УДК: 616-001.17-089-053.9

# ЭФФЕКТЫ ЛЕЧЕНИЯ ОЖОГОВОЙ БОЛЕЗНИ У ЛИЦ ПОЖИЛОГО И СТАРЧЕСКОГО ВОЗРАСТА

**Умедов Хушвакт Алишерович**
*ассистент, кафедры хирургических болезней №2 лечебного факультета*
**Раджабов Фируз Гиёсиддинович**
*ассиситент, кафедры кафедры клинической фармакологии*
*Самаркандский Государственный Медицинский Университет*
*Самаркандский филиал РСНЭМП*
*г. Самарканд, Республики Узбекистан*

**Резюме:** *Изучены результаты лечения 510 пациентов с глубокими ожогами, в возрасте от 60 до 92 лет. При исследовании данной категории пациентов наблюдались стойкая гипотония, повышение ЦВД, изменения в ЭКГ и явления гемоконцентрации. Первые 24 часа, после поступления больных с ожоговым шоком, в 69% наблюдений удалось стабилизировать гемодинамику. В период токсемии (у 169 больных) и септикотоксемии (у 184) инфузионно-трансфузионная терапия (ИТТ) была направлена на борьбу с интоксикацией, анемией, гипо-и диспротеинемией. Для местного лечения ожоговых ран были использованы протеолитические ферменты, 10% раствор мочевины, лазеротерапия, мазь прополиса и металлокомплексы иммобилизированные в текстильном материале, 409 пациентов были оперированы. Умерло 72 (17,6%о) пациента.*

**Ключевые слова:** *ожоги, пожилой и старческий возраст, лечение*

# EFFECTS OF TREATMENT OF BURN DISEASE IN ELDERLY AND SENILE PATIENTS

Umedov Khushvakt Alisherovich
*Teacher of the Department of Surgical Diseases No. 2*
Radjabov Firuz Giyasiddinovich
*Teacher of the Department of clinik farmakologiya*
*Samarkand State Medical University,*
*Samarkand Branch of the Republican Scientific Center for Emergency*
*Republic of Uzbekistan, Samarkand*

Abstract: *510 patients aged 60-92 with deep burns had been under the observation of the authors 100 burnt patients were admitted in a shock state. They demonstrated stable hypotony, elevated CIT (Central Intraocular tension) the change in ECG and less marked hemoconcertration. I.T.T. in the first 24 hours resulted in hemodynamic stabilization on the background of cardiac glucosides administration. The authors succeeded in taking 69% of*

*burnt patients out of shock state. I.T.T. in the period of acute burn toxaemia (in 169) and septicotoxaemia (in 184) was directed to the struggle against intoxication, anaemia, hypo and dysproteinaemia. To tear away necrotic tissues proteolytic ferments were used, 10%> solution of urea, laserotherapy, propolis ointment and me-tallocomplexes, 409 patients were operated. Out of 72 persons died (17,6%).*

**Keywords:** *burns, elderly age, treatment.*

**Relevance.** Treatment of burn disease in elderly and senile persons is a section of clinical gerontology, which is one of the urgent problems of modern surgery, since thermal trauma is observed in 15-35% of persons of this age group. Mortality rates for burn disease in patients of older age groups range from 24 to 63%, and has no tendency to decrease in the last decade. Despite the wide coverage of this problem, both in domestic and foreign literature, many of its aspects are still far from being resolved. Views on the choice and volume of infusion media for the treatment of burn shock remain contradictory, as well as indications for various types of skin grafting, technique, volume and timing of execution from the moment of thermal injury have not been sufficiently developed. The existing views on the choice of early necrectomy and skin grafting in elderly and senile patients are even more characterized by a lack of unity. Advanced

age of patients, severe concomitant diseases that cause thermal trauma on the background, the development of the so-called mutual burden syndrome makes necrectomy for extensive burns difficult to tolerate for a certain group of these patients. At the same time, forced conservative treatment is often accompanied by the development of burn exhaustion and sepsis, which leads to death in more than 80% of patients.

