

DIAGNOSTICS AND MODERN METHODS OF TREATMENT OF PATIENTS WITH ACUTE INTESTINAL OBSTRUCTION

¹Fayziev Yakubdjan Nishanovich, ²Akhmedov Mirkhalil Djalilovich

^{1,2}Tashkent Pediatric Medical Institute, Uzbekistan

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Abstract. *The problem of diagnosis and surgical treatment of patients with acute intestinal obstruction (ACI) is one of the most difficult in urgent surgery, which is due to the steady increase in the number of this patient population, late admission to the hospital, diagnostic errors at the prehospital stage, a large number of postoperative complications, and a high mortality rate, which is 20-50% and does not tend to decrease [1, 2, 8].*

Keywords: *diagnostic errors, acute renal failure, invagination, gastroenteroanastomosis.*

In recent years, many authors attribute the increase in the incidence of acute obstructive pulmonary disease, which now accounts for 10% of all urgent abdominal diseases, to the increasing operational activity in the diagnosis and treatment of surgical diseases, as well as to the development of adhesive disease [2, 3]. The occurrence of an adhesive process after laparotomy was noted in 64-93% of cases. It should be noted that the results of treatment of acute renal failure largely depend on the timing of diagnosis and the volume of emergency care. Postoperative mortality ranges from 4.6 to 40%, depending on the duration of the disease. The main causes of high mortality are the complexity of early diagnosis, late access to patients, late delivery of medical care, as well as the erasure and atypical clinical picture of the disease during pregnancy [2, 11, 12].

Materials and methods: the results of treatment of 199 patients treated in the 7th city clinical hospital of Tashkent and in the 2nd clinic of the Tashkent Medical Academy from 2012 to 2016 with a diagnosis of OCD were analyzed. They ranged in age from 20 to 82 years. There were twice as many men as women. In 21 (14.7%) patients, intestinal obstruction was resolved conservatively. The remaining 178 patients were operated on.

Of these, 24 (16.1%) patients were treated for acute obstructive intestinal obstruction, 35 (23.5%) for strangulated intestinal obstruction, 68 (45.6%) for acute adhesive intestinal obstruction, and 1 (0.3%) for invagination.

We have developed an algorithm of therapeutic and diagnostic measures that includes diagnostic elements of all types of acute intestinal obstruction and indications for a particular method of surgical treatment.

When patients were admitted to the hospital, a history of the disease and life was collected to determine the type and nature of intestinal obstruction, and a rectal examination was performed to exclude distal gastrointestinal tract block. Also, along with laboratory methods, an abdominal X-ray and ultrasound examination were performed to detect the "pendulum-like movement" of the small intestine and the presence of free fluid.

Patients with cancer-related OCN were characterized by weight loss, bloating, non-discharge of gases, and lack of stool. Rectal examination most often revealed the formation of a rectum (4 cases) or an empty ampoule – a symptom of the "Obukhov hospital" (19 cases). It was also possible to eliminate OCD caused by fecal stones (11 cases).

In case of adhesive intestinal obstruction, the pathognomonic symptom was the presence of pronounced constant abdominal pain and intermittent cramping pains. At high PH, the leading symptom was vomiting. At the same time, there may be stool and gas discharge due to emptying of the small and large intestine below the obstruction site, which sometimes leads surgeons to misinterpret the clinical picture of the disease, late diagnosis and delayed surgery.

Also, if obturation intestinal obstruction was suspected, there was knowledge of previous operations, such as gastric resection, the presence of calculous anamnesis, helminthic infestations and mental illnesses. Phytobezoars were found in patients with gastric resections, especially those performed according to Billroth-II (17 patients). The absence of gallstones during the examination in patients with calculous history made it possible to suspect obstructive intestinal obstruction (2 cases). Patients with mental disorders mainly had trichobezoars (2 cases) and foreign bodies (4 cases).

In the developed algorithm, if a high obturation form of OCN is suspected in phytobezoars and foreign bodies, an endoscopic diagnostic method was introduced, precisely in order to assess the possibility of endoscopic elimination. Because a retrospective analysis of such a contingent of patients showed that in some cases, during the operation, a block was found located in the area of gastroenteroanastomosis or in the duodenum, which could be eliminated endoscopically (phytobezoar - 2 cases, a concretion in the lumen of the stomach and duodenum – 3 cases).

After hospitalization, conservative measures were initiated, including gastric decompression, an infusion program, intestinal stimulation, and enemas, which lasted for two hours.

When signs of intestinal obstruction appeared (relief of pain, nausea, elimination of bloating, discharge of gases and stool), a control X-ray was performed to assess the passage of the gastrointestinal tract using a barium sulfate solution. The decision on further tactics is made after repeated radiography of the abdominal cavity (after 1.5-2 hours and 3.5-4 hours). With mechanical obstruction in the jejunum, a stable barium depot in a certain segment of the small intestine is determined after 1.5-2 hours. If the contrast agent is detected in the cecum after 4 hours, but the main amount remains in the small intestine, the tactics are determined depending on the clinic.

Otherwise, it was decided to perform laparoscopy with the possible elimination of OCN by laparoscopic method. When performing laparoscopic surgery for OSC, the most important stage is the primary entry into the abdominal cavity and the introduction of trocars. Abdominal puncture technique was performed using a blunt-edged trocar or entering the abdominal cavity using the Hassan technique. Postoperative management of all patients was carried out according to a single generally accepted tactic.

