



EVALUATION OF THE EFFECTIVENESS OF THE SURGICAL METHOD IN THE TREATMENT OF RECURRENCE OF CHRONIC POLYPOUS ETHMOIDITIS

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<https://doi.org/10.5281/zenodo.7998002>

Resume,

The search for surgical interventions in the treatment of chronic recurrent polypous latticed formations is one of the urgent problems of modern rhinology. Among the existing methods of treatment of the polyposis process, currently only schemes with the use of corticosteroid drugs can affect almost all pathogenetic mechanisms of the polyposis process. However, there are currently no uniform and safe standards for prescribing these drugs.

This article presents information about the results of a study conducted to evaluate the effectiveness of surgical treatment of chronic polypous ethmoiditis.

Key words: polypous ethmoiditis, surgical intervention, chronic process.

Relevance. Despite great advances in the development of pharmacology, the appearance of more and more new drugs and the active introduction of minimally invasive endoscopic surgery instead of radical, highly traumatic operations on the nasal cavity and the sinuses, the incidence of polyposis rhinosinusitis remains high.

Periodicals over the past decade have reported that patients with polyposis of the larynx constitute about 32% of the total population (7).

The lack of a downward trend in the incidence of chronic polyposis ethmoiditis is mainly due to the fact that at the current stage it is impossible to ensure complete recovery of this group of patients and prevent nasal polyposis recurrence.

According to several authors, the immediate recurrence rate after surgical treatment of polyposis rhinosinusitis is 19-45% [2]. However, the rate of recurrent surgery-bronchial asthma, intolerance to non-steroidal anti-inflammatory drugs, and periods of topical corticosteroids-is significantly higher in patients with an asthmatic triad, even in the postoperative period (6).

In some cases, intervals between remissions range from 3 to 5 months and require repeat polypotomies, sometimes more than 10 (3).

A surgical approach to the treatment of polyposis ethmoiditis is highly effective during close follow-up, but is associated with a risk of rhinobronchial reflex development in patients with bronchial asthma and does not guarantee polyposis recurrence in the delayed period [1].

This condition is primarily due to the lack of influence of the polyposis process on the etiopathogenetic mechanisms of development [4]. The multifactorial nature of the polyposis process and the complex etiopathogenetic processes underlying the development of the disease underlie the choice of optimal treatment tactics[5].

Objective of the study. To improve early diagnosis, prevention and treatment of recurrent chronic polyposis ethmoiditis in the population.

Materials and methods of the study. A total of 200 patients with chronic polyposis ethmoiditis (125 males and 75 females) were examined at the department and departments of otorhinolaryngology, based on the clinic of Andijan State Medical Institute during 2020-2023 were selected to study the polypoidal processes of the patients' rectal sinuses.

Results of the study. The current treatment of chronic polyposis ethmoiditis involves the long-term use of surgery and medication. Surgical possibilities inside the cavity, the use of endoscopes allow to remove polyps and pathological content from the affected rectal sinuses, but it should be understood that the success of surgery and reduction of recurrences of this disease depends on the combination of preoperative preparation, postoperative treatment and continuous monitoring by otolaryngologist. Surgical treatment alone will not lead to the desired result.

Our patients were prepared for the operation on an outpatient basis. The doctor referring the patient for surgery issued a referral for the tests required for the operation. Patients with additional complications, such as bronchial asthma, were consulted by a pulmonologist and their external respiratory function (fvd) was checked. A CT scan of the accessory sinuses is mandatory in all patients with polyposis rhinosinusitis.

Patients with bronchial asthma and intolerance to non-specific anti-inflammatory drugs (NSAIDs - aspirin, analgin, etc.) receive a short course of systemic corticosteroid therapy, 30/40 mg prednisone daily, 3 days before and 3 days after surgery. Corticosteroid therapy prevents bronchial asthma exacerbation in the postoperative period, reduces the size of polyps, reduces tissue swelling and bleeding.

We used topical corticosteroids as preparation for surgery. These were considered to be modern hormonal drugs that do not have a general effect on the body. Their use allowed a slight reduction in the size of the polyps, which made them easier to remove. If there is purulent discharge in the nasal cavity, the patient has been prescribed antibiotic therapy.

The type of micro-organism and its sensitivity to antibiotics is determined in the pre-operative period. Antibiotic therapy started the day before surgery and continued during the recovery period. Preoperative and intraoperative antibiotic therapy to prevent infectious complications was carried out by single administration. The attending physician determined the specific antibiotic and how it was administered. The modern surgical treatment of polyposis was based on the principle of functional rhinosurgery under the control of an endoscope or microscope.

The term functional rhinosurgery meant removal of polyps under vision from all nasal cavities and accessory sinuses, maintenance of mucosa and restoration of nasal breathing, and ventilation of the accessory sinuses. Radical surgical treatments, including complete removal of the mucosa of the accessory sinuses and resection of the nasal cavities, were not justified, as the recurrence of polyposis did not stop.

Special instruments were used during the operation, allowing good control of the surgical process and the completeness of polyp removal. Most operations for widespread polyposis are performed under anaesthesia. The operation is also possible with local anaesthesia. Most often, the structure of the structures inside the nose - the nasal septa, the nasal cavities - is corrected at the same time, but without their traditional resection. After the operation, tampons are inserted into the nose at night to prevent bleeding. The next day the tampons were removed.

From the second day, the treatment of the inflammatory process began. The first three days were mostly nasal showers with physiological solution. On the third or fourth day the sinuses were flushed with drains. Depending on the nature of the inflammation, medication was used. For bacterial inflammation, an antiseptic solution of Octenisept was used to flush the sinuses at a dilution of 1:6 or 1:8. The antibiotic was prescribed depending on the sensitivity of the microflora. Third-generation cephalosporin antibiotics (Ceftriaxone) are now well established. Ceftriaxone was administered intravenously at a dose of 1 g during surgery.

If polyposis is detected in the sinuses during surgery, the sinuses are irrigated with Octenisept diluted 1:6 and sometimes a general antifungal therapy is administered.

Conclusion. Surgical treatment methods at present surgical interventions in the lamina and appendicular sinuses are performed using updated devices and modern video endoscopic equipment: microdebriders and navigation systems, allowing to minimize trauma during the surgery and preserve the normal anatomy of the nasal cavity.

Visual control allows not only maximum preservation of the anatomical integrity of the accessory sinuses, but also facilitates rapid restoration of mucociliary transport and aerodynamics of the nasal cavity, thus reducing the period of rehabilitation of patients.

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