Currently, almost all experts in medicine meet the need of surgical patients receiving antiplatelet agents or anticoagulants for a long time due to the presence of disease or invasive procedures that are associated with a high risk of arterial or venous thrombosis. In the USA, about 2.5 million meet with the drawn discontinuation of oral anticoagulants (OAK), including mainly warfarin. Each year, approximately 10% of patients using anticoagulation is suspended due to the need to perform invasive procedures. Regarding these patients methodology proposed temporary switch from receiving anticoagulants or antiplatelet agents for parenteral heparin thromboprophylaxis necessary to support and, simultaneously, reducing the risk of bleeding. This methodology in English literature called bridging-therapy. The fact that the need for urgent surgery in patients during treatment with oral anticoagulants brings almost nothing our efforts prevention of venous thromboembolic events through direct and indirect anticoagulants because the anticoagulation after its withdrawal leads to the formation of thrombophilia through the development deficit of antithrombin III (AT III) the case of unfractionated heparin (UFH) and low molecular weight heparin (LMWH) and protein C during treatment with indirect anticoagulants.

Addressing the need bridging therapy taken in each case. Remember that according to statistics, about 20% of arterial thrombosis is fatal and 40% lead to lifelong disability. Up to 6% of recurrent venous thromboembolism (VTE) also lead to fatal consequences, but only 3% of major postoperative bleeding leading to fatal consequences. In general, the risk of bleeding during the implementation of the interference with 2 times the risk of thrombosis.

An important role in the maintenance of blood coagulation system plays a vitamin K, which stimulates the synthesis in the liver of prothrombin (FII) proaktseleryn (FV) prokonvertyn (FVII, Prauera Stewart factor (FH) Christmas factor (FIH). But, the reduced form vitamin K takes a direct part in activating factors listed above. The mechanism of action of vitamin K is activated by carboxylation of amino acid residues glutamic acid molecules coagulation factors under the action of the enzyme gamma glutamincarboxylaze, cofactor which is a reduced form of vitamin K. in the process of converting molecules of clotting factors glutamate in carboxy glutamat reduced form of vitamin K is converted to oxidized forms - vitamin K epoxide, which does not have the property to stimulate the synthesis of clotting factors in the liver. The reverse conversion of inactive vitamin K epoxide in an active reduced form is in the body under the action of enzymes vitamin K-epoksydreductase (phase I) and vitamin K reductase (second stage). The complex of these enzymes blocked by indirect anticoagulants. The following types of vitamin K:

- Vitamin K1 - filohinon (derived from alfalfa);
- Vitamin K2 - menahinon (derived from rotten fish meal, synthesized by intestinal bacteria);
- Vitamin K3 - menadione (synthetic);
- Vikasol - bisulfitnoho sodium salt derivative of vitamin K3 (overseas is not used, because in high doses causes erythrocyte hemolysis, hyperbilirubinemia and icterus, (VanWinckel M., 2009)). Vitamin deficiency is very rare. Many vitamin K is found in green leafy chestnut, nettle, alfalfa, cabbage, spinach, pumpkin, berries of mountain ash. In animal products, vitamin K is found only in pork liver. Vitamin K1 can be used in cases of indirect anticoagulants overdose with or without clinically significant bleeding, and on the need for urgent surgery in patients receiving anticoagulant therapy. There method of temporary abolition of indirect anticoagulants without a bridging therapy when indirect anticoagulant canceled 2-3 days before the planned operation and, at the time of surgery international normalized ratio (INR) is 1,6-1,9 (prothrombin index (PTI) = 62,5-52%), the surgery could be performed because the bleeding risk is low (DeuketisJ.D. etal., 2012). Bridging therapy performed by a complex scheme, which includes a phased restoration and unlike admission OAK, and pursues prevent arterial or venous thrombosis in patients. Below is a list of diseases or pathological states in which appointed prolonged antithrombotic therapy. In case of urgent surgery before the operating time of 6.12 hours and a moderate degree of trauma should be discontinued reception
OAK, Vit K1 given to the patient at a dose of 5-10 mg / in, repeat the analysis INR before surgery. In surgical interventions a high degree of trauma other than cancellation of the OAK and the control input INR Vit K1 duplicated after 6 hours. In general, the risk of bleeding during surgery to perform 2 times the risk of thrombosis. More recently developed BleedMAP scale for assessing the risk of bleeding during invasive intervention implementation. When evaluating using the scale 1 point corresponds to each of the following risk factors: bleeding in history (Bleed) implanted in the heart of a mechanical valve prosthesis (M), the active form of cancer (A) and a low level of platelets in the blood (P, of plateled, 1500000 number of platelets / ml or less). Despite the fact that the validity of this scale has not been subjected to in the course of evaluating prospective study, using it allows to establish the risk of bleeding based on the clinical data. It should also be noted that at present it is the only scale available to assess the risk of bleeding in the use of anticoagulants during performance of invasive surgery.