**Materials and methods.** We observed 510 patients with deep burns aged 60 to 92 years. Deep burns from 1 to 5% of the body surface were in 69 patients, from 6 to 10% – in 238, from 11 to 20% – in 158, from 21 to 30% – in 30 and more than 30% of the body surface in 15 victims. In a state of burn shock of varying severity, 100 elderly and senile victims were admitted. The severity of burn disease was determined mainly by the area and depth of the lesion. At the same time, with the Franc index (IF), up to 30 units were in 88 patients, from 31 to 60 – in 210 victims, from 61 to 90 units – in 170, from 91 to 120 units. – in 15 patients, from 121 to 150 – in 20 victims and over 150 units . – in 7 patients.

**Results and their discussion.** Treatment of victims with burns consisted of two full-fledged components parts: general and local. General principles of treatment. The basis of general treatment is infusion-transfusion therapy (ITT), which has its own characteristics in each of its periods. The most important stage of treatment of a severely burned person, which largely determines the further prognosis of burn disease, is antishock therapy.

Our studies have been conducted in 100 elderly and senile victims who were admitted in a state of burn shock showed that from the very first hours they had persistent hypotension (in 84), the central venous pressure increased pressure (CVD), electrocardiogram parameters changed significantly (in 94). Another important feature of the course of burn shock, according to our data, is the lower severity of hemoconcentration. So, in a group of patients with IF up to 30 units. the number of erythrocytes at admission was 4.5 ± 0.12 x1012 / l, in patients with IF

from 31 to 60 units, their number was 5.0±0.10x10 /l in the group with an IF of more than 61 units – increased to 6.3±0.15x10 /l. The hemoglobin content, respectively, was 145±3.1 g/l in the first group, 146.0±3.8 g/l in the second, and 167.0±4.6 g/l in the last group. Based on the characteristics and severity of the course of burn shock in elderly and senile people, the tactics of ITT were built. When determining the amount of injected fluids, we compiled an individual scheme of fluid therapy for each patient, taking into account the age, area and depth of the lesion of the skin, as well as the functionality of the cardiovascular system and the function of external respiration, primarily the injected fluid in the first a day of burn shock averaged 2.5-3 liters. On the second day, the amount of transfused fluid decreased by half from the initial volume, averaging from 0.5 liters for mild, and 1.5-1.7 liters for severe and extremely severe burn shock. Transfusion on the first day of 2.5-3 liters of liquid with a rate of administration of 20-30 drops per minute against the background of the use of cardiac glycosides and cardiotonic drugs (ATP, cocarboxylase, vitamins) allowed in most cases to achieve stabilization of hemodynamics. During the period of burn shock, especially on the first day when. The most significant drop in blood pressure and CVD was noted in patients with polyglucin, stabizol and refortan transfusions were successfully used.

We found that in 75 patients with burn shock, an increase in potassium levels (6.3 ± 0.4

mmol / l) and a decrease in sodium content (98.8 ± 4.5 mmol / l) is observed in the blood. To normalize the potassium and sodium levels in the blood, balanced solutions containing sodium ions (acesol, Ringer–Locke solution, sodium chloride solution), 10% glucose solution. In order to study the nature of metabolic disorders in 20 victims, the indicators of acid-base state (CBS) were studied. At the same time, subcompensated metabolic acidosis was detected in all examined patients. To correct violations of the CBS, we performed transfusion of alkaline solutions (4% sodium bicarbonate solution, lactasol), the amount of which was determined by the deficiency of bases. In cases of a combination of metabolic and respiratory acidosis, along with the administration of alkaline solutions, measures were taken to improve the function of the external

respiration (oxygen therapy, bronchospasm control, etc.).

