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✓ *Resume,*

Functional disorders from paresis of the gastrointestinal tract to intestinal paralysis are one of the main causes of death in peritonitis of any etiology, including acute intestinal obstruction in children.

The article describes the causes of acute intestinal obstruction in children, methods of treatment and prevention.

Key words: acute intestinal obstruction, treatment, children's age, method.

ЛЕЧЕНИЕ ОСТРОЙ КИШЕЧНОЙ НЕПРОХОДИМОСТИ У ДЕТЕЙ СОВРЕМЕННЫМИ СПОСОБАМИ

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Функциональные нарушения от пареза желудочно-кишечного тракта до паралича кишечника являются одной из основных причин смерти при перитоните любой этиологии, в том числе острой кишечной непроходимости у детей.

В статье описаны причины возникновения острой кишечной непроходимости у детей, методы лечения и профилактики.

Ключевые слова: острая кишечная непроходимость, лечения, детской возраст, способ.

БОЛАЛАРДА ЎТКИР ИЧАК ТУТИЛИШЛАРИНИ ЗАМОНАВИЙ УСУЛЛАРДА ДАВОЛАШ

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✓ *Резюме,*

Ошқозон-ичак тракти парезидан ичак фалажигача бўлган функционал бузилишлар ҳар қандай этиологияли перитонитнинг, жумладан болаларда ўткир ичак тутилишида ўлимнинг асосий сабабларидан биридир.

Мақолада болаларда ўткир ичак тутилишининг сабаблари, даволаш ва олдини олиш усуллари баён этилган.

Калит сўзлар: ўткир ичак тутилиши, даволаш, болалик, усул.

Relevance

Intestinal obstruction accounts for 1.5-9.4% of all diseases of the abdominal cavity and causes 3- 5% of admissions to surgical hospitals [3]. The mortality rate for intestinal obstruction is 3-10%, postoperative reaches 30% and occupies one of the first places among emergency surgical diseases according to this indicator [1]. In recent years, the number of patients with certain types of acute intestinal obstruction (intussusception,

inversion, nodulation) has decreased by 2-3 times [2.5].

Thus, invagination accounts for 3-5%, inversion and nodulation - 4-6% of all forms of intestinal obstruction of non-tumor genesis. At the same time, the number of patients with obstructive intestinal obstruction of tumor genesis (20-30%) and adhesive abdominal disease (50-80%) increased [4].

Acute intestinal obstruction (ACN) is one of the most common diseases in abdominal surgery. According to our data, its specific weight from all types of intestinal obstruction in children is up to 40%, which is generally consistent with the literature data [6].

Treatment of patients with adhesive disease of the abdominal cavity is a difficult task, which is associated with the severity of the clinical course and the development of formidable complications, the lack of adequate unified methods for preventing relapses [2,7], clearly undefined indications for the use of various methods of treatment of ACN.

The purpose of the study. Analysis of the results of treatment of young children with acute intestinal obstruction.

Materials and methods

The object of the study was 175 children admitted to the clinic in 2019-2021. The bulk of the applicants are children from 8 to 14 years old - 105 people (60%). There were 108 boys and 67 girls, which was 1.6:1. Destructive appendicitis was the leading cause of primary surgery (in more than 50% of patients).

The results of the study. In 53 (30.29%) children, conservative therapy made it possible to exclude acute surgical pathology in a short time. The first group consisted of 85 (48.57%) patients who had previously been operated on for various reasons in an "open" way. Their OCN was confirmed clinically and with the help of instrumental diagnostic methods. In 43 (50.59%) children of this group, conservative therapy helped to completely stop the manifestations of ACN and discharge children without surgery.

The remaining 42 (49.41%) patients underwent laparotomy, and conservative measures served as preoperative preparation. The second group consisted of 37 (21.14%) children who had been operated on laparoscopically earlier or who had surgical intervention for ACN started with diagnostic laparoscopy. In 3 (8.11%) of them, OCN was resolved with the help of conservative measures, in the remaining 34 (91.89%), surgical treatment was performed endovideolaparoscopically.

Indications for surgical intervention were non-relieving abdominal pain, tachycardia, vomiting, persistent bloating, changes in the UAC with an increase in leukocytosis and LII. The largest number of children operated on for ACN was concentrated in the age range of 4-18 years (90.8%). The analysis of sexual differentiation was dominated by boys 2.3:1. Before surgical

treatment, all children were injected with broad-spectrum antibacterial drugs to prevent purulent-septic complications.

