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Acute Intestinal Obstruction Continues to be One of the Most Urgent and Intractable Problems of Pediatric Emergency Surgery

Nurmetova Dilnoza Farhodovna [1]

[1] Bukhara State Medical Institute

Abstract: However, to date, the features of the clinical picture of early adhesive-paretic obstruction in children have not been adequately described, the indications for modern research methods and their significance in the diagnosis of this pathology have not been defined. Indications for conservative or surgical methods of treatment have not been defined, the role of modern sparing surgical technologies in the treatment of early adhesion-paretic obstruction in children has not been studied.

Keywords: adhesive-paretic obstruction, children, surgery, diagnostics.

Relevance. Currently, there are various classifications of adhesive intestinal obstruction in the literature (Gataullin N.G., 1978; Khunafin S.N., 1985; Blinnikov O.I., 1988; Bairov G.A., Isakov Yu.F., 1988; Zhenchevskii R.A., 1989; Plechev V.V., 1990). The proposed classifications are developed taking into account the etiology, pathogenesis, clinic of intestinal obstruction on the basis of experimental data and own observations. They deal with both early and late intestinal obstruction. As a basis for the study on the study of early intestinal obstruction, we took the classification of adhesive intestinal obstruction, which is very common in pediatric surgery, proposed by G.A. Bairov. (1988).Among early adhesive obstruction in children, the author singles out early adhesive-paretic intestinal obstruction, which, in his opinion, is observed up to 6-8 days after surgery. It differs in causes, has its own characteristics of clinical manifestations and requires appropriate treatment tactics. However, to date, the features of the clinical picture of early adhesive-paretic obstruction in children have not been adequately described, the indications for modern research methods and their significance in the diagnosis of this pathology have not been defined. Indications for conservative or surgical methods of treatment have not been defined, the role of modern sparing surgical technologies in the treatment of early adhesion-paretic obstruction in children has not been studied. Thus, the timely diagnosis and choice of rational treatment tactics for early adhesive-paretic intestinal obstruction in children still remains one of the most difficult tasks in pediatric abdominal surgery. treatment of early adhesive-paretic intestinal obstruction in children.

Material and methods. A scientific study of one-component highly specific types of effects on patients in two groups was carried out. Criteria for inclusion in the study groups: children aged 1 to 15 years who were operated on for appendicular peritonitis complicated by early adhesion-paretic intestinal obstruction. Depending on the method of treatment, the patients examined by us were divided into two groups. The main group consisted of 70 patients in the treatment of which we used a set of diagnostic measures developed by us, including, in addition to clinical and radiological examinations, ultrasound and laparoscopic diagnostics. All children of the main group used the method developed in the clinic for the laparoscopic elimination of early adhesive-paretic intestinal obstruction with prolonged stimulation of the motor function of the gastrointestinal tract using a pacemaker. The control group consisted of 71 children with early adhesive-paretic intestinal obstruction, operated laparoscopically using in the postoperative period drug stimulation of the gastrointestinal tract.

Results and discussion. We have studied the causes and features of the clinical picture of early adhesive-paretic intestinal obstruction in 141 children. The highest probability of early adhesive-paretic intestinal obstruction was observed in patients who were initially operated on for peritonitis in the late stages from the onset of the disease. When studying the timing of the operation from the onset of symptoms, it was revealed that most of the patients in both the main and control groups were operated on the 3rd, 4th day for hagreno-perforative appendicitis.

As can be seen from Table. 2, the primary operation was performed later than a day in 32.8% of children in the main group and in 35.2% in the control group. Among the patients observed by us, 93 (65.9%) children were initially operated on for destructive appendicitis in central district hospitals; 41 (29.1%) - in the general surgical departments of city hospitals and only 7 - (4.9%) in the RCCH. It should be noted that in the main and control groups, surgical treatment for destructive appendicitis complicated by peritonitis was more often performed through the Volkovich access -Dyakonov (79 children, 56.1%), less often - median laparotomy (62 patients, 43.9%) and ended with drainage of the abdominal cavity (in 133 cases, 94.4%)

The analysis of the clinical material shows that the main causes contributing to the onset of early adhesive-paretic intestinal obstruction in all the patients examined by us were an unstopped inflammatory process (s) or an unresolved purulent focus in the abdominal cavity, which maintained intestinal paresis and caused an adhesive process. Against the background of the underlying disease (peritonitis), the symptoms of obstruction are initially not sufficiently pronounced and develop gradually.