Clinical case. Patient M, born in 1937 coach was brought in surgical ward KMKL number 10 01/08/16 was complaining of pain in the epigastric and right upper quadrant, yellowing of the skin and sclera, general weakness, dark urine. History of the disease: it is known that the patient marks the appearance of jaundice without evidence of pain from 01.01.16 year. After 2 days began to disturb pains in the right iliac region who migrated from the right flank in the right upper quadrant and epigastric region, nausea. Ambulatory examined in a private clinic where an ultrasound revealed signs of acute cholecystitis and laboratory signs of hyperbilirubinemia (total bilirubin 148 mc mol / l). From the hospital refused. Repeatedly asked for help 08.01.2016.

History lives: 06.10.14r. - prosthesis aortic valve, so that the patient always takes warfarin 5 mg / day, clopidogrel 75 mg / day, Cordaron 200 mg / day. At admission medium condition, icteric skin, sclera, respiratory rate of 16 min., Pulse filling and tension, regular, heart rate - 88 per min., No shortage of pulse, blood pressure 120/90 mmHg, SpO2 - 98% (saturation measured by pulse oximeter). Auscultation of the lungs- respiration is symmetrical, rigid, no wheezing; Cardiac sonorous, rhythmic, auscultated systolic murmur over the aorta. Belly moderately swollen, palpation painful and stressful in the right upper quadrant and epigastric region. Symptoms Kera and Ortner positive. Preliminary diagnosis: cholelithiasis, calculus acute cholecystitis, choledocholithiasis, chronic hepatitis. Completed laboratory examination, complete blood platelets + (Hb - 140 g / l Leu. - 9.4H / l L. -4.5 T / L, CE-0.9 tr. - 77.8 g / l leucogram: p-13% C 71%, 8% m, l, 8%), blood type, Rh - factor (O (I) Rh +), urinalysis, biochemical examination of blood (albumin 32 g / l of bilirubin fractions (354/296/58 mc mol / l), ALT (59 IU / l), AST (53 U / l), blood amylose (111.9 U / l), blood sugar (6,4 mmol / l), urea (8,4 mmol / l), creatinine (143.8 mmol / l)), coagulation: (PTI- 58% thrombin time (TT - 22 c), INR (3.1 ), APTT (48 c), fibrinogen - 6210 mg / l, 2.8 mg fibrin ethanol "+"); ECG (sinus rhythm, normal position of the axis of the heart), ultrasound of the abdominal cavity (acute cholecystitis, chronic hepatitis), radiography of the chest (without lesions). The treatment: 9.01.16r. after 6 hours of conservative treatment (i/v infusion of crystalloid, antibiotics, antispasmodics) if symptoms of peritoneal irritation decision to perform surgery patient in the intensive care unit performed catheterization of the internal jugular vein to the right, i/v put vitamin K1, pour 450 ml FFP O (I). Surgery performed with the use of an all-out / in relaxants and anesthesia with endotracheal intubation. During the operation, the patient revealed acute calculus cholecystitis, choledocholithiasis, suppurative cholangitis, holanhio liver abscess, obstructive abscess that spread in the abdomen, diffuse fibrinous-purulent peritonitis, chronic hepatitis. Done cholecystectomy, external drainage choledochitis for Pikovsky, installed tube to decompress the stomach and the small intestine probe for enteral nutrition. Length of stay of the patient in the operating room - 2 hours, fluid balance - blood loss - 100 ml, urine output of 50 mL, aspirate of abdominal 300 ml of fluid, i/v crystalloid introduced in 1400 mL. The patient is transported to the intensive care unit, continued i/v sedation. Early postoperative hemorrhage complicated with upper gastrointestinal tract (acute gastric erosions). A conservative haemostatic therapy using FFP (4 doses) packed red blood cells (3 doses), tranexamic acid (1 gram i/v).
However, bleeding resumed at 6 hours after the previous stop. It was decided to use the figures obtained by Oktapleks - INR - 3.5, and reduced hemoglobin dynamics to 87 g / L, continued bleeding nasogastric tube. Oktapleks applied at the recommended dosage according to the manufacturer's instructions 1.6ml / kg of patient body weight. The satisfactory result. 01.10.16 patient was extubated and restored at the level of consciousness and stable hemodynamic parameters. In laboratory examination: Hb - 90 g / l, Er. - 2.9 t / l, tr. - 169 g / l;: p-12% s-74%, m- 7%, , 17%; PTI- 75%, APTT - 58s, INR - 1.8, albumin - 29.1, urea - 8.5 mmol / L, creatinine - 1607mkmol / l, bilirubin 210/160/50 mmol / L, ALT - 59 U / l, AST - 52Od / l, blood amylase - 68.7 U / l. Given coagulation parameters, the patient was scheduled preventative dose of heparin. Heparin is the drug of choice was due to re-present risk of bleeding and the presence of an antidote (protamine sulfate). A per two days warfarin was added to the heparin controlled key indicators of blood coagulation (INR 1.6, PTI - 85%). On the 10th day after surgery the patient was discharged in good condition with restored taking oral anticoagulants.

**Conclusion:** In patients with marked jaundice present significantly higher risk of bleeding during surgery and in the postoperative period. This risk greatly reinforced by the fact of taking oral anticoagulants. Application Protocol bridging therapy with the additional use of prothrombin complex concentrate factors allowed not only prevent the development of life-threatening bleeding in the postoperative period, but also prevent the possibility of postoperative thrombosis and save patient lives.