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БИЛИАР ИЧАК ТУТИЛИШИДА ХИРУРГИК ТАКТИКА

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ХИРУРГИЧЕСКАЯ ТАКТИКА ПРИ БИЛИАРНОЙ КИШЕЧНОЙ НЕПРОХОДИМОСТИ

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Резюме. Ушбу мақолада хирургиянинг кам учрайдиган касалликларидан бири бўлган ўт тошли ичак тутилиши ҳақида гап боради. Этиологиясида асосан “катта” ўт тошлари ва ички билиодигестив оқмалар катта роль ўйнайди. Бу патология бошқа ичак тутилиши турларидан клиник ва диагностик жиҳатдан катта фарқ қилмайди, лекин билиар илеуснинг даво тактикаси ўзига хос томонлари бўлиб, алоҳида хирургик даво тактикасини талаб этади.

Калит сўзлар: Ўт-тош касаллиги, ичак тутилиши, билиар илеус, хирургик тактика, энтеротомия.

Abstract. The article deals with one of the rare surgical diseases – gallstone intestinal obstruction. In the etiology play a "large" gallstones and internal biliary-enteric fistulas. The clinic and diagnosis of this pathology may not differ from other types of intestinal obstruction, but the treatment tactics of biliary ileus has several features and requires special surgical tactics.

Keywords: Gallstone disease, intestinal obstruction, biliary ileus, surgical tactics, enterotomy.

Gallstone intestinal obstruction (biliary ileus) (GIO) is an acute intestinal obstruction (AIO) caused by obstruction of the intestine by gallstones. The first time such a complication was described was in 1654 by E. Bartholin, which was identified during an autopsy. In 1901, in Russian literature I.D. Sarychev used this term, but the first operation for this diagnosis was performed by N.V. Sklifosovsky in 1892 [1, 4, 6, 7, 10].

In the etiology of gastrointestinal tract infections, the main role is played by “large” gallstones (more than 2.5-3 cm in diameter) and internal biliodigestive (choleenteric) fistulas (due to the constant pressure of the stone on the wall of the gallbladder and intestines, a bed sore develops between the walls and is complicated by vesicular-intestinal fistula). “Small” stones with sizes up to 2 cm usually do not experience such a complication.

According to the data, gallstone obstruction can develop in all segments of the gastrointestinal

tract: mainly the ileum and (64.5%) and jejunum (25.1%), stomach 8.2%, duodenum 1-3% in patients are obstructed. According to H.J. Mondor (1940) with gastrointestinal tract disease there is a classic triad: the patient’s advanced age, signs of ileus and palpation of a rocky formation in the abdomen. Especially gastrointestinal tract gives signs of small intestinal obstruction.

According to a number of authors, the development of a clinic of colonic obstruction is also possible. In the available literature, as well as in our practice, we have not encountered such clinical observations, however, it can be assumed that the development of gallstone colonic obstruction is possible either with the formation of a vesicocolic fistula, or in the presence of anatomical prerequisites from the colon [3, 9].

Among such fistulas, cholecystoduodenal fistulas are usually found, which is associated with topographic and anatomical features and the relationships

of these organs. Such pathologies include Bouveret syndrome, in which the gallstone is obstructed at the level of the pyloroduodenal zone. According to E.I. Galperin et al., cholecystotransversal and cholecystogastric fistulas are much less common, no more than 3.5%. Casuistic cases of cholecystojejunal fistulas are described. When the bile ducts are involved in the fistula, the formation of hepaticocholedochoduodenal, hepaticocholedochogastric, hepaticocholedochotransversal fistulas is possible [2, 5, 7, 8].

The main methods for diagnosing GCI are those standard studies that are used for other types of GCI (ultrasound, fluoroscopy, CT, endoscopy, laparoscopy) [7, 11].

X-ray studies can reveal the main pathognomonic sign - Rigler's triad, which is caused by the shadow of an ectopic gallstone and aerobilia. Ultrasound can reveal some nuances of gastrointestinal tract diseases: large stones in the gallbladder; due to deformation of the gallbladder, it is impossible to visualize the neck of the gallbladder; aerocolia - identification of hypoechoic formations in the intrahepatic and extrahepatic bile ducts; identification of high-intensity structures in the intestines. With plain radiography, the information content can increase to 65%, and computed tomography gives up to 95%. With the help of EGDS, it is possible to detect biliodigestive fistulas, stones in the duodenum, and also, the detection of aerocolia after EGDS on plain fluoroscopy is one of the main signs of gastrointestinal tract disease [5,7,9,10].

