ISSN 2181-3187

SURGICAL TACTICS IN COMBINED GYNECOLOGICAL AND SURGICAL PATHOLOGY

Ganiev F.I.
SAMARKAND STATE MEDICAL UNIVERSITY FACULTY OF PEDIATRICS No. 2 DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

The problem of surgical treatment of combined diseases of the abdominal organs has long attracted the attention of specialists in various fields.

The combination of diseases of the abdominal organs and female genital organs is quite common and, according to various authors, ranges from 2.8 to 63%, in particular, diseases of the appendix accompany gynecological pathology in 3.1 - 3.3%, gall bladder - in 3 ,1 - 15% [4,6,7,8]. Simultaneous surgery is the simultaneous performance of two or more independent operations for various diseases for which surgical treatment is indicated [5]. Improving the diagnostic capabilities of practical medicine, improving anesthesiology and resuscitation during surgical interventions, and introducing new minimally invasive technologies into medical practice make it possible to perform surgical interventions less traumatic, with minimal blood loss, significantly reducing the duration of the postoperative period. This creates real conditions for expanding the indications for simultaneous operations, reducing the number of intra- and postoperative complications, reducing the patient's time in hospital and the duration of temporary disability, and represents broad prospects for improving the results of surgical treatment of patients with concomitant diseases [1,3].

The idea of examining the organs of the abdominal cavity by introducing lighting devices into it was first put into practice by the outstanding Russian obstetrician-gynecologist Dmitry Oskarovich Ott back in 1901. Since then, his method has continuously developed and is today commonly known as laparoscopy. Currently, laparoscopic access is widely used in all areas of surgery, and gynecology is no exception. According to some data, more than 90% of all gynecological operations in the world are currently performed laparoscopically [1].

One of the first triumphs of modern laparoscopic surgery was the performance of laparoscopic cholecystectomy Ph. Mouret in 1987. The number of operations on the biliary tract is steadily growing every year, which is associated with a widespread increase in the incidence of cholelithiasis. According to summary statistics, in European countries the incidence of cholecystolithiasis has increased from 10.8 to 18.5% [4, 8].

Purpose of the study: Improvement of methods of combined surgical treatment of diseases of the pelvic and abdominal organs.

ISSN 2181-3187

Material and methods: We examined 185 patients with various diseases of the abdominal cavity and pelvic organs at the City Medical Association (endoscopic center) and in the 3rd maternity complex of Samarkand. All those examined were divided into two main groups. The first group included 107 patients who underwent laparoscopic and traditional simultaneous operations (main group), the second group included 78 patients with traditional surgery (control group), who underwent one isolated operation.

In the main group of 107 patients, 47 (43.9%) with uterine fibroids up to 12 weeks of pregnancy underwent laparoscopic hysterectomy + laparoscopic cholecystectomy for chronic calculous cholecystitis in 40 (85.1%) patients and 7 (14.9 %) of patients with acute calculous cholecystitis. In addition, the main group is characterized by performing a combination of traditional and minilaparotomy operations. In 40 (37.4%) patients with uterine fibroids larger than 12 weeks of pregnancy, laparotomy and hysterectomy were performed and, as a simultaneous step in chronic calculous cholecystitis, cholecystectomy was performed using minilaparotomy access. Also, with complete and incomplete uterine prolapse, transvaginal hysterectomy and as a simultaneous stage of hernia repair for an umbilical hernia were performed in 20

Technique of laparoscopy. To perform laparoscopic operations in the pelvis, the patient was placed in the Trendelenburg position - an elevated pelvic end with an inclination angle of 200-300. With these inclinations, the intestinal loops are displaced into the upper parts of the abdominal cavity under the influence of gravity and the pressure of the insufflated gas, which significantly improves the view of the rectouterine cavity and facilitates access to the uterus and appendages, and laparoscopic cholecystectomy was performed in the Fowler position with an elevation of 200-250 the head end of the operating table and its tilt 150-200 to the left.

After treatment of the surgical field, pneumoperitonium was applied. Carbon dioxide was injected, which is easily and quickly resorbed, does not cause pain or discomfort in patients and does not form emboli, has a certain effect on the respiratory center and increases the vital capacity of the lungs.

In typical cases, the optimal place for gas insufflation into the abdominal cavity is the point located at the intersection of the midline of the abdomen with the lower or upper edge of the umbilical ring.

Carbon dioxide insufflation was carried out using a Veress needle with a spring mechanism. Along the midline of the abdomen, starting from the edge of the umbilical ring, a longitudinal skin incision is made, 10-11 mm long. The needle was inserted only by moving the hand. The needle traction was carried out with constant force, without interruption, until the effect of “sinking” was felt and a click of the spring mechanism appeared. The optimal pressure for introducing carbon dioxide into the abdominal cavity is 12-14 mmHg. After creating pneumoperitonium, an 11 mm trocar

ISSN 2181-3187

was introduced, then a laparoscope.

All patients underwent similar general anesthesia with the use of mechanical ventilation against the background of the use of non-depolarizing muscle relaxants, based on multicomponent modern anesthesia using central analgesics with a combination of antipsychotics and ketamine. Spinal anesthesia was used in some patients. The drugs were used in standard calculated dosages, taking into account age and concomitant pathology.

