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THERAPEUTIC AND SURGICAL MEASURES CARRIED OUT FOR SIMULTANEOUS PATHOLOGIES (COMBINATION OF GYNECOLOGICAL AND SURGICAL PATHOLOGIES) IN WOMEN

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Relevance. Numerous studies in recent years indicate not only the widespread prevalence of simultaneous diseases of the abdominal organs, but also unsatisfactory results of their treatment. In addition, simultaneous surgical treatment of patients with two or three diseases of the abdominal organs is a complex and not fully resolved problem [1,2].

The widespread dissemination of endoscopic surgery has provided a unique opportunity to redefine the boundaries of two specialties - gynecology and surgery, since operative laparoscopy is not only equivalent, but also preferable to classical treatment [5,6]

Information about this is rare in the literature, although in practice many gynecologists and surgeons note the need to perform such operations.

In this regard, the goal of our work was to improve the methods of combined surgical treatment of diseases of the pelvic and abdominal organs**.**

Materials and methods of research. The study is based on an analysis of the results of surgical treatment of 200 patients with various concomitant diseases of the abdominal organs, who underwent simultaneous surgical intervention.

The patients were divided into two main groups: the first - 107 patients who underwent laparoscopic and traditional simultaneous operations (main group), the second - 93 patients with traditional surgery (control group), who underwent one isolated operation

A comparison was made of the surgical approaches used when performing simultaneous operations.

The average age in the main group was 38.6±6.6, and in the control group 41.3±5.9 years. It should be noted that all patients were of working age.

In the main group of 107 patients who underwent simultaneous laparoscopic interventions, 47 (43.9%) had calculous cholecystitis - chronic calculous cholecystitis was in 40 (85.1%), acute in 7 (14.9%). In case of chronic calculous cholecystitis, cholecystectomy was performed using a minilaparotomy approach in 40 patients (37.4%), with complete and incomplete uterine prolapse, transvaginal hysterectomy was performed in 20 patients (18.7%). The laparoscopically simultaneous stage of the operation was uterine fibroids in 47 patients. In addition, the main group is characterized by performing a combination of minilaparotomy and traditional operations.

Thus, the simultaneous traditional stage of the operation for calculous cholecystitis was uterine fibroids of various localization in 40 women, and during

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transvaginal hysterectomy, the simultaneous stage was hernia repair for umbilical hernia in 20 patients.

The control group (comparison) consisted of 93 patients with gynecological and surgical pathologies, who underwent one operation each (hysterectomy, ventroplasty, cholecystectomy) for benign diseases (uterine fibroids, endometriosis, prolapse of the vaginal walls, chronic cholecystitis or umbilical hernias).

All patients were examined and prepared for surgery on an outpatient basis. Clinical examination of patients included a general blood and urine test, biochemical blood test, ECG, chest X-ray, ultrasound of the pelvic organs, liver and gall bladder. Ultrasound of the gallbladder and liver was performed to exclude gallstones, hydatid cysts and other formations in the liver. Particular attention was paid to the degree of vaginal cleanliness, which should correspond to grades I-II.

Research results and discussion. During 2010-2015, 5120 laparoscopic operations were performed, of which 107 (2.1%) were simultaneous**.**

Laparoscopic cholecystectomy + laparoscopic hysterectomy was performed in 47 patients. Laparoscopic cholecystectomy was performed using a standard technique: one 10 mm trocar was inserted through the umbilicus, after which, under laparoscope control, two 5 mm and one 10 mm trocars were inserted in the right hypochondrium along the anterior axillary, midclavicular and midline. Using a monopolar coagulator, the cystic duct and cystic artery were isolated, hemostasis was performed using a bipolar coagulator, and the drug was removed from the abdominal cavity through a midline incision.

After completion of the cholecystectomy operation, the laparoscope was rotated 180°, the patient was transferred from the Fowler position to the Trendelenburg position, and the pelvic organs were inspected. Laparoscopic extirpation of the uterus and appendages for fibroids in 47 cases was a simultaneous step to 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, the absence of previous laparotomies and, as a consequence, the presence of a pronounced adhesive process, the absence of an inflammatory process in the gallbladder and genital organs).

Fixation of the cervix and expansion of the cervical canal were carried out using the Clermont-Ferrand uterine manipulator 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. 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. 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.

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After this, the uterus and appendages were removed through the vagina and sutured externally with interrupted catgut sutures. Peritonization was not performed. At the end of the operation, sanitation of the abdominal cavity, thorough examination and hemostasis of the surgical field and its drainage were performed. The postoperative period in 1 (0.5%) patient was complicated by the leakage of bile from the cystic duct stump. Relaparoscopy and application of an additional titanium clip were performed. There was no lethal outcome.

Minilaparotomic cholecystectomy for calculous cholecystitis and, as a simultaneous stage, laparotomic hysterectomy were performed in 40 patients. For these operations, a set of surgical instruments developed by M.I. was used. 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. 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 in the area of the hepatoduodenal ligament. Laparotomy hysterectomy was carried out using the usual method using a Pfannenstiel incision. 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. Then we proceeded to perform a hysterectomy through the vagina using the Steckel technique.

In the control group, all patients underwent isolated operations: hysterectomy in 33 (35.4%) patients, transvaginal hysterectomy in 21 (22.5%), anterior colporrhaphy and posterior colpoperineoplasty in 15 (16.3%), cholecystectomy in 11 (11.8%) and ventroplasty – 13 (13.9%), i.e. the same ones that were performed in the main group and also using classical methods, but one operation for each patient.

A comparative study of two statistically comparable groups of patients who underwent simultaneous and single operations, based on clinical and laboratory studies, showed that there are no significant changes in the patient's body associated specifically with simultaneous interventions.

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 ml, 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.

Our experience in laparoscopic gynecological one-stage operations performed entirely laparoscopically and in combination with traditional approaches reveals the

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advantages of this method, primarily due to low trauma and cosmetic effect. Therefore, when choosing an access, recently we proceed from the ability to perform any operation or stage in any low-traumatic way, be it laparoscopic or mini access.

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. When performing simultaneous operations using laparotomy access in the main and control groups, the length of the incision was identical (12-13 cm).

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.

Thus, with high professionalism and accumulated experience of operators, as well as highly qualified anesthesiological and resuscitation support, simultaneous operations in gynecology and surgery through classical and combined approaches can take their rightful place in the practice of departments, since if the above conditions are met, they do not pose a great danger for patients, and are perceived positively by them.

Literature:

1. Александров Л.С., Ищенко А.И., Ведерникова Н.В. Сочетанные операции в гинекологии //Ж.: Акуш. и гин. -2003.-№ 4.-с.4-11;
2. Ганиев Ф.И.,- Негмаджанов Б.Б., Нарзуллаев Х.Б., Азимов С.А., Лапароскопия в гинекологии и хирургии //Материалы VII съезда акушеров-гинекологов Республики Узбекистан.- Ташкент, 2013.- С. 245-246;
3. Баков В.С. Симультанные лапароскопические оперативные вмешательства при сочетанных заболеваниях органов брюшной полости и малого таза. //Автореф. дисс. канд. мед. наук.- Рязань, 2000. -24с.;
4. Емельянов С.И., Протасов А.В., Рутенбург Г.М. Эндохирургия паховых и бедренных грыж. — СПб., 2000.
5. 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 //Ж.: Эндоскопическая хирургия.- 2001.-№6.-С.10-14;
6. Пучков К.В., Баков В.С., Иванов В.В. Симультанные лапароскопические оперативные вмешательства в хирургии и гинекологии. — М., 2005.