Purpose of the study. To analyze and justify the diagnostic and surgical tactics of patients with gastrointestinal tract disorders.

Materials and methods. Diagnostic and surgical tactics were analyzed in 754 patients with acute intestinal obstruction who were treated surgically in the Samarkand branch of the Republican Scientific Center for Emergency Medical Care, Samarkand, and the Bulungur Regional Medical District of the Republic of Uzbekistan from 2016 to 2022. Among them, 13 patients (1.7%) revealed gastrointestinal tract disease. The age of the patients ranged from 42 to 76 years, with an average of 57 years. It should be noted that the majority of patients in this category were elderly. Of these, there were 5 (38.4%) male patients and 8 (61.6%) female patients.

All patients were diagnosed with various acute diseases of the abdominal organs in the preoperative period. "Acute appendicitis" was diagnosed in 3 (23%) cases, "acute cholecystopancreatitis" was hospitalized in 2 (15.4%) patients, acute appendicitis was diagnosed in 7 (53.8%) patients, and one patient was diagnosed with "acute appendicitis" before surgery. thrombosis of mesenteric vessels. According to clinical signs, pain in 8 patients (61.5%) was characterized throughout the abdomen, and in 3 cases (23.1%)

there was local pain (in the epigastric and right abdominal region), in one case (15.4%) it was determined peritoneal symptoms. The main symptoms of CI such as nausea, vomiting, and stool and gas retention were identified in all patients. All patients urgently underwent standard clinical, instrumental and laboratory research methods to make a diagnosis. In 12 (92.3%) patients, concomitant pathologies (hypertension, obesity, diabetes mellitus, etc.) were identified and corrected by specialists.

Results and discussions. According to the standard, emergency surgery is indicated for all types of intestinal obstruction. The surgical approach in all patients was midline laparotomy. In this case, there are several tactical options: only enterolithotomy (without interventions on the biliary tract); if a fistula is detected, enterolithotomy and simultaneous operations on the biliary tract are indicated, as well as enterolithotomy with delayed intervention on the biliary tract.

There are several opinions on the scope of the operation: Several authors believe that in technically feasible cases, high qualifications of the surgeon and stable condition of the patient, it is necessary to perform a one-stage operation (liquidation of CI and removal of the biliodigestive fistula). In such situations, the risk of developing CI recurrence can be 7.9%, 1/3 of such cases occur in the first month of the postoperative period. When performing a staged operation, in the "cold" period (usually after 4-5 months), cholecystectomy was performed with fistula separation. Postoperative mortality was not detected after staged operations, since with the first tactic it was up to 18%.

There are also several opinions on the level of enterolithotomy. Many authors suggest performing an enterotomy at the level of the stone, below the level of obstruction on the "normal" intestinal wall, which may reduce the risk of intestinal suture failure. Others move the stone longitudinally and then excise the intestine. We believe that it is necessary to perform an enterotomy at the site of strangulation on the antimesenteric edge of the intestine, and in case of pronounced morphological changes in the intestinal wall, resection of the gangrenous intestine with a stone is carried out.

We agree with the opinion of surgeons who categorically reject the simultaneous performance of cholecystectomy and closure of the cholecystoduodenal fistula due to the presence of pronounced inflammatory changes in the subhepatic space and the extremely high risk of failure of the duodenal sutures.

At the revision stage, one should remember about the possibility of finding several stones in the intestinal lumen, which requires a complete revision of the small intestine. Intraoperative nasointestinal decompression (NID), indicated for the surgical

treatment of acute small intestinal obstruction, is not always performed in the case of gastrointestinal tract obstruction. This is due to the technical difficulty of passing the probe through the duodenum involved in the inflammatory infiltrate in the right hypochondrium. Thus, intraoperative LID for gastrointestinal tract disorders is performed according to individual indications, depending on the degree of dilation of the intestinal loops and the severity of duodenal deformation.

Conclusion. Biliary ileus (BIL) is a very rare occurrence, in which the clinical manifestations are very similar to other types of BI. This gives the surgeon a differentiated approach to diagnosis, choice of method and scope of surgical intervention. In cases where the patient is in serious condition and has complex concomitant pathology, the best option for surgical intervention is only enterolithotomy. Cholecystectomy and fistula repair can be considered selectively and are performed in the presence of symptoms of cholecystitis and cholangitis.

A one-stage intervention is indicated for stable patients in the preoperative period who have a satisfactory cardiorespiratory and metabolic state, which allows for a longer and more traumatic surgical intervention.