Results and its discussion. In the main group, all patients underwent simultaneous operations: laparoscopic hysterectomy + laparoscopic cholecystectomy in 47 (43.9%), laparotomic hysterectomy + minilaparotomic cholecystectomy in 40 (37.4%), transvaginal hysterectomy + umbilical herniectomy in 20 (18, 7%) patients. In the control group, only isolated operations were performed: hysterectomy in 33 (42.3%), transvaginal hysterectomy in 21 (26.9%), cholecystectomy in 11 (14.1%) and ventroplasty in 13 (16.7%) sick.

Laparoscopic extirpation of the uterus and appendages for fibroids was performed in 47 patients, and the simultaneous stage of the operation was laparoscopic cholecystectomy. For such operations, the selection of patients was carried out carefully (the size of the uterus is no more than 12 weeks of pregnancy, a history of uncomplicated urgent labor, no previous laparotomies, no inflammatory process in the gallbladder or genital organs). For uterine fibroids before 12 weeks of pregnancy, we used the standard method of laparoscopic hysterectomy: laparocentesis up to 1 cm long was performed along the lower edge of the umbilical ring. Using a Veress needle, CO2 gas was insufflated into the abdominal cavity, pneumoperitonium was created, bringing the pressure to 15 mm Hg, after which the Veress needle was replaced with a 10 mm trocar and a 10 mm laparoscope was inserted. After entering the abdominal cavity, additional two 5 mm trocars were inserted in the left and right iliac regions. Fixation of the cervix and dilation of the cervical canal were carried out using the Clermont-Ferrand uterine manipulator (which has an “anatomical zone” of varying lengths depending on the length of the cervix) in order to ensure the position of the uterus in the anteversio and a certain position of the posterior vaginal vault between the uterosacral ligaments.

The ureters in the middle part of the posterior layer of the broad uterine ligament were isolated transparietally on both sides. This was done in order to safely cut the infundibulopelvic ligaments.

The uterine arteries were isolated transparietally and, using a high-frequency coagulator AUTOKON 350, monocoagulation in the “aerosol coagulation” mode with a coagulation effect of t3 (stage 3) was carried out. The intersection of the round ligaments of the uterus, infundibulopelvic and sacrouterine ligaments was also performed using monocoagulation.

ISSN 2181-3187

Dissection and reduction of the plica vesico-uterina was carried out using sharp and blunt methods with scissors until the vagina was identified. The cervix was cut off from the vaginal vaults using the “anatomical zone” of the Clermont-Ferrand uterine manipulator. After this, the uterus and appendages were removed through the vagina and sutured externally with interrupted vicryl sutures. Peritonization was not performed. At the end of the operation, the abdominal cavity was sanitized, a thorough examination and hemostasis of the surgical field was carried out, and its drainage was performed. The postoperative period in 1 (0.5%) patient was complicated by the leakage of bile from the cystic duct stump. Relaparoscopy was performed with the application of an additional titanium clip. There was no lethal outcome.

After completion of the laparoscopic hysterectomy operation, the laparoscope was turned 1800 degrees, the patient was transferred from the Trendelenburg position to the Fowler position, and the abdominal organs, in particular the liver and gallbladder, were inspected. During the simultaneous stage of the laparoscopic cholecystectomy operation, additional two 5 mm and one 10 mm trocars were introduced into the abdominal cavity in the right hypochondrium along the anterior axillary, middle clavicular and midline.

The cystic duct and artery were isolated with an L-shaped monopolar coagulator, onto which titanium clips were applied. The gallbladder was completely isolated from the bed using mono-bipolar coagulators and removed from the abdominal cavity through a midline incision. Initially, titanium clips were applied to the a.cysticus, but our further research showed that in the presence of a powerful coagulator such as AUTOKON-350, there is no need for its clipping.

After completion of the main stage of the operation, all patients operated on for calculous cholecystitis underwent thorough sanitation and drainage of the subhepatic space.

Laparotomic hysterectomy for uterine fibroids larger than 12 weeks of pregnancy and, as a simultaneous stage, minilaparotomic cholecystectomy for calculous cholecystitis was performed in 40 patients. Laparotomic hysterectomy was performed using the usual technique using a Joel-Kohen incision. To carry out the simultaneous stage of minilaparotomy cholecystectomy, we used a set of surgical instruments developed by M.I. Prudkov. The set of instruments for minilaparotomy includes: a support circle for attaching retractor mirrors (wound retractors), mobile narrow mirrors, one of which is equipped with a point light source connected via a fiber light guide to the illuminator. The set of instruments also includes specially designed clamps, dissectors and scissors, as well as other devices that facilitate manipulation in the abdominal cavity through minilaparotomy access. Minilaparotomy cholecystectomy was performed with access through a pararectal incision, with the length of the incision not exceeding 6 cm, which was sufficient for safe manipulation

ISSN 2181-3187

in the area of the hepatoduodenal ligament. The duration of the operation increased compared to laparoscopic surgery by 20 ± 1.2 minutes. Blood loss was in the range of 120-150 ml. In the postoperative period, 1 (0.5%) patient had parenchymal bleeding from the vaginal stump in the early postoperative period. A relaparotomy was performed - ligation of the internal iliac arteries. The postoperative period proceeded smoothly. There was no lethal outcome.

