

Methods: We performed a retrospective analysis of 73 SPKT recipients who underwent transplantation between 1988 and 2015.

Results: 50.68% of patients were male. During the time of surgery the mean age was 37.8 ± 7.44 years. DM1 was diagnosed average 25 ± 6.08 years before SPKT. For 21.9% it was pre-emptive transplant. 60.9% and 17.19% were on haemodialysis and CADO respectively (the mean dialysis time was 29.05 months). Reoperation due to pancreatic and kidney complications amounted respectively 23.3% vs 8.3%. DGF was observed in 9.6% of kidney graft recipients. Mean HLA - A, - B, - DR mismatches were: 1.42, 1.58, 1.27. All patient received induction of immunosuppression (polyclonal immunoglobulins: ATG/Thymoglobulin – 64% or monoclonal: daclizumab/basiliximab – 36%). Kidney graft survival at 1, 5, 10, 15 years 100%, 97%, 85% and 67%; and pancreas survival is 95%, 92%, 87% and 67% respectively. There was noticed tendency to increase creatinine level (from 1.18 at 1 year to 1.78 at 15 years) and decrease of haemoglobin level (from 13.84 at 1 year to 12.65 at 15 years). Patients with longer time of dialysis were more commonly infected by HCV ($p=0.004$), more often hospitalized due to cardiovascular complications ($p=0.004$) and had shorter survival time ($p=0.03$). HBV infection correlated with longer time of hospitalization during transplantation procedure ($p=0.006$), more often delay grant function of pancreas ($p=0.008$), higher serum level of CRP ($p=0.04$) and more frequent hospitalizations in subsequent years ($p=0.003$).

Conclusion: Shorter dialysis time improves patient prognosis after SPKTx. HBV and HCV infection is associated with more frequent complications and worse prognosis. Cardiovascular complications are more likely to affect dialysis patients.

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PS031

The impact of suturing hemostasis on ovarian reserve during conserving surgeries on the ovaries



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Aim: To determine the effects of using suturing hemostasis in cases of cystectomy of unilateral endometriomas and mature teratomas (MT).

Introduction: Nowadays there is a noticeably growing rate of benign ovarian tumors requiring urgent treatment. It is known that ovarian tumors lead to diminished ovarian reserve (OR). Conserving surgeries bring to a further reduction of OR.

Methods: The study involved 66 patients with endometriomas and 69 with MT. The mean age was 28.07 ± 5.3 . All patients underwent laparoscopic cystectomy. The methods to stop bleeding were: ligature hemostasis with absorbable polyglycolic suture, USP 2-0 (I group) and bipolar coagulation (BPC) – Autcon II 350, current power 35 W – (II group). Before and 6–12 months after surgery serum levels of Antimüllerian hormone (AMH) were evaluated; by ultrasound (Toshiba Aplio 500, 3.6–8.8 MHz) we measured the volume of healthy ovarian tissue (V_{cm^3}), antral follicle count (AFC), their site and diameter.

Results: At the pre-surgical stage patients with endometriomas had reasonably lower ultrasound and biochemical markers than patients with MT. 6 months after suturing hemostasis patients with endometriomas had a 1.8 times higher AFC, its diameter and, as a

result, the volume of ovarian tissue of the operated gonad compared to the group after BPC. Studying similar indices by the patients with MT showed the difference of 1.3 times respectively. Deformed follicles with small diameter (3–4 mm) ousted to the periphery were located on the echograms. Six months after laparoscopy the AMH level of all patients decreased, the biggest reduction (1.7 and 1.9 times correspondingly to groups) was noted by the patients with endometriomas.

Conclusion: To preserve women's reproductive potential after conserving surgeries on the ovaries, intracorporeal suturing is a preferred hemostatic method over bipolar energy. Enucleation of endometriomas and MT leads to diminished OR regardless of the energy type used as a hemostasis.

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PS102

Complications after open surgery for the abdominal aorta and its branches depending on patients' age



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Aim: Age is one of the risk factors for postoperative complications in open surgery of the aorta. The awareness of their frequency may lead to earlier diagnosing and referral for procedure in order to avoid negative results of surgery and further therapy.

Introduction: The aim of our study was to assess the dependent of age frequency of postoperative complications among patients undergoing primary open surgical procedure within abdominal aorta due to aneurysm (AAA) or/and peripheral arterial disease (PAD).

Methods: The study group consisted of 249 patients (84.7% men), aged 69.1 ± 8.2 with AAA or/and PAD who underwent open abdominal aorta surgery between August 2015 and January 2017. Patients were divided into three groups depending on age group I < 65 years (61 patients, aged 58.8 ± 5), group II 65–74 yrs (118 patients, aged 68.5 ± 2.8) and group III > 74 yrs (70 patients, aged 79.1 ± 3.4). We considered coexistent diseases, smoking habit, Revised Cardiac Risk Index for Pre-Operative Risk (Lee index), some laboratory tests, type and mode of surgery (elective vs urgent/emergent). Statistical analysis was performed with Kruskal Wallis and Chi2 tests.

Results: Frequency of some complications such as myocardial infarction, pneumonia, sepsis, stroke or bleeding was similar in compared groups. Nevertheless, we observed a statistically significant difference in the frequency of acute kidney injury demanding dialysis (respectively, for groups I–III: 3.28% vs. 17.80% vs. 20.00%; $p=0.013$), multi-organ failure (1.64% vs. 10.17% vs. 14.29%; $p=0.039$) and intrahospital mortality (1.64% vs. 11.86% vs. 18.57%; $p=0.009$). The groups were comparable regarding the coexistent diseases – the only differentiative feature was hypertension that occurred less in group I (62.30%) than in other groups (82.20% and 81.43%, $p=0.01$). There was no significant difference between groups in preoperative risk determined by Lee index and mode of surgery procedure. However, older patients had higher mean creatine level on admission than younger patients (72.2 ± 21.5 vs. 91.3 ± 34.2 vs. 94.4 ± 37.7 $\mu\text{mol/l}$, $p<0.005$), lower eGFR (109 ± 31 vs. 84.5 ± 29.1 vs. 73.8 ± 24.7 ml/min/1.73 m^2 , $p<0.001$) and more