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Research Article

A SET OF DIAGNOSTIC, TACTICAL AND THERAPEUTIC MEASURES TO IMPROVE THE TREATMENT OF ACUTE AND CHRONIC PARAPROCTITIS

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RustamovMurodullaIsomiddinovich
PhD Assistant of the Department of General Surgery, Samarkand State Medical Institute, Republic of Uzbekistan, Samarkand, Uzbekistan

RustamovInoyatullaMuradullaevich
PhD Assistant of the Department of General Surgery, Samarkand State Medical Institute, Republic of Uzbekistan, Samarkand, Uzbekistan

ABSTRACT

Results of surgical treatment of patients with acute and chronic paraproctitis. These results suggest that the choice of the optimal amount and method of surgical intervention in acute paraproctitis and rectal fistula is crucial in preventing relapses and complications, and ensuring a favorable outcome in the long term. A differentiated approach to the choice of surgical intervention in patients with acute and chronic paraproctitis improves both immediate and long-term outcomes of patients in this category

KEYWORDS

Acute abscess, rectal fistula, surgery.

INTRODUCTION

Paraproctitis is one of the most frequent diseases in proctological practice. Diagnostic and treatment issues of this disease are constantly discussed in the Russian and foreign press, however, they are still not completely solved and often become a subject of discussions. According to data of leading clinics in our

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country and abroad patients with acute paraproctitis make up 0,5-4% among patients with general surgical pathology and 20-40% in the structure of proctologic diseases. Patients with chronic paraproctitis comprise 0.5-4% of the total number of surgical inpatients and 30-35% of patients with rectal diseases. The lack of familiarity of surgeons with this pathology leads to a large number of unsatisfactory outcomes. Many patients with acute paraproctitis do not always receive timely and qualified care, undergo prolonged treatment, and are out of active employment for a long time. As a result of the long-term chronic course of the purulent process in the perianal area, a cicatricial deformity of the perineum with anal sphincter insufficiency develops, often leading to persistent disability of the patients . The percentage of unsatisfactory treatment results is still rather high. In 13-20% of patients operated on for acute paraproctitis, there are pyoinflammatory complications in the wound, in 4-10% of patients the disease relapses or develops into a chronic course, in 6-8% of patients there is anal sphincter failure and in 17-36% of operated patients there is discomfort in the anus.

According to most studies, after surgical treatment of rectal fistulas, suppuration of the postoperative wound occurs in 10-13% of patients, recurrence of the disease in 1.5-10.2% of operated patients, and anal sphincter failure in 1.5-27.9% of patients. After surgical intervention for intra- and transsphincter fistulas, anal discomfort occurred in 1.8-22.4% of patients.

The prevalence and frequency of this pathology, especially in persons of working age, unsatisfactory immediate and long-term outcomes of the disease motivate researchers to search for new, most modern approaches aimed at improving the results of paraproctitis treatment.

PURPOSE OF THE STUDY

To develop a set of diagnostic, tactical and therapeutic measures aimed at improving the treatment outcomes of acute and chronic paraproctitis.

MATERIALS AND METHODS

866 patients with acute and chronic paraproctitis were treated in the proctology department of SamMI clinic No 1 during 2016-2022. We retrospectively analyzed the treatment of 866 patients (601 men (69.3%); 265 women (30.7%)). By age: 20-40 years old - 314 (36.2%), 40-60 years old - 301 (34.7%), 60 and over - 35 (4.0%).

650 patients were operated for acute paraproctitis. Localization of pus in pararectal tissue: acute subcutaneous paraproctitis - 327 (50,3%); acute submucosalparaproctitis - 76 (11,6%); acute ischiorectalparaproctitis - 204 (31,3%); acute pilviorectalparaproctitis - 29 (4,6%); acute retrorectalparaproctitis - 3 (0,4%); anaerobic paraproctitis - 11 (1,8%). Diabetes mellitus was observed in 21 (3,2%) patients.

Diagnostics of acute paraproctitis was based on the anamnesis, clinical picture, results of objective examination of patients. In preoperative period we carried out examination, palpation of perianal area, finger examination of rectum, laboratory, X-ray, ultrasound, bacteriological examination of patients.

Treatment of patients with acute paraproctitis presents a complex and difficult task which includes radical sanation of purulent focus, liquidation of distant consequences of the pathological process, prevention of recurrence of the disease.