The combination of transvaginal hysterectomy and umbilical hernia is of greatest interest. This pathology was present in 20 patients. The indications for these operations were complete prolapse of the uterus, as well as stress incontinence, vaginal prolapse and the presence of an umbilical hernia. The operation began with hernia repair, since the presence of infection in the umbilical wound in the postoperative period can lead to recurrence of the hernia. The skin above the navel was cut in a semicircle above or below the navel. Then, with a scalpel, the skin of the navel was separated from the surrounding tissues and the hernial orifice was isolated. The contents of the hernia were resected (most often it was the tissue of the greater omentum) and the hernial orifice was closed with interrupted sutures. Then we proceeded to perform a hysterectomy through the vagina. Many gynecologists underestimate vaginal hysterectomy and avoid doing it because they are convinced that the same thing can be done better and safer with an abdominal approach. A gynecologist with experience in vaginal operations has a good understanding of the anatomy of the operated area and sees it no less clearly than during abdominal operations. Start the operation

The total duration of the operation in the main group was 87.13±13.2 minutes, and in the control group 77.13±11.1 minutes. When performing laparoscopic simultaneous operations, the total duration of the operation decreased by an average of 21 minutes.

When comparing the size of the surgical access, the use of laparoscopic technology made it possible to reduce the invasiveness of the access - the length of the surgical incision was up to 1 cm when both stages of the operation were performed laparoscopically.

Determination of the degree of blood loss in the main and control groups showed that in the main group, during simultaneous operations, blood loss was 94.4□11.7, and in the control group, blood loss during surgery was 85.4□16.4 ml. The above clearly shows that the difference in blood loss during simultaneous and isolated operations is insignificant.

When comparing data from the postoperative period, the advantages in the main group were expressed in the fact that the need for pain relief was the same as in the control group.

The next indicator of the advantages of the main and control groups is the timing of activation of patients and the elimination of postoperative intestinal paresis and the

ISSN 2181-3187

beginning of feeding of patients. In both groups, patients became active on the 1st day, and oral feeding occurred on days 2-3 after surgery.

Thus, a comparison of parameters indicating the traumatic nature of the operation, such as the total duration of the operation, the degree of blood loss, the need for pain relief and its duration in the postoperative period, the beginning of the activation of patients and the beginning of food intake showed that simultaneous operations do not differ in comparison with isolated operations.

LITERATURE:

1. Адамян Л. В. Эндоскопические методы выполнения симультанных операций в гинекологии / Адамян Л. В., Панин А. В., Козаченко А. В. // Эндоскопия в гинекологии. — М., 1999. — С. 135-148.

2. Александров Л.С., Ищенко А.И., Ведерникова Н.В. Сочетанные операции в гинекологии. Акуш. и гин. 2003; 4: 11–4.

3. Ахтамов Дж.А., Негмаджанов Б.Б., Нарзуллаев Х.Б., Азимов С.А., Ганиев Ф.И.,- Лапароскопия в гинекологии и хирургии// VI съезд акушеров-гинекологов Республики Узбекистан. Ташкент. Октябрь. 2003г. Ст. 245-246.

4. Баков В.С. Симультанные лапароскопиччеcкие оперативные вмешательства при сочетанных заболеваниях органов брюшной полости и малого таза. Автореф. дисс. канд. мед. наук. Рязань. 2000. -24с.

5. Гордеев С.А.—Симультанные лапароскопические операции http://www.cetl.ru/articles/surgery/art 31.phtml.

6. Емельянов С.И., Протасов А.В., Рутенбург Г.М. Эндохирургия паховых и бедренных грыж. — СПб., 2000.

7. Запорожцев Д.А., Луцевич О.Э., Гордеев С.А., Прохоров Ю.А.—Новые возможности оперативной лапароскопии в лечении заболеваний органов малого таза в сочетании с желчнокаменной болезнью //Эндоскопическая хирургия.№6,2001,С.10-14.

8. Коркан И.П., Алдангарова Г.А. Симультанные операции в акушерстве и гинекологии.// Клиницист.- 1995г.,- №1, -С.30-34.

9. Пучков К.В., Баков В.С., Иванов В.В. Симультанные лапароскопические оперативные вмешательства в хирургии и гинекологии. — М., 2005.

10. Рутенбург Г.М., Протасов А.В. // Эндоскопическая хирургия. - 1997. - № 4. - С. 40-41.

11. Рожков А.Г., Дронов В.И., Фоменко А.В., Петров В.П. Сочетанные лапароскопические операции.//Анналы хирургической гепатологии. М.,1996.- №1.- С.60-61.

12. Седов В.М., Стрижелецкий В.В. Осложнения в лапароскопической хирургии и их профилактика. —34 Тихоокеанский медицинский журнал, 2007, №СПб.: Санкт-Петербургское медицинское издательство, 2002.