Studies conducted during the shock period in 88 elderly and senile burned patients revealed hypercoagulation changes in the blood. Transfusion of fibrinolysis plasma with heparin in 72 patients at a dose of 10 units per 1 ml

of plasma, a total of 1000 units per day contributed to an increase in fibrinolytic blood activity, an increase in blood clotting time and antithrombin activity. In 22 victims with extensive burns and severe anemia (the number of red blood cells below 2.8 ± 1012/l), on the second day, blood transfusion (erythrocyte mass) was included in the antishock therapy complex short shelf life. Hemotransfusions contributed to a decrease in tissue hypoxia as a result of the recovery of dead erythrocytes, a more persistent increase in hemodynamic parameters and an improvement in protein metabolism. To obtain a diuretic effect, 42 patients were injected with a 15% solution of mannitol in an amount of 150-200 ml with simultaneous infusion of 2 ml of 1% solution of lasix, which also helped to reduce congestion in the small circle of blood circulation.

In order to relieve peripheral vascular spasm during burn shock, all patients were injected intravenously 0.125% novocaine solution in a dose of 150-200 ml, which also has a significant analgesic effect. Based on the conducted studies, it should be noted that the effectiveness of the above principles of treatment of burn shock lies in the fact that we managed to bring 69% of patients out of this state.

During burn toxemia (in 169 patients) and septicotoxemia (in 184 patients) ITT was mainly aimed at combating intoxication, anemia, hypo and dysproteinemia.

As is known, in an aging organism, a decrease in all types of metabolism is manifested, therefore, nutrition was carried out fractional 4-6 times a day, which contributed to better absorption of nutrients. Probe feeding was used in 40 patients with anorexia. Protein hydrolysates, a mixture of Probe-Sh were injected into the probe drip daily,

concentrated glucose solutions, fat mixtures. The daily caloric content of the supplement to the hospital diet averaged 1700-2000 kcal. For better digestibility of the administered drugs, patients were prescribed a complex of vitamins B, C, insulin and anabolic hormones. The average duration of the probe feeding was 24 days and with parenteral administration of protein preparations (10% albumin, protein, infezol, plasma) allowed to reduce the manifestation of hypo- and dysproteinemia.

**Local treatment.** The tactics of local treatment of burn wounds is determined by one indicator – the depth of the burn lesion. With superficial burns of I-II-III degree, it should be aimed at the earliest epithelization of wounds,

with deep ones (III-IV degree) – at the fastest cleansing of the wound from necrotic tissues and the earliest restoration of the skin by autodermoplasty.

Local treatment of burns, in the absence of shock, begins with the primary toilet of the burn wound. For surface burns, drying agents are used, as well as ointment and wet-drying dressings. At the same time, a significant difference in the healing time (from 10-12 to 25 days) and the frequency of complications (up to 2-4%) with open and closedmethods of treatment of superficial burns was not revealed. Our experience shows that the tactics of local treatment of deep burns is largely determined by the area of the burn. Early excision of a burn scab (early necrectomy) is the most expedient and radical a method to get rid of necrotic tissues. This requires good anesthetic support and adequate transfusion therapy, with deep burns of 8-10% of the body surface. Usually, early necroectomy is performed 7-15 days after the burn, when the necrotic scab loses its connection with viable areas of the underlying tissues and there is less risk of infection dissemination. Self-rejection of the burn scab, complete cleansing of the wound, maturation of granulations ready for autodermoplastic closure occurs, as a rule, within 3-8 weeks after injury. The long-term existence of necrotic tissues, especially with their transition to wet necrosis, sharply worsens

the condition of the victims, therefore, we conducted a comparative study of ways to more quickly reject them in elderly and senile burned patients. Currently, various complexes of methods of local treatment of burns have been developed and applied, affecting both the local wound process and the body in general. The available observations show that it is necessary to influence the pathological processes in a burn wound with the simultaneous use of several therapeutic agents, different in nature of origin and mechanism of action. As a result of direct