According to the type of surgical treatment, children, as mentioned above, are divided into two groups. The first group is children who have had laparotomy. The second group is children, in relation to whom endovideoscopic techniques were used. In the second group, the work was carried out with the operation of an endovideolaparoscopic stand "Endomit" with two LCD screens, a ultrasound machine and a set of tools represented by atraumatic clamps, dissectors, scissors, mono- and bipolar coagulator. In all cases, I used a 5 mm telescope with both straight and oblique optics of 30°.

The conclusion about the place of introduction of the first port was made on the basis of ultrasound and X-ray picture of the abdominal cavity. After examination of the abdominal cavity, ports for manipulative instruments were inserted in areas free of splices, in planes perpendicular to the plane of the laparoscope. In the future, the question of choosing a method of surgical treatment – conversion or laparoscopic adhesiolysis was decided. The prevalence of the adhesive process, the presence and nature of the exudate, the viability of the organs involved in the process, the degree of gas filling of the intestinal loops were evaluated.

To establish the localization of the site of obstruction and the presence of a strangulation component, expanded intestinal loops filled with barium suspension over the site of obstruction and collapsed intestinal loops below the intestinal obstruction zone helped. When assessing the prevalence of the adhesive process, we were guided by the classification proposed by O.I. Blinnikov [1]. This classification implies the division of the prevalence of adhesions in the abdominal cavity into 4 types: type I - a single extrusion or planar adhesion, type II - adhesive conglomerate, which is limited to one anatomical area, type III - adhesions are located in more than 2 areas of the abdominal cavity, parenchymal organs can be included in the adhesive process, type IV - all parts of the abdominal cavity are filled with adhesions fixing intestinal loops.

It was not difficult to separate planar adhesions in an acute or blunt way between intestinal loops with a loose adhesive process (early OCN), as well as adhesions between the anterior abdominal wall and the intestine. Single cord-like strands intersected and were partially directed for pathological and morphological examination. The greatest technical difficulties with the expenditure of surgical time are

associated with the separation of adhesive conglomerates with the involvement of postoperative scars of the anterior abdominal wall, which is observed more often with late adhesive intestinal obstruction.

In the first group of children in the early postoperative period, 12 (28.57%) people had 15 (35.71%) of various complications. From the abdominal cavity, complications were observed in 7 (16.67%) patients: early SCN in 2 (4.76%), peritonitis in 3 (7.15%), wound suppuration in 1 (2.38%) and intestinal eventration in 1. Complications outside the abdominal cavity and anterior abdominal wall were recorded in 5 (11.9%) children: bronchitis in 1 (2.38%) case, pneumonia in 1 (2.38) child, duodenitis in 1. Anemia of moderate severity was diagnosed in 2 children (4.76%).

In the second group, 5 complications were recorded in 4 patients (11.76%). In 3 (8.82%) cases - perforation of the bowel loop. In 2 (5.88%) children, perforation occurred during laparoscopic separation of the intestinal conglomerate from the postoperative scar, which required conversion. One (2.94%) child was diagnosed with perforation after the development of purulent peritonitis clinic, for which laparotomy was performed. 1 (2.94%) child was re-admitted to the operating room due to a recurrence of OCN that developed 7 days after laparoscopic adhesiolysis, which also required laparotomy. All these characteristics of complications were statistically significant ($\chi^2 = 8.12$; $p = 0.0873$). No deaths were recorded in both groups.

When comparing the time spent in the hospital in children operated "traditionally" and children who used the endovideoscopic method of treatment, it becomes obvious a significant reduction in the bed-day index in the 2nd group of patients. This is due to faster rehabilitation, less pain, early recovery of gastrointestinal functions, and a lower percentage of complications. When performing the conversion, the average bed day index slightly differed from the same during laparotomy.

Conclusion

The use of laparotomy access in children with ACN is traumatic, leads to an aggravation of the inflammatory and adhesive process, longer rehabilitation and endogenous intoxication, a higher percentage of complications, which reaches 35.71%.

The method of video endolaparoscopy in the treatment of ACN is low-traumatic, safe, highly informative, promising both in the diagnostic

algorithm and for the treatment of this pathology in children.

The use of endovideoscopy in the treatment of ACN in children has significantly improved the results of treatment: to reduce the percentage of complications by 3 times (from 35.71 to 14.71%); to reduce the time spent in hospital (from 16.2 k / d after laparotomy to 10.03 k / d); to reduce the number of relapses by 6.5 times (from 35.29 to 5.4%).

With the local spread of the adhesive process in the abdominal cavity (type I and II according to O.I. Blinnikov), a laparoscopic method of dissection of adhesions is indicated in the treatment of OCN.

With a widespread adhesive process (type III and IV), laparoscopy should be used for diagnostic purposes to determine the volume of surgery followed by laparotomy.

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