experience with the use of retroperitoneal approach (RA) for elective treatment of infrarenal abdominal aortic aneurysm (AAA) as well as emergency repairs for ruptured AAA. Material and methods: January 2005 to November 2005, nine patients were operated for AAA using the RA. All patients were males, mean age of 63 ± 5 years. Four patients had previous heart surgery. Three patients were subjected to coronary angiography. Two patients were in hemorrhagic shock, and were transferred immediately to the operating theater. Results: We have performed 4 emergency and 5 elective procedures with RA for AAA repair. Hospital mortality was 22% (2 patients). They both underwent emergency surgery due to AAA rupture. Seven patients were successfully treated using tube graft or bifurcated graft interposition. Their postoperative recovery was uneventful. There was none significant postoperative bleeding. Average extubation time was 5.5 ± 3.4 hours. Average intensive care unit stay was 8 hours. Diet feeding was resumed by postoperative day 1. Average hospital stay was 6.5 ± 1.3 days. Conclusion: Although our series is small, we have come to conclusion that the extraperitoneal approach to the AAA is technically easy and fast, with good exposure of the abdominal aorta and the iliac system, short ICU and hospital stay, with minimal disturbance of gastrointestinal and respiratory function and early mobilization.



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ANEURYSM OF THE ASCENDING AORTA: SURGICAL EXPERIENCE IN SIXTY-FIVE PATIENTS

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Introduction: This report will summarize our experience in treatment of patients with ascending aortic aneurysm (AAA).

Material and methods: Records of 65 consecutive patients from January 2002 to August 2005 were reviewed. Acute aortic dissection patients were excluded. There were 46 men and 19 women, mean age of 57 ± 12 years. Twenty-three patients (35%) had severe aortic stenosis with poststenotic dilatation of the ascending aorta, with bicuspid aortic valve present in 6 (11%). Elective operations were done in 83 %, emergency procedures in 17% of the patients. Aortic arch cannulation was used in 50 patients (77%); right subclavian artery cannulation with antegrade cerebral perfusion during circulatory arrest in 12 patients (18%). Supracoronary graft replacement was done in 29 (45%), reduction aortoplasty in 28 (43), Bentall in 5 (8%), David in 3 patients (4%). Graft replacements were Biogluce reinforced. Freehand xenopericardial valve replacement was done in 14 (22%), aortic valve resuspension in 11 (17%), noncoronary sinus reconstruction in 9 patients (14%).

Results: Hospital mortality was 5 (8%). Non-fatal neurologic complications developed in 5 (8%). There were 6 (9%) surgical bleedings. One patient required reoperation due to heart failure and severe aortic regurgitation.

Conclusion: Our data shows good early results with different techniques used for AAA, with mandatory midterm and long-term studies to evaluate the validity of the procedures used.

UNILATERAL ANTEGRADE CEREBRAL PERFUSION PROVIDES EFFECTIVE AND RELIABLE CEREBRAL PROTECTION DURING SURGERY OF COMPLEX THORACIC AORTIC PATHOLOGY

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Introduction: Cerebral protection is vital in surgery of aortic aneurysms and dissection involving the aortic arch. Currently antegrade cerebral perfusion (ACP) is the most supportive technique to prevent injury of the brain during circulatory arrest. We present our results over the last 5 years using unilateral ACP in patients undergoing complex surgery of their aorta. **Patients & Methods:** 86 pts (40 female, 46 male) – mean age 61 yrs (range 18 – 88 yrs) underwent unilateral ACP with the use of moderate or deep hypothermic circulatory arrest during their aortic repair. 34 pts had to undergo emergent surgery. **Results:** Temporary neurological deficits occurred in only 4 pts (4, 6%), permanent neurological deficit in 1 (1, 21%) patient. Hospital mortality was still high 20, 5% (7 pts) in the emergent group however, low in elective patients 5, 7 % (3 pts). Causes of death in the emergent group were in 5 pts severe intra-/ immediate postoperative LCO-Syndrome due to myocardial ischemia, 1 Bowel ischemia and in 1 patient a massive cerebral haemorrhage at postoperative day 30.

Conclusion: Unilateral antegrade cerebral perfusion during complex and prolonged repair of the thoracic aorta together with moderate hypothermic circulatory arrest proves to be effective and reliable for cerebral protection. However, in cases of emergency there is still a high mortality due to (pre-existing?) myocardial ischemia which needs better preoperative evaluation /diagnosis.