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Rectal fistula is an inflammatory process in anal crypt, intersphincter space and pararectal tissue with formation of fistulous passage. Patients with this pathology account for about 216 (25%) of all proctologic patients.

Extrasphincteric fistulas are classified according to their degree of complexity. In the first degree of extra-sphincteric fistula complexity, the internal orifice is narrow with no scarring around it, no pustules or infiltrates in the tissue, and the course is fairly straight. In grade 2, there is scarring around the internal orifice, but no inflammatory changes in the tissue. In third-degree extra-sphincteric fistulas, there is a narrow inner orifice without scarring around it, but there is purulent inflammation in the tissue. In the fourth degree, they have a wide internal orifice surrounded by scarring, with inflammatory infiltrates or purulent cavities in the cellular spaces.

In transfincter and extrasphincter fistulas, the examination of the patient should be supplemented by fistulography and determination of the sphincter function of the anus. The most common types of operations for rectal fistulas are excision of the fistula into the rectal lumen; excision of the fistula into the rectal lumen (Gabriel operation); excision of the fistula into the rectal lumen with opening and drainage of the leak; excision of the fistula into the rectal lumen with sphincter suturing; excision of the fistula with ligature; excision of the fistula with relocation of a mucosa or muco-muscular flap of the distal rectus to eliminate the internal fistula opening .

The greatest problem is the treatment of extrasphincteric fistulas, with recurrences of 6-10%. In the preoperative period, laboratory, radiological, endoscopic and bacteriological examinations were performed.

DISCUSSION OF THE RESULTS OF THE STUDY

The choice of the optimal volume and method of surgical intervention in acute paraproctitis is decisive in terms of preventing relapses and complications and ensuring a favorable result in the long-term period.

Surgical interventions were performed under epidural or spinal anesthesia.

With subcutaneous and submucosal forms of paraproctitis, an abscess was opened into the lumen of the rectum according to Gabriel - 285 patients (43.8%).

In ischiorectal and pelviorectal forms of paraproctitis, a two-stage surgical approach was used. In the acute stage of the disease, an abscess was opened, sanitized and drained.

Necrectomy with a wide opening of purulent streaks was used in patients with anaerobic forms of paraproctitis, which were characterized by extensive purulent-necrotic lesions of pararectal tissue and severe clinical course.

In the postoperative period, intensive antibacterial, infusion therapy was carried out. Antibiotics were used taking into account the sensitivity of the microflora.

In the formation of pararectal fistulas, a radical operation was performed - excision of the purulent passage with the elimination of the internal opening of the fistula. After opening an abscess of the pararectal tissue without eliminating the internal opening of the paraproctitis, a recurrence of the

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disease or fistulas of the rectum occurred in 70-100% of cases.

When choosing an operative intervention, the following was taken into account: the ratio of the fistula and the internal opening to the sphincter; the presence of a cicatricial process along the fistula; the presence of infiltrates and purulent streaks in the pararectal tissue.

Operations were performed for rectal fistulas - 216, intrasphincteric fistulas - 64 (30.5%), transsphincteric - 96 (44.5%), extrasphincteric - 56 (25.0%).

With intrasphincteric fistulas, operations were performed: excision of the fistula into the intestinal lumen with suturing the bottom of the wound. There was no suppuration of wounds, relapses, insufficiency of anal sphincter.
For transsphincteric fistulas, excision of the fistula with suturing of a part of the external sphincter and the ligature method were used. Wound suppuration was noted in 3 patients (3.1%), relapses - in 8 (8.3%), anal sphincter insufficiency - in 2 (2.0%).

In case of extrasphincteric fistulas, excision of the fistula and the ligature method, excision of the fistula with displacement of the mucous flap were performed. There was suppuration of the wound in 2 patients (3.5%), relapses - 3 (5.3%), anal sphincter insufficiency - 1 (1.7%). The average duration of inpatient treatment was 8 bed-days. The total duration of temporary disability is 23 days.

CONCLUSIONS

Thus, a differentiated approach to the choice of the method of surgical intervention, optimization of preoperative preparation and postoperative treatment of patients with acute paraproctitis can improve both the immediate and long-term results of treatment of patients in this category, reduce the duration of treatment and temporary disability, the number of complications and relapses.

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