

The medical management of this patient is aimed at secondary prevention of cardiovascular events. Thromboprophylaxis is achieved through Aspirin and Clopidogrel, blood pressure control – through Metoprolol and Molsidomine. Atorvastatin is given for lipid control.

Conclusion. Double Outlet Right Ventricle is a rare form of congenital heart disease with high complexity. Surgical intervention of the anatomical defects should be done early in life to prevent mortality and regular follow-ups are necessary to prevent morbidity and development of complications.

TOTAL VASCULAR ISOLATION IN SEGMENTAL LIVER RESECTION FOR ECHINOCOCCAL CYST

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Introduction. Echinococcal disease is widespread in many countries of the world. According to some estimates, more than 1 million people in the world are currently affected by echinococcosis, and the incidence in some endemic and non-endemic regions varies more than 200 times. In the last decade, there has been an increase in the incidence of echinococcosis and the expansion of the geographical boundaries of the disease.

Aim of the study. To improve the results of surgical treatment of patients with echinococcal liver cysts.

Materials and methods. The article presents the results of surgical treatment of two patients who underwent segmental resections of the liver for echinococcosis using the technique of total vascular isolation. Patients were admitted to the Department of Surgical Pancreatology, Hepatology and Transplantation of Grodno Regional Clinical Hospital, Belarus with complaints of heaviness and aching pain in the right upper quadrant of the abdomen. Both patients underwent a complex of laboratory and instrumental research methods, including MRI, CT and ultrasound of the abdominal and retroperitoneal organs. According to MRI, both patients in the S7 segment of the liver subcapsularly revealed rounded focal formations with clear contours of 50*33 mm and respectively 45*30 mm, with the presence along the posterior wall of a hyperdense component with clear contours of 5 * 6 mm. The fact of the close location of liquid formations to the right hepatic vein in both cases has been established.

Patients underwent segmental resection of the liver for an echinococcal cyst using the method of total vascular isolation. In both cases, a laparotomy was performed with a J-shaped approach in the right upper quadrant of the abdomen. To carry out total vascular isolation of the liver, the inferior vena cava in the supra- and subhepatic sections, as well as the hepatoduodenal ligament were mobilized using a thread-Pringle maneuver. During the

mobilization of one of the veins, one patient was found to have a linear traction defect in the wall of the inferior vena cava. Thanks to the use of total vascular isolation, intraoperative blood loss was avoided at this stage. The place of "linear traction" was stitched with a vascular suture over the vascular clamp of Satinsky. Liver parenchyma transection was performed using ligasure triad apparatus, bipolar and monopolar coagulation, as well as using precision stitching of visualized vascular and biliary structures. Resections of the 7th segment of the liver with the above-described formations were performed step by step.

Results and discussion. The duration of the operation in both cases was about 6 hours. Intraoperative blood loss averaged about 400 ml. Both patients were discharged from the surgical hospital in a satisfactory condition for 10 and 15 days respectively in the postoperative period. During the pathohistological examination of macropreparation, the diagnosis of echinococcal cyst was confirmed in both cases. There were no relapses of the disease, as well as repeated admissions to the hospital within a follow-up period of up to 1.5 years.

Conclusion. The use of the method of total vascular isolation allows to reduce significantly intraoperative blood loss, and also makes it possible to avoid extensive resections in echinococcal liver cysts.

CLINICAL AND LABORATORY FEATURES IN PATIENTS WITH DIFFERENT PHENOTYPES OF HEART FAILURE

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Introduction. The 2016 European Society of Cardiology guidelines have introduced a new classification of heart failure (HF) based on the left ventricular ejection fraction (LVEF), which classifies patients into HF with preserved ejection fraction (LVEF $\geq$ 50%), HF with reduced ejection fraction (HFrEF) (LVEF $<$ 40%), and HF with mid-range ejection fraction (HFmrEF) (LVEF 40-49%). Previous clinical trials that targeted the outcome of different strategies in HFrEF usually included patients with LVEF lower than 35-40%, which makes our study relevant.

Aim of the study. To evaluate clinical and laboratory differences in patients with HF with reduced and mid-range LVEF.

Materials and methods. The study included 80 patients with HF and LVEF $<$ 50% who were admitted to the Grodno State Cardiological Center for treatment from January to November 2024. Group 1 included 45 patients with HFrEF, while Group 2 included 35 patients with HFmrEF. Statistical analysis was performed using the STATISTICA 12.0 software.

Results and discussion. Patients with HFrEF and HFmrEF were predominantly male (29 (64%) vs 25 (71%), $p > 0.05$), comparable in age,