

опухоли (опухолевая эмболия легочной артерии при вводимом наркозе -1, отек мозга - 1, сердечная недостаточность - 1). Период наблюдения за остальными пациентами в среднем составлял 28,3 месяца (от 2 до 96 месяцев). В течение наблюдения умерли 16 (51,6%) пациентов. Во всех случаях причиной смерти являлась прогрессия опухоли.

Заключение Локорегиональный рецидив почечно-клеточного рака является редкой, но очень сложной онкоурологической проблемой. Наиболее частой причиной его возникновения можно считать неполное удаление опухоли в зоне резекции, что зачастую (25,8%) связано с внутривенным распространением новообразования. Тем не менее, почти в 30% случаев рецидивы опухоли исходят из мультифокальных почечных опухолей или метастазов в региональные лимфатические лимфоузлы. Учитывая, что рецидивирование рака в остатке почки наиболее часто обнаруживается в течение первых двух лет после операции, необходимо тщательное наблюдение за пациентами в течение этого периода. Онкологические результаты хирургического лечения пациентов с локорегиональным рецидивом ПКР не являются удовлетворительными, что требует исследования эффективности адъювантной таргетной и иммунотерапии у этой категории больных.

A NEW SURGICAL TECHNIQUE OF THE RENAL ARTERY CONTROL DURING NEPHRECTOMY WITH TUMOR THROMBUS REMOVAL

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Introduction The nephrectomy safety during removal of kidney tumors with intravenous extension mostly depends on control of the renal artery. But in certain situations control of the renal artery is a very complicated and dangerous stage of the operation due to presence of the venous collaterals and massive size of the tumor thrombus. Search of the renal artery often accompanied the displacement of the renal vein, inferior vena cava or kidney, which can lead to thrombus fragmentation and pulmonary embolism in the presence of fragile or soft tumor thrombus.

Material and methods We present a novel method of control of the renal artery after performing thrombectomy. While surgical access to the renal artery passes anteriorly through the transected renal vein. The main stages of this surgical approach are transection the renal vein in the area of cavorenal segment, displacement of the renal vein with tumor thrombus laterally and anterior access to the renal artery.

We present video of the anterior approach to the left renal artery after thrombectomy in patient with the left renal vein tumor thrombus to the level of cavarenal junction. After duodenum mobilization we performed the isolation of the inferior vena cava. In case of the tumor thrombus extension to the inferior vena cava the technique of three tourniquets was used. In patients with only renal vein tumor thrombus the vascular clamp was placed distally to the thrombus apex. After transection of the renal vein the both venous ends were sutured and ligated.

Then displacement of the transected renal vein with tumor thrombus laterally and mobilization of anterior and lateral surface of aorta were performed. In the case of the left-side tumors the renal vein was separated bluntly and sharply from the aorta and mesenteric root. Renal artery was ligated and sectioned. Left renal vein with tumor thrombus were passed under the mesenteric root. At the final stage of the operation carried out mobilization and removal of the kidney.

Results We used this surgical technique in 13 patients with tumor thrombus of the renal vein (n=3) and inferior vena cava (n=10). Ligation of the renal artery from the anterior approach was successfully performed in all 13 patients. Overall considerable technical difficulties when using this maneuver was 7.7%. The average blood loss during the operation does not exceed 1990.0 ml. Intraoperative mortality and pulmonary embolism was not observed.

Conclusion Our experience has demonstrated the feasibility and safety of a new surgical technique, including anterior ligation of the renal artery after thrombectomy. This approach decreases the blood loss from the venous collaterals during kidney mobilization and reduces the risk of pulmonary embolism.