manipulation. The next step after EPST is to contrast the bile ducts and perform cholangiography to detect pathology. 2. Endoscopic lithoextraction - removal of calculi using the Dormia extraction basket, a balloon lithoextractor. In case of large stones, a lithotripter basket is used for fragmentation and subsequent removal of the stone. During the analyzed period, the following have been successfully completed: 90.8% of litho-extractions in 2016, 92, 3% in 2017, 93% in 2018, 93.7% in 2019 and 95.6% in 2020. In other cases, the attempts were unsuccessful due to technical difficulties and, large concrements disproportionate to the instruments, the infringement of the Dormia basket during lithoectraction. 3. In patients with not removed large calculi, tumor lesions of the pancreatic head, Klatskin's tumor, ERCP, EPST were performed, supplemented with biopsy of altered tissues suspicious of oncopathology. For the purpose of decompression, stenting of the extrahepatic bile ducts was performed. For this purpose, polymer stents were used, the life of which is 36 months. Nitinol self-expanding stents are installed in inoperable patients with malignant lesions of the pancreatobiliary zone. The risk of acute pancreatitis after ERCP is associated with cannulation and contrast enhancement of the main pancreatic duct. During the analyzed period, 10 cases of post-manipulation pancreatitis were recorded, which is 1% of all manipulations performed. After manipulation, these patients underwent anti-pancreatic therapy with control of blood biochemical parameters.

Conclusions. Endoscopic retrograde interventions are essential for the diagnosis and decompression of the biliary tract. The use of minimally invasive endobiliary technologies in patients with obstructive jaundice syndrome of various origins makes it possible to divide treatment into 2 stages. In this case, at the first stage, with the help of endobiliary interventions, the biliary tract is decompression with restoration of the bile passage. The second stage is the correction of the underlying pathology. Such a staged division of treatment in patients with obstructive jaundice syndrome significantly improves treatment results, reduces postoperative mortality and the number of postoperative complications.

APPLICATION OF ABDOMINOPLASTY AS THE FIRST STAGE OF TREATMENT OF A PATIENT WITH MORBID OBESITY

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Relevance. The World Health Organization has defined obesity and overweight as "abnormal or excessive accumulation of fat that can negatively affect health" and declared this pathology a global epidemic. To classify obesity in many countries, including Russia, the body mass index (BMI) is used, calculated by the formula: weight (kg) / height (m2). At the same time, BMI ≥ 25 indicates overweight, and BMI ≥ 30 indicates obesity.Many foreign researchers attribute overweight and obesity to multifactorial, complex, multigenic disorders that are closely related to the characteristics of the psychosocial and cultural environment.

Material and methods. Patient H., 54 years old, was examined. Preoperative examination revealed a picture of morbid obesity of alimentary constitutional genesis, abdominal type, complicated by a giant fat fold of the anterior abdominal wall and secondary lymphedema. An atypical middle abdominoplasty with a reconstructive component of the anterior abdominal wall was performed.

Results. Successful removal of 60 kg fat "apron".

Findings. Based on our clinical experience, we can say that patients with advanced morbid obesity respond positively to complex treatment with minimal complications in the postoperative period. Removal of the main adipose tissue collector has a positive effect on further weight loss in combination with conservative therapy.

COMBINATION OF STRETCH AND NON-STRETCH HERNIOPLASTY

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Relevance. The choice of the method of reconstruction of the deep inguinal ring and the posterior wall of the inguinal canal with local tissues remains relevant.

Material and methods. 14 patients with a combination of tension and non-tension hernioplasty 3 4 1 - located laterally from the spermatic cord. 2 - represented by a deep inguinal ring. 3 - the inguinal canal, respectively, to the lateral muscles. 4 - the medial section of the inguinal canal, respectively, the aponeurosis of the rectus muscle. For the plastics of the first three sections, the use of an endoprosthesis does not have any advantage over local tissues when used according to the proposed method. We exclude the capture in one suture of the transverse fascia (PF) with muscles, aponeurosis with muscles, especially all three together. We restore the PF within the damage with U-shaped seams, which firmly cling to the PF fibers. For this suture, we use a thread superimposed on the stumps of the hernial sac, which allows us to trace the course of the needle under visual