endoscopic correction of the pathology of the bile ducts is performed, and the second stage is cholecystectomy. With the historically established priority of retrograde endoscopic interventions in the treatment of choledocholithiasis, there is an alternative, intraoperative antegrade endoscopic papillosphincterotomy (IAEPST).

Aim: To study intraoperative endoscopic correction of choledocholithiasis.

Material and methods: The analysis of one-stage surgical treatment of cholecystocholedocholithiasis using IAEPST in 386 patients for the period from 2016 to 2020 was carried out. In a planned manner, 281 (72.7%) patients were operated on, in an emergency - 105 (27.3%) patients. The age of the patients ranged from 24 to 87 years, of which 330(85.5%) women and 56 (14.5%) men. The main methods of preoperative diagnosis of complicated gallstone disease were: ultrasound of the abdominal cavity and fibroesophagogastroduodenoscopy (FEGDS) with examination of the large duodenal papilla (BSDP). All patients underwent intraoperative cholangiography (IOC) as the final diagnostic stage to determine the indications for transpapillary interventions.

Results. The laparoscopic approach was used in 362 (92.9%) patients, the minilaparotomic approach was used in 4 (1.0%), the traditional laparotomic approach was used in 20 (5.2%) patients. In the group of planned patients, IAEPST with calculus removal was performed in 246 (87.6%) patients. IAEPST for BSDPK stenosis was performed in 35 (12.4%) patients. In cases of multiple choledocholithiasis and uncertainty about the complete debridement of the common bile duct, surgical treatment was completed with external drainage of the common bile duct through the cystic duct stump in 9 (3.2%) patients. In the postoperative period, in 3 (1.0%) patients with external drainage of the common bile duct, control fistulography revealed choledocholithiasis, which was eliminated retrograde endoscopically. In the group of emergency patients, IAEPST and removal of calculi were performed in 89 (84.8%) patients. IAEPST for BSDPK stenosis was performed in 16 (15.2%) patients. In cases of multiplecholedocholithiasis, uncertainty in the complete sanation of the common bile duct, surgical treatment was completed with external drainage of the common bile duct through the cystic duct stump in 6 (5.7%) patients, endoprosthetics of the common bile duct in 1 (0.95%) patient. In the postoperative period in 4 (3.8%) patients with external drainage of the common bile duct, control fistulography revealed choledocholithiasis, which was eliminated retrograde endoscopically. In 1 (0.9%) patient, the endoprosthesis was removed in the postoperative period, in combination with the retrograde endoscopic removal of calculi. Complications associated with IAEPST developed in 7 (1.8%) patients. 2 patients developed acute pancreatitis of mild and moderate severity, conservatively arrested, 4 patients had transient asymptomatic hyperamylasemia, conservative treatment, 1 patient had bleeding from a papillotomy cut, endoscopic hemostasis.

Conclusions. Intraoperative antegrade endoscopic papillosphincterotomy for the correction of choledocholithiasis allows: performing one-stage treatment of cholecystocholedocholithiasis, reducing the psychoemotional load on the patient, shortening the duration of hospitalization, and reducing the number of specific complications of retrograde EPST.

FEATURES OF DIAGNOSTICS AND TREATMENT OF PATIENTS WITH REFLUXESOPHAGITIS ON THE BACKGROUND OF SLIDING DIAPHRAGM HERNIAS

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Introduction. Currently, there is an increase in the number of patients suffering from refluxesophagitis and HH. The most common method of surgery for this pathology is various fundoplication methods, and the purpose of antireflux correction in HHH is to restore the anatomical and functional state of the esophago-gastric junction and create an adequate antireflux barrier.

Aim: features of diagnostics and treatment of patients with refluxesophagitis on the background of sliding diaphragm hernias.

Materials and methods. Our clinic has experience in performing 83 antireflux surgeries for sliding hiatal hernia (HSPH). Of these, 1 (1.2%) patients were diagnosed with the presence of Barrett's esophagus, and 11 (13.2%) patients had a complicated course of refluxesophagitis in the form of peptic esophagitis, cicatricial esophageal strictures. To select the most adequate method for correcting SHPD, all patients underwent a measurement of the esophageal opening of the diaphragm (PF) using ultrasound balloonography. In addition, at the intraoperative stage, we measured the POD value using esophagogastric probes of various diameters.

Results. If the POD dimensions did not exceed 35 mm, the purpose of antireflux corrections was to create a mechanical pulp or cuff using the Nissen or Tupe methods. In the case of a greater expansion of the POD, antireflux fundoplication was supplemented