

performed for lower extremity fractures have lower LEFS score after surgery, but in the next months it is improving. In the late outcome the patients that applied for plate removal from femur comparing with those who did not showed lower LESF score - 44.23 ± 2.12 . After osteosynthesis of tibia the score was 40.15 ± 1.72 for the patients that applied for plate removal.

After plates osteosynthesis good and satisfactory functional results were achieved in 94.9 % (37 patients) of cases for femoral fractures and 93,2 % (69 patients) cases of tibial fractures. The osteosynthesis allows us to improve functional results due to better reduction and stability of fractures. The relation between the functional statuses of lower extremity after osteosynthesis with the removal procedures was found, as LEFS scores was significantly lower for those patients that applied for plate removal.

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GROIN HERNIA: ANATOMICALLY DETERMINED RISK FACTORS FOR THE RECURRENCE

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The analysis of scientific publications of last 5 years shows that the questions of anatomical preconditions, role of gender and physique in recurrences of groin hernias after mesh hernia repair remain up-to-date. Considered as a “gold standard”, tension-free hernioplasty has many advantages comparing to tissue repair, but the question of the graft’s size remains a subject of discussions.

The aim: to substantiate anatomical parameters influencing choice of graft’s size and shape in groin hernia repair. In the research took part 74 patients of both gender with primary groin hernias. All the patients were divided into 3 groups due to type of physique: 26 patients (35.1%) of endomorph type, 20 patients (27%) of ectomorph type and 28 patients (37.8%) of mesomorph type. An in-depth analysis of anatomical parameters of the groin region was performed in these groups. Received data were used to calculate the optimal sizes of the prosthetic mesh for the groin hernia repair depending on the physique and gender.

Results of the study show that the anatomical parameters of pelvis and groin regions in particular vary not only in people of different gender and type of physique, but sometimes may vary in one person. That leads us to necessity of individual approach to the choice of size of hernia mesh in every individual case. Based on the obtained data the optimal size of the allograft for the groin hernia repair for the patients of different physique and gender were calculated. We may conclude that groin allografts of standard size (6×11 cm) correspond not to all patients. During the operation, surgeons have to modify the size of standard graft with the scissors or to use a bigger piece of mesh to form the graft of necessary size. All that may lead to mistakes and raise the risk of complications and recurrence.

The anatomical sizes of groin regions vary not only in people of different gender and body structure, but sometimes may also vary in one person, and require an individual approach to the choice of size of hernia mesh in every individual case.

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THE ROLE OF PREOPERATIVE PREPARATION IN THE ANAL FISSURE TREATMENT

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Preoperative preparation of the patient is of great importance in the prevention of early and long-term complications of surgical intervention, and thus plays the integral role in their quick recovery after the proposed surgical treatment to the state of working capacity.

Taking this into account, it is extremely important to improve the preoperative preparation of the patient for surgical excision of the anal fissure to prevent possible complications and achieve a favorable treatment result.