Literature:

1. Alperovich B.I. et al. Guide to bile duct surgery // ed. E. I. Galperina, P. S. Vetsheva. – 2nd ed. – Moscow: Vidar-M, 2009. – 559 p.
2. Achilov M.T., et al Diagnostic features and methods of surgical tactics of biliary ileus. // Journal of Biomedicine and Practice. 2021, No. 6, issue 1, pp. 304-308.
3. Babazhanov A.S., et al - Improving the methods of hernioabdominoplasty for simultaneous surgical diseases. // "Science and Peace" International scientific journal, Russia, Volgograd. No. 4 (80), 2020, Volume 2. Page 65-67.
5. Babazhanov A.S., et al Features of treatment of patients with bile leakage after cholecystectomy. // "Science and Education" international center for scientific cooperation. 02/07/2018 pp. 131-136.
6. Bondarenko A.V., Pavlov K.I. A unique complication of cholelithiasis // Surgery of Ukraine. - 2014. - No. 2. - P. 125 - 128.
7. Bokhan K.L. Gallstone intestinal obstruction. Vestn hir 1996; 4: 110-112.
8. Gulamov O.M., et al The use of endoscopic methods in the diagnosis and complex treatment of erosive and dysplastic changes in the mucous membrane of the esophagus. // Journal of Biomedicine and Practice. No. 2 (2023). pp. 399-405.
9. Davlatov S.S., Rakhmanov K.E., Saidullaev Z.Ya. Algorithm for the management of patients with bile leakage after cholecystectomy. // Journal of Hepato-Gastroenterological Research, No. 1 (Volume 1) 2020 pp. 21-27.

9. Kubaev A. S. Algorithm for the diagnosis and treatment of upper micrognathia taking into account morphofunctional changes in the middle zone of the face // European research: Innovation in science, education and technology. – 2020. – С. 98-101.

10. Rizaev J., Kubaev A. Preoperative mistakes in the surgical treatment of upper retro micrognathia // European journal of molecular medicine. – 2021. – Т. 1. – №. 1.

11. Saidullaev Z.Ya., Davlatov S.S., Khamdamov B.Z., Amonov M.M. Modern methods of surgical treatment of cholelithiasis. // Doctor's Bulletin. No. 3 (100) 2021 yil pp. 155-161.

12. Toirov A.S., Babazhanov A.S., Bobomuradov B.M., Akhmedov G.K. - Tactics for cholelithiasis with complications of obstructive jaundice. // Science and World" International scientific journal, Russia, Volgograd. No. 5 (69), 2019. volume 3. pp. 62-64.

13. Akhmedov G.K., et al Morphological Substantiation Of The Effect Of An Infrared Diode Laser On The Regeneration Of The Esophageal Mucosa. // Web of Medicine: Journal of Medicine, Practice and Nursing. Vol. 1 No. 2 (2023) P. 27-37.

14. Gulamov O.M., Ahmedov G.K., Khudaynazarov U.R., Saydullayev Z.Ya. Diagnostic and treatment tactics in gastroesophageal reflux disease. // Texas Journal of Medical Science Date of Publication: 18-03-2022. A Bi-Monthly, Peer Reviewed International Journal. Volume 6. P. 47-50.

15. Isomiddinovich R. M. et al. The analysis of surgical treatment results in patients with Fourniers gangrene //European science review. – 2018. – No. 9-10-2. – pp. 148-150.

16. Rustamov I.M., Karabayev J.A. Modern approach to the treatment of patients with acute gangrenous-necrotic paraproctitis //Research Focus. – 2023. – Т. 2. – No. 1. – pp. 469-472

17. Rizaev J. A., Khaidarov N. K., Abdullaev S. Y. Current approach to the diagnosis and treatment of glossalgia (literature review) //World Bulletin of Public Health. – 2021. – Т. 4. – С. 96-98.

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Резюме. В данной статье речь идет о желчно-каменной непроходимости, одном из редких заболеваний хирургии. Большую роль в его этиологии играют «крупные» желчные камни и внутренние билиодигестивные свищи. Эта патология мало чем отличается от других видов кишечной непроходимости с клинико-диагностической точки зрения, однако тактика лечения билиарной непроходимости имеет свои особенности и требует отдельной тактики хирургического лечения.

Ключевые слова: желчнокаменная болезнь, кишечная непроходимость, желчная непроходимость, хирургическая тактика, энтеротомия.