observations, we have accumulated practical experience in the use of various methods of complex treatment of burn wounds. One of the first methods we applied was the use of immobilized proteolytic enzymes (trypsin, chymotrypsin, etc.) in combination with a 10% urea solution. Such a combination (in 67 patients) makes it possible to accelerate the rejection of necrotic masses, stimulate the cleansing of burn wounds, and prepare wounds for surgical closure faster. In the process of developing and deepening research to improve the effectiveness of local treatment, such therapeutic effects as semiconductor laser therapy were also included in the complex of therapeutic measures. Making a comparative assessment of helium-neon (in 20 patients) and semiconductor lasers (in 55 patients) currently used in medicine, we give preference to semiconductor lasers. They have more favorable working conditions as mobile, portable, capable of working both in continuous and impulsive mode of operation and having sufficient therapeutic power. Even more promising is the combined use of semiconductor laser therapy and topical application of immobilized enzymes, in particular, such a natural biologically active drug as propolis. In our practice (in 70 patients), we have consistently used different generations of propolis preparations: starting with 5-10% propolis ointment, collitinin and up to immobilized propolis in the form of multifunctional napkins "Coletex". These napkins are a binary action enzyme immobilized on a textile material. One of the most modern and promising methods of local treatment of burn wounds is the use of metal complexes immobilized on a textile carrier (in 45 patients). In various compounds of zinc and silver can be used as a metal. The above-mentioned metal complexes combine both necrotic and bactericidal effects. A rational combination of proteolytic enzymes trypsin, chymotrypsin or collitin, as well as metal complexes representing a kind of biological scalpel "melt" necrotic tissues by activating plasmin have an anti-inflammatory effect. As a result of a decrease in the activity of bacterial penicillinase, the destruction of the fibrin membrane of bacteria, the resistance of the purulent microflora decreases. Summarizing the above, it should be noted once again that the use of a comprehensive method of local treatment of burn wounds using physical factors and chemically active drugs accelerates the cleansing of a burn wound, provides the necessary regenerative activity of tissues. As a result, burn surfaces are prepared faster for the final stage of complex therapy - skin grafting. In both general and local treatment of burn disease, in order to prevent and treat various infectious complications, we conduct antibacterial therapy. The main method of restoring the skin in deep burn wounds is surgical treatment with the use of skin grafting. To this end, we performed autoplasty of the skin in 409 victims aged 60 to 92 years with an area of deep burns from 2% to 25% of the body surface. Of these, 186 patients with an area of deep burns (from 2 to 15%) underwent early necrectomy in a period of 7 to 15 days. Skin grafting was performed immediately after removal of necrotic scabs on an area of up to 5% of the body surface in 116 (62.4%) patients and in 70 (37.6%) affected from 5 to 15% of the body surface, a total of 201 autodermoplastics (from 500 to 850 cm). Good engraftment of skin flaps was in 156 (83.9%) patients, partial detachment of grafts occurred in 25 (13.4%) victims and complete lysis of transplanted flaps was observed in 5 patients in whom early necrectomy was performed on an area of 10-15% of the body surface, in whom due to rejection of grafts the general condition deteriorated. Despite the restorative therapy, the condition of the victims progressively worsened and after 10 days, 2 patients had a fatal

outcome. In 171 (91.9%) of those who washed, operations were performed in one stage, and in 15 (8.1%o) - in two stages, which was caused by heavy bleeding from the wound surface and insufficiently complete removal of necrotic scabs. The second stage of the operation was performed 6-7 days after the first with the removal of the remaining necrotic scabs. In this case, good engraftment was noted in 13 patients, and in two -

partial detachment of grafts was observed. When preparing burn wounds for autoplasty, stage-by-stage gentle necrectomies were performed in 211 victims (group II), with the removal of necrotic tissues as they were rejected.

Along with sparing necrectomy, necrolytic therapy using proteolytic enzymes and keratolytic drugs was used in 22 patients in order to quickly reject necrotic tissues.

