



ASPECTS OF TREATMENT OF ACUTE OBTURATIONAL INTESTINAL OBSTRUCTION

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Abstract: the results of treatment of 46 patients with acute obstructive intestinal obstruction were analyzed. It was shown that acute obstructive large bowel obstruction of tumor etiology occurred in 40 (86.9%) cases, obstructive small bowel obstruction was diagnosed in only 6 (13.1%) patients. Postoperative complications were observed in 8 (17.4%) patients. Postoperative mortality was 13% (6). Strict adherence to operating techniques, high-quality preoperative preparation, multicomponent postoperative therapy aimed at eliminating endotoxemia and preventing fatal complications from other organs and systems will improve the results of treatment in this category of patients.

Key words: intestinal obstruction, endotoxemia

Аннотация: проанализированы результаты лечения 46 больных с острой obturационной кишечной непроходимостью. Показано, что острая obturационная толстокишечная непроходимость опухолевой этиологии имела место в 40 (86,9%) случаев, obturационная тонкокишечная непроходимость диагностирована всего у 6 (13,1%) больных. Послеоперационные осложнения наблюдались у 8 (17,4%) пациентов. Послеоперационная летальность составила 13% (6). Строгое соблюдение операционной техники, качественная предоперационная подготовка, многокомпонентная послеоперационная терапия, направленная на ликвидацию эндотоксемии и профилактику фатальных осложнений со стороны других органов и систем позволят улучшить результаты лечения данной категории пациентов.

Ключевые слова: кишечная непроходимость, эндотоксемия.

Introduction: obstructive intestinal obstruction is a syndrome characterized by a violation of the passage of contents through the small or large intestine due to partial or complete closure of their lumen, while there is no compression of the mesentery. The incidence of acute obstructive colonic obstruction among all types of acute intestinal obstruction averages 24.3% [2,377]. Various postoperative complications occur in 18.6% of patients, and mortality reaches 21.1% [1,22].

The purpose of the study: to analyze the immediate results of treatment of patients with acute obstructive intestinal obstruction, to study the frequency and structure of postoperative complications, the causes of death.

Materials and methods: the results of treatment of 46 patients with acute obstructive intestinal obstruction were retrospectively analyzed. Men - 38 (82.6%), women - 8 (17.4%). The age of patients is from 29 to 90 years.

Results and discussion: examination of patients with suspected acute intestinal obstruction is carried out in the admissions department of the surgical building under the supervision of the surgeon on duty. The examination plan for such patients should allow the surgeon to answer the following questions: 1. Does the patient currently have acute intestinal obstruction, or is

the current clinical picture due to manifestations of another disease?; 2. What is the nature of intestinal obstruction: dynamic or mechanical?; 3. If the obstruction is mechanical, what kind - obstructive or strangulation? 4. Are there general disturbances in water and electrolyte balance, acid-base balance and endotoxemia and how pronounced are they?

For acute obstructive intestinal obstruction, the following clinical symptoms are characteristic: cramping abdominal pain; vomiting (may be "late" with low obstruction); bloating (the lower the level of obturation in the intestinal tract, the more pronounced bloating), asymmetry is possible; retention of stool and gases. After an objective examination and a mandatory rectal examination, the patient undergoes an x-ray of the abdominal cavity. X-ray signs of intestinal obstruction are the presence of Kloiber's porridge of the small intestine or large intestine, intestinal arches, and the radiological symptom of the "fish skeleton".

The diagnostic algorithm for examining patients with acute intestinal obstruction includes ultrasound of the abdominal organs. Signs of intestinal obstruction according to ultrasound are the detection of dilated loops of the small and large intestines, their overflow with liquid, "a symptom of fluid transfusion in the intestinal loop", sometimes it is possible to visualize a thickened and swollen intestinal wall, the presence of free fluid in the abdominal cavity. Contrast studies (irrigography and the study of the passage of barium through the gastrointestinal tract) are used for difficulties in diagnosis.

All patients are required to carry out preoperative preparation: infusion of colloids, crystalloids and other measures aimed at stabilizing the patient's condition and reducing endotoxemia.