Results and their discussion. As a result of a complex of therapeutic and diagnostic measures, 21 (14.7%) patients managed to eliminate the phenomena of acute renal failure by conservative means. 23 (15.8%) patients with SSCN, selected according to indications, underwent video laparoscopic adhesiolysis with decompression of the upper gastrointestinal tract.

The remaining patients underwent open surgeries. All operations for OCN were performed under endotracheal anesthesia, the operative approach was a broad median laparotomy.

In the remaining patients with acute renal failure, adhesiolysis was performed by laparotomy. Hagen-Thorn mesosigmoplication was performed in 2 patients with inversion of the intestine. Among 48 patients with obstructive intestinal obstruction, three cases were caused by trichobezoars, one of which reached a diameter of more than 10 cm in diameter; in 3 cases, the

cause was a gallstone that penetrated the lumen of the small intestine through the vesicoduodenal fistula; in 4 cases, foreign bodies of the stomach and duodenum were detected; in 32 patients phytobezoar was detected and in other cases oncopathology. In cases with obstruction of tumor origin, the operation ended with the removal of the stoma for further treatment in a specialized hospital.

Intubation and decompression of the intestine are considered mandatory during the operation. We prefer nasoenteral intubation. At the same time, intubation reduces intestinal hypertension, allows good emptying of non-peristaltic intestines, normalizes blood circulation, provides a functionally advantageous position of the intestine, promotes early recovery of motility, and the implementation of early enteral nutrition.

Complications in the early postoperative period were observed in 31 (10.4%) patients. 5 patients had failed entero-enteroanastomosis, 9 patients were re-operated for repeated adhesive obstruction. Postoperative wound suppuration was observed in 14 cases. The overall mortality rate in acute renal failure was 9.9%, the highest in the group of patients operated on for acute renal failure of tumor origin-17.7%. Such a high mortality rate is due to the late admission of patients to the hospital from the moment of the onset of the disease, the elderly age of patients and the presence of severe concomitant pathology.

Analyzing the results, it is worth noting that the patients' complications were less the earlier they sought medical help. Of the 43 patients whose acute renal failure was resolved conservatively, 37 (86.1%) were treated within 6 hours of the onset of the first symptoms. In the observations of Minnulin M. M. et al. in 100% of patients who also applied within 6 hours, OCN resolved conservatively [1].

Various authors have their own therapeutic and diagnostic algorithms and indications for surgical treatment of OCN. A.M. Khadjibaev et al. developed an algorithm consisting of diagnostic signs and a scale for assessing physiological disorders-SAPS (Simplified Acute Physiology Score). [2] However, this method does not allow a differentiated approach to each patient in order to determine specific indications for a particular type of surgery to resolve OCD before the operation begins. Our therapeutic and diagnostic algorithm helps prevent unnecessary traumatic operations, reduces the risk of postoperative complications, and improves the prognosis of survival.

Laparoscopy, which is performed strictly according to indications, has found limited use in the treatment of acute renal failure [4, 5, 9, 12]. An indication for an emergency operation of videolaparoscopic adhesiolysis is the presence of an "acoustic window" for abdominal puncture in multiple operations on the abdominal organs and in the presence of reliable signs of OSC. However, laparoscopic procedures should be performed by an experienced surgeon, as there is a high risk of damage to the abdominal organs. M.Z.Li et al. we conducted a systematic review and meta-analysis of 334 patients, which showed the obvious advantages of laparoscopic adhesiolysis, but strictly emphasized the choice of patients according to indications and the operation by experienced specialists [5].

Laparoscopic adhesiolysis can reduce injuries, the duration of operations, mortality in the postoperative period, and the duration of hospitalization. Farinella E. et al. It is indicated that when performing this intervention, the duration of the operation was on average 75 minutes, while only performing a mini-laparotomy intervention required 98 minutes. The days of hospitalization decreased by more than 3 times [8]. It was also noted that after laparoscopic adhesiolysis, there is

no recurrence of adhesions, which, among other things, is shown by the studies of H. Tsumura et al., who followed their operated patients for 41 months and did not notice a recurrence of adhesions in any of them [12].

There are other ways to prevent the development of relapses of USCN. Shaposhnikov V. I. et al. proposed the infusion of fat emulsion "Lipofundin" into the abdominal cavity or its introduction into the parietal and visceral leaves of the peritoneum. In the long-term follow-up period of 2 to 6 years, there was no recurrence of USCN [4].

Conclusions

1. The effectiveness of treatment of patients is higher, the earlier the patient seeks medical help when signs of OCD appear and the earlier specialized medical care begins to be provided;

2. Laparoscopic adhesiolysis in patients with acute renal failure is successful when it is performed as indicated at an early stage in patients with a small number of previous laparotomies. This allows you to reduce the time of hospitalization and reduce the number of postoperative complications. It should be noted that laparoscopic adhesiolysis is performed only by an experienced surgeon.

3. Mandatory during the operation for acute adhesive intestinal obstruction, we consider intubation of the intestine with a nasoenteral probe, which has obvious advantages.

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