

OPTIMIZATION OF SURGICAL TREATMENT OF BILE PERITONITIS AS A COMPLICATION OF ACUTE CHOLECYSTITIS

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The results of examination and treatment of 82 patients with biliary peritonitis as a complication of acute destructive cholecystitis are presented.

Group I (comparison group) included 33 patients with peritonitis as a complication of acute destructive cholecystitis, operated in the period 2001-2010, in the complex treatment of which standard generally accepted approaches were used. To the second group (main group) - 49 operated in the period 2011-2020, in which the algorithm for conducting diagnostic and treatment measures was based on the principles of FTS - the accelerated recovery program (APC) and minimally invasive surgical interventions were used as priority methods of surgical treatment .

Among 82 patients with destructive cholecystitis complicated by biliary peritonitis, according to the nature of the pathological process, leakage was observed in 55 (67.1%) patients, of which diffuse - in 9 (16.4%) and delimited - in 46 (83.6%) . Perforated bile peritonitis was in 27 (32.9%) patients, of which diffuse - in 10 (37.1%) and limited - in 17 (62.9%).

In patients of the comparison group, depending on the volume, the operations performed were divided into 3 types: - cholecystectomy , sanitation and drainage of the subhepatic space were performed in 19; – cholecystectomy , sanitation and drainage of the abdominal cavity performed 9; – cholecystectomy , choledocholithotomy , sanitation and drainage of the subhepatic space were performed in 5 patients. In all cases, a wide upper-middle access was used.

In the main group of patients, the following types of operations were performed: microcholecystostomy and puncture with a beater under ultrasound guidance 11; LCE, sanitation and drainage of the subhepatic space completed 9; LCE, sanitation and drainage of the abdominal cavity (right lateral canal and small pelvis) 4 . ; LCE, sanitation and drainage of the subhepatic space, EPST 3; ChE from minilaparotomic access and choledocholithotomy , drainage of the choledochus and sanitation and drainage of the subhepatic space 6; ChE, sanitation and drainage of the abdominal cavity from an open wide laparotomy access in 16 patients.

In the main study group, in 11 patients with acute destructive cholecystitis and delimited accumulation of bile in the subhepatic space with an initially

severe general condition, gallbladder decompression was performed using percutaneous transhepatic microcholecystostomy (CCMCS) and puncture of the biloma under ultrasound guidance. After performing microcholecystostomy, these patients underwent ultrasound-guided puncture with a beater to evacuate a limited accumulation of fluid in the abdominal cavity.

Laparoscopic cholecystectomy was completed by sanitation and drainage of the subhepatic space in 9 patients with acute destructive cholecystitis and local peritonitis. In diffuse bile peritonitis, LCE was supplemented by sanitation of the abdominal cavity with mandatory additional drainage of the right lateral canal and the pelvic cavity in 4 patients. 3 patients in combination with choledocholithiasis after LCE underwent EPST, 6 patients underwent CE and choledocholithotomy from an open mini-access. At the same time, 16 patients with diffuse bile-purulent peritonitis underwent CE and sanitation of the abdominal cavity through a wide laparotomy approach.

Thus, according to the principles of minimally invasive interventions in the main study group, 33 patients (67.3%) with acute destructive cholecystitis complicated by various forms of biliary peritonitis were operated on.

Various purulent-septic complications after operations for acute destructive cholecystitis and biliary peritonitis were observed in 11 patients of the comparison group, which amounted to 33.3%, in the main study group, postoperative complications developed in 8 patients, which amounted to 16.3%. Mortality was 6.1% in the comparison group and 4.1% in the main group.