223 patients (group II) with extensive deep burns of 10-25% of the body surface underwent autoplasty of the skin on granulating wounds. In one stage - in 133, in two stages - in 45 and in three stages and more than 45 patients (383 operations). In order to increase the area of closed wounds in patients with extensive burns, we performed autoplasty of the skin in 32 patients, of which 17 victims had a "vintage" method and 15 cases used skin plastic surgery using the Moulem-Jackson method. To increase the possibilities of skin grafting with limited skin resources in 102 patients, so-called mesh grafts were used, which resulted from the application of special dermatome notches on the skin flaps taken in the usual way, as a result of which they took the form of a mesh (from 500 cm to 1100 cm2). This method was used in patients with extensive deep burns and in victims with limited burns, occurred against the background of significant violations of cardiac activity and respiratory function, as well as in weakened patients with various complications (bedsores, pneumonia, hepatitis). In these cases , the preservation of the victims' lives came to the fore, sometimes to the detriment of functional results. Preference was given to mesh grafts obtained with a magnification factor of 1:1, 1:1.5, which contributed to faster epithelization of cells to grafts, since larger perforation leads to slow epithelization of the remaining small ones wounds due to drying of the wound in the cells of the grafts.

The tactics of multi-stage autoplastic substitutions of the skin with the determination of the volume of plastic surgery in each individual case, depending on the condition of the victims and the preparedness of burn wounds, was the most rational in this contingent of patients.

When granulating wounds were closed with solid grafts, bandages were performed 2-3 days after skin grafting, and the use of mesh grafts with good drainage ability allowed the first dressing to be delayed up to 5-6 days.

In our observations, out of 383 autoplastics of the skin on granulating wounds (group II), complete engraftment of grafts was noted in 272 cases (71.0%), engraftment of 70% of transplanted flaps was observed in 92 cases (24.1%) and complete lysis of skin flaps occurred only in 19 cases (4.9%). In 27 patients in the postoperative period there were complications from transplants (inflammation, edema, blistering, lysis at the edges), suppuration of wounds of donor sites (in 32 patients), which made it especially difficult to treat patients with more than 15%) burn areas and a shortage of donor skin resources. We used semiconductor laser irradiation on the skin of the intended donor site in 48 patients in order to accelerate the reparative processes of the skin. The use of this method in patients, especially with extensive burns, made it possible to reduce the healing time of donor skin wounds left after the split skin

flap was removed from 16.9 ± 0.8 to 13.1± 0.2 days. Complications from transplanted transplants were not observed.

Irradiated flaps served as sources of active epithelization of wounds. In the case of incipient autograft lysis (60 cases), in order to preserve the skin flap, it is advisable to irradiate the graft with laser beams in the early postoperative period. Among 409 operated patients, 72 people died, which is 17.6%.

**Conclusions:**

1. Burn shock in victims aged 60 and older is marked by a significant severity of the course, which is characterized by severe disorders of cardiac activity, respiratory function and hypercoagulation of blood.

2. The main principles of ITT tactics of burn shock in elderly and senile patients is to reduce the total volume of transfused fluids by 2.5-3 liters on the first day, even with severe shock with an infusion rate of 20-30 drops per minute, against the background of the introduction of cardiac glycosides and cardiotropic drugs under control

ECG, CVD, blood pressure, which allowed in 69% of cases to bring patients out of shock without severe overload of the cardiovascular and pulmonary systems.

3. One of the ways to correct hypercoagulation of blood in severely burned patients is transfusion of fibrinose plasma with heparin (10 units per 1 ml of plasma).

4. For the local treatment of burn wounds, the use of physical factors and chemically active drugs contributes to a faster cleansing of wounds from necrotic tissues.

5. We consider multi-stage plastic surgery with small intervals between them and the predominant use of autoplasty with mesh grafts to be the best methods of treating deep burns in the elderly.

6. The use of laser therapy on donor sites and in the area of transplanted autoflesh makes it possible to enhance regenerative processes in patients with deep burns, which is very important in the elderly.

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