Despite the ongoing complex treatment, the condition of all the patients observed by us did not improve during the first three days, moderate abdominal pains remained without distinct localization, bloating, gas and fecal retention, and vomiting was periodically noted. This was regarded as the usual course of peritonitis on days 2-3. One of the earliest and most constant symptoms of early postoperative adhesive obstruction is abdominal pain, which in most of our observations - 123 (87%) - was cramp-like in nature and sharply increased after drug stimulation of peristalsis . At the same time, after stimulation, scanty stools with mucus were observed in 131 patients (92.9%). An objective examination revealed: bloating in 122 patients (86.6%), sluggish intestinal motility, auscultated in 81 (57.5%) children ; the absence of peristalsis was observed in 15 (10.6%) patients. Congestive discharge from the stomach was noted in 119 cases (84.3%). Thus, the diagnosis of early adhesion-paretic intestinal obstruction has significant difficulties due to the causes of its occurrence and the characteristics of the clinical picture. Timely diagnosis of early adhesive-paretic intestinal obstruction, in our opinion, is possible with a thorough clinical analysis of the course of the postoperative period, but X-ray, ultrasound and endoscopic methods of investigation are of primary importance. Among 71 patients in the control group, 28 (39.4%) had local pneumatosis small and large intestine, constricted loops of the small intestine - in 22 children (30.9%). The presence of classical radiographic signs of intestinal obstruction - fluid levels with gas bubbles of various sizes - was observed only in 21 children (29.5%).

Depending on the level of obstruction, they were located in different areas of the abdominal cavity: in the upper floor in 10 (47.6%), in the right half - in 8 (38.1%), in the lower abdomen - in 3 (14.2%) %) of children. A retrospective analysis of X-ray studies of the gastrointestinal tract in 71 patients admitted to the clinic with suspected early adhesive-paretic ileus showed that on the basis of only a survey radiograph in combination with clinical data, the diagnosis of early adhesive-paretic intestinal obstruction was confirmed only in 6 (8.5%) of patients. The rest of the patients in the control group underwent a dynamic X-ray contrast study - the passage of barium through the intestines. According to our data, an X-ray contrast study with a barium suspension takes an average of 18 hours, and it takes 16 hours to confirm the diagnosis of acute adhesive intestinal obstruction, and 20 hours to exclude it. In addition, repeated repeated X-ray examination, taking into account radiation exposure, is not indifferent to the child's body. Thus, the analysis of the diagnostic significance of X-ray examination in early adhesive-paretic intestinal obstruction showed its insufficient information content, combined with high radiation exposure. control - in 57 (80.2%).Ultrasound monitoring of the state of the abdominal cavity was performed starting from 2-3 days after the primary operation

for peritonitis. If necessary, the study was repeated daily until stable remission. Abdominal visualization of the translational movements of chyme particles in the intestinal lumen ("pendulum" symptom), uneven gas filling of the intestine, free fluid in the abdominal cavity, conglomerates of intestinal loops (infiltrates, abscesses, omentitis), as well as microsymptoms, allowing to diagnose this pathology at early stages of development. We have identified a set of symptoms indicating the possibility of early adhesive-paretic intestinal obstruction:

1. The absence of positive dynamics in the patient's condition on the 2-3rd day after the primary operation, whose surgical treatment for peritonitis was carried out later than 24 hours from the onset of the disease. 2. Preservation of signs of intoxication, hyperthermic syndrome, intestinal paresis for 2-3 days after the operation.

3. Increase or absence of dynamics of decrease in the volume of stagnant contents in the stomach for 2-3 days after surgery.

4. Preservation of pain in the abdomen, aggravated after medical stimulation of the intestine.

5. Identification during abdominal sonography of signs indicating early adhesive-paretic intestinal obstruction. The presence of the listed symptoms in the anamnesis, clinical picture and instrumental examination data is a direct indication for postoperative diagnostic laparoscopy, which, if necessary, can also become a therapeutic measure. Among the patients operated on by us, laparoscopy revealed various early adhesive-paretic intestinal obstruction. Compression of the intestinal lumen by intra-abdominal infiltrate was observed in 94 (66.6%) patients, deformation of the intestine in the form of a "double-barreled" - in 124 (87.9%), soldering of the intestinal loop to the surgical wound from the abdominal cavity - in 27 (19.1 %), inflammatory changes in the intestinal wall - in 32 (22.7%).Intestinal paresis due to ongoing peritonitis was observed in 10 (7.1%) children. A combination of various causes: ongoing peritonitis and infiltrate - in 13 (9.2%) patients. As can be seen from the table, the maximum number of repeated operations 48 (67.7%) in the main group were performed on the 3rd day from the onset of symptoms of early adhesive-paretic intestinal obstruction, while in the control group 31 (43.6%) on the 8th day after the primary operation for peritonitis. Diagnostic and therapeutic laparoscopy in the early postoperative period allows timely elimination of intestinal paresis, a full revision of the abdominal cavity, elimination of intestinal obstruction without deserosis of the loops and minimal trauma, which reduces the recovery time of the functions of the gastrointestinal tract, reduce the duration of the postoperative period.

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