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METHODS OF TREATMENT OF BURN SHOCK AND MULTIPLE ORGAN FAILURE IN PATIENTS WITH THERMAL TRAUMA

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Abstract: *Treatment of burn disease in elderly and senile people is a section of clinical gerontology, which is one of the urgent problems of modern surgery, since thermal trauma is observed in 25-45% of people of this age group. Mortality rates for burn disease in patients of older age groups range from 30 to 70%, 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 implementation with the moment of receiving a thermal injury. 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.*

Key words: *severely burned, burn disease, deep burns, earlier surgical treatment, early necrectomy.*

Relevance. Treatment of burn disease in elderly and senile people is a section of clinical gerontology, which is one of the urgent problems of modern surgery, since thermal trauma is observed in 25-45% of people of this age group. Mortality rates for burn disease in patients of older age groups range from 30 to 70%, 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 implementation with the moment of receiving a thermal injury. 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. The advanced age of patients, severe concomitant diseases that cause the development of the following on the background of thermal trauma 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 427 patients with deep burns aged 60 to 90 years. Deep burns from 1 to 5% of the body surface were in 64 patients, from 6 to 10% – in 215,

from 11 to 20% – in 128, from 21 to 30% – in 15 and more than 30% of the body surface in 5 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. there were 80 patients, from 31 to 60 – 180 victims, from 61 to 90 units – 135, from 91 to 120 units. – in 15 patients, from 121 to 150 – in 15 victims and over 150 units . – in 2 patients.

Results and their discussion: Treatment of victims with burns consisted of two full-fledged components: 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 80 elderly and senile victims who were admitted in a state of burn shock showed that from the very first hours they had persistent hypotension (74), increased central venous pressure (CVD), significantly changed electrocardiogram indicators (84). 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 on against the background of the use of cardiac glycosides and cardiotonic drugs (ATP, cocarboxylase, vitamins), it was possible in most cases to achieve hemodynamic stabilization. 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, transfusions of polyglucine, stabizol and refortan 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 parameters in the blood, balanced solutions containing sodium ions (acesol, Ringer–Locke solution, sodium chloride solution), 10% glucose solution were transfused.

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 external respiration (oxygen therapy, bronchospasm control, etc.). Studies conducted during the shock period in 88 elderly and senile burned patients revealed hypercoagulation changes in 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 activity of the blood, an increase in time blood clotting 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 compensation 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 130-180 ml with a simultaneous infusion of 2 ml of a 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 with 0.125% novocaine solution at 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 142 patients) and septicotoxemia (in 169 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. With anorexia in 40 probe feeding was used for patients. Protein hydrolysates, a Probe-Sh mixture, concentrated glucose solutions, and fat mixtures were injected into the probe daily. The daily caloric content of the supplement to the hospital diet averaged 1500-1800 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 the 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 recovery

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 closed methods 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 method to get rid

of necrotic tissues. This requires good anesthetic support and adequate transfusion therapy, with an area of deep burns 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, the maturation of granulations ready for autodermoplastic closure occurs, as a rule, within 3-8 weeks after the injury. The long-term existence of necrotic tissues, especially with their transition to wet necrosis, sharply worsens. Self-rejection of the burn scab, complete cleansing of the wound, the maturation of granulations ready for autodermoplastic closure occurs, as a rule, within 3-8 weeks after the 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 the burn wound with the simultaneous use of several medicinal products, 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 57 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 10 patients) and semiconductor lasers (in 45 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). 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 burn wounds, provides the necessary regenerative activity of tissues. As a result, burn surfaces are prepared faster for the final stage of complex therapy - skinplasty. 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. Dermal plastic surgery was performed immediately after removal of necrotic scabs on an area of up to 5% of the body surface in 106 (62.4%) patients and 60 (37.6%) victims from 5 to 15% of the body surface, a total of 191 autodermoplastics (from 500 to 850 cm).

Good engraftment of skin flaps was in 136 (83.9%) patients, partial detachment of grafts occurred in 15 (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 151 (91.9%) of those who washed, operations were performed in one stage, and in 5 (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 in 201 victims (group II), stage-by-stage sparing necrectomies were performed, with the removal of necrotic tissues as they were rejected. Along with gentle necrectomy, necrolytic therapy using proteolytic enzymes and keratolytic drugs was used in 12 patients in order to quickly reject necrotic tissues. 213 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 113, in two stages - in 45 and in three stages and more than 45 patients (363 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 in 15 cases skin plastic surgery was used according to 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 cm 2). This method was used in patients with extensive deep burns and in victims with limited burns that 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 wounds due to drying of the wound in the graft cells. Tactics of multi-stage autoplastic substitutions of the skin with the determination of the volume of plastic surgery in each in a separate case, depending on the condition of the victims and the preparedness of burn wounds, it was 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 262 cases (71.0%), engraftment of 70% of transplanted flaps was observed in 82 cases (24.1%) and complete lysis of skin flaps occurred only in 19 cases (4.9%). In 17 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 remaining 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. 52 people died among 399 operated patients, 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 62% of cases to bring patients out of shock without severe overload of the cardiovascular and pulmonary systems.

3. One of the ways to correct blood hypercoagulation 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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