From the moment of diagnosis, the patient must be operated on within the next 2 hours. In case of untimely implementation of the intervention, all reasons and justification for the delay must be reasonably justified in the medical history. Surgical intervention includes the most radical elimination of the cause of obstruction, intestinal decompression. When performing resections of the small and large intestine, special importance should be attached to assessing the viability of the anastomosed areas; in doubtful situations, we prefer the imposition of decompression stomas. From the imposition of left-sided "colo-colo" anastomoses with low colonic obstruction, we refused due to the high risk of fistula failure.

Surgical interventions for acute intestinal obstruction should be performed by highly qualified surgeons, strictly observing all the principles of surgical technique and individual medical and tactical characteristics of patients in each case.

Among our patients, acute obstructive large bowel obstruction of tumor etiology was observed most often - 40 (86.9%) cases, obstructive small bowel obstruction occurred in only 6 (13.1%) patients. Tumors of the sigmoid colon were detected in 26 (65%) patients, descending colon - in 7 (17.5%), ascending colon - in 5 (12.5%), caecum - in 1 (2.5%), transverse - in 1 (2.5%) patient. The operation of choice for tumors of the right half of the colon was right-sided hemicolectomy with the imposition of side-to-side ileotransverse anastomosis (6).

With tumors of the sigmoid colon, patients (26) underwent the Hartmann operation with the removal of the proximal descendostoma. Intraoperatively, in 17 patients, tumor invasion into the parietal peritoneum of the left lateral canal of the abdominal cavity was detected, in 3 patients there was tumor invasion into the small intestine, which required additional resection of the small intestine section with the imposition of a small-intestinal anastomosis

"side-to-side". We do not use the imposition of a primary colonic anastomosis due to the high probability of developing insufficiency. In case of a tumor of the transverse colon (1), a section of the transverse colon with a tumor was resected with the removal of the proximal transversostomy and suturing of the distal part of the transverse colon. If the tumor was localized in the descending colon (7), left-sided hemicolectomy was performed with the removal of the proximal transversostomy and suturing of the distal part of the colon with transanal drainage of the remaining distal part of the colon. 19 (47.5%) patients had metastases to regional lymph nodes, 5 (12.5%) patients had distant metastases to the liver in the form of nodes with a diameter of 1 to 3 cm in III, V, VII, VIII segments.

In 6 (13.1%) patients there was an acute obstructive small bowel obstruction. All patients underwent surgery. Intraoperatively: the level of obturation was in the terminal ileum. In 3 of them, the presence of a phytobezoar was diagnosed, which, after fragmentation, was redeployed to the right sections of the colon. Enterotomy was not required. In 3 other patients, the cause of the obstruction was gallstones with an approximate diameter of about 4.5 cm, redeployed into the lumen of the small intestine from the biliary tract (most likely from the gallbladder) through the biliodigestive fistula. During the operation, a pronounced adhesive process took place in the subhepatic space on the right, which did not allow a detailed revision. It was not possible to move the stones distally into the caecum. The stones were removed from the lumen of the small intestine through an enterotomy performed distally from the block, followed by suturing the enterotomy opening in the transverse direction.

Various postoperative complications were observed in 8 (17.4%) patients: necrosis and "collapse" of the colostomy into the abdominal cavity (2), suppuration of the postoperative wound (3), pneumonia (2), myocardial infarction (1). In 2 patients, relaparotomy was performed, the cause of which was necrosis and "falling through" of the descendostomy into the abdominal cavity on the 3rd and 4th days after the operation with the development of fecal peritonitis. The patients underwent complete removal of the remaining part of the descending colon with a necrotic area and removal of the transversostomy. Postoperative mortality was 13% (6). The causes of deaths were severe abdominal sepsis against the background of peritonitis caused by intra-abdominal complications (2), myocardial infarction (2), severe pneumonia (1), pulmonary embolism (1).

Conclusion: the treatment of acute obstructive intestinal obstruction is an actual problem of abdominal surgery. The main ways to improve the results of treatment of this category of patients, in our opinion, are: strict adherence to operating techniques; high-quality preoperative preparation; multicomponent postoperative therapy aimed at eliminating endotoxemia and preventing fatal complications from other organs and systems.

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