СЕКЦІЯ 8
АКТУАЛЬНІ ПИТАННЯ КЛІНІЧНОЇ ХІРУРГІЇ ТА ОФТАЛЬМОЛОГІЇ

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DIFFERENTIATED APPROACH TO THE TREATMENT OF ACUTE PERITONITIS

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Acute peritonitis is one of the most crucial problems of surgery. Eloquent evidence of this is the mortality rate, which, in common forms, reaches 70%.

The aim of the study was to increase the effectiveness of treatment of patients with acute peritonitis through a comprehensive analysis of the leading mechanisms of its progression and the development of sound diagnostic and treatment measures on this basis. A retrospective analysis consisted of medical records of 169 patients, 79 of whom had postoperative complications. The analysis of variance of clinical and laboratory parameters was performed. Taking into account the results, a two-stage prognostic scale was developed. At the first stage, before the operation, indicators were selected according to the scale, that corresponded to a certain number of points. Patients were preliminarily divided into groups of normal, increased, medium and high risk of postoperative complications. This allowed us to apply measures to prevent complications at the stage of preoperative preparation.

The final risk determination was performed taking into account the data of intraoperative audit and laboratory tests, which were contained in the scale at the second stage of forecasting. Patients were divided according to risk groups.

It is essential to be guided by standard indications in patients of group of usual and increased risk for definition of indications to preoperative preparation and its volume.

The conducted research and informativeness of the prognostic scale allowed us to offer an algorithm that reflected the main stages of diagnostic and treatment measures. Its application allowed to differentiate the required amount of measures at all stages of treatment on the basis of a reasonable selection of risk groups.

The application of the developed set of measures makes it possible to prevent suppuration of the postoperative wound, to avoid intra-abdominal complications in patients with diffuse peritonitis. to reduce mortality in patients with diffuse and general peritonitis by 9%, to reduce the incidence of residual intra-abdominal infiltrates in almost 19%, to reduce the length of residence of patients with peritonitis in the hospital by an average of 2.5 days.

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THE PREDICTORS OF THE GASTRODUODENAL ULCEROUS REBLEEDING

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Nowadays, the gastroduodenal ulcerous rebleeding remains an actual problem. The frequency of recurrent ulcerous bleeding remains high, which demands further research of its prognosis and treatment methods. The aim of investigation was to analyse the risk factors for ulcerous rebleeding. 203 patients were examined. Clinical, anthropometric, biochemical, genetic, optical, histological methods of examination were used.

In most cases ulcerous defects were localized in the duodenum - 127 cases (62,3%). Gastric ulcer was diagnosed in 68 patients (33.3%). Gastroduodenal ulcer occurred in 9 patients (4,4%). The lack of ulcer history occurred in most cases (109 patients (53,4%). 10 patients (4,9%) had the ulcerative history up to 1 year, 21 patients (10,3%) - up to 1-3 years, 16 people (7.8%) suffered from peptic ulcer disease from 5 to 10 years. 39 patients (19,2%) had the ulcerous history of more than 10 years. We conducted injections around the ulcer for endoscopic haemostasis. For this we used saline sodium chloride with adrenaline in the ratio of 1:10. The relapsed rate in this case was, depending on the location and other factors, 2-5%. In case of the haemostasis achievement failure by endoscopic way, a surgery was performed.

Rebleeding was recorded in 24 cases (11,8%). 15 patients (62,5%) with relapses were diagnosed with II A class by Forrest. On the Glasgow Blatchford Score, 3 patients (12,5%) with a 0 number of items had relapses, 11 of them (45,83%) had the number of items below 5, and the other 10 (41,67%) - above 5. The relapses frequency went higher as the number of items on the Rockall Score, most cases happened to patients with 5-6 number of items (n=16 (66,67%) and higher indicators occurred in separate cases.

Clinical predictors of bleeding relapse were comorbid pathology, bleeding in anamnesis, body temperature, hemostatic therapy use before admission, pulse rate, pulse pressure, and hemorrhage class according to Forrest classification.

Laboratory predictors of bleeding relapse were creatinine concentration, test on availability of fibrinogen B, fibrinase level, amount of reduced glutathione, general number of leukocytes, the whole blood protein, prothrombin index, plasma recalcification time, antithrombin III, non-enzymatic fibrinolytic activity (NFA) and enzymatic fibrinolytic activity (EFA) ratio (NFA/EFA ratio) of the blood plasma, its proteolytic activity of azocollagen, oxidation degree of plasma neutral proteins, the ratio of diene conjugates (DC), ketodienes and adjoint trienes (KAT), 5G4 and G43A polymorphism of PAI-1 gene.

A new method to assess the reliability of hemostasis was created by means of irradiation of a clot by the green and red laser beams. To describe F IIa and IIb stigmata objectification method was suggested, and they should be supplied with the indices H (High risk of relapse) when there was a dominating dispersion zone of the green laser beam, or L (Low risk of relapse), when the red laser beam dispersion was dominant.

A new prognostic two-stage scale was developed which separated the groups of high and low risk of bleeding relapse. The previous scale contained clinical and endoscopic criteria (comorbidity class, history of bleeding, body temperature, use of hemostatic therapy in the prehospital stage, pulse rate, pulse pressure, bleeding class according to Forrest). A delimiting criterion was the sum of 7 points. Sensitivity of the scale was 89,66%, specificity – 86,8%. The basic main scale contained also such criteria as leukocyte count, creatinine, plasma protein, prothrombin index, plasma recalcification time, fibrinogen B test scores. A delimiting criterion of the basic main scale was the sum of 11 points. Sensitivity of the scale was 92,86%, specificity – 92,16%. The extended main scale contained also such criteria as fibrinase, glutathione reduced, antithrombin III, NFA/EFA ratio of the blood plasma, its proteolytic activity by azocollagen, oxidation degree of plasma neutral proteins, the ratio of DC, KAT, 5G4 and G43A polymorphism of PAI-1 gene. A delimiting criterion of the extended basic scale was the sum of 17 points. Sensitivity of the extended basic scale was 100%, specificity – 95,83%.

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ULTRASONOGRAPHY AS A METHOD OF DIAGNOSIS OF VOCAL MOBILITY DISORDERS IN PATIENTS OPERETED ON DIFFERENT FORMS OF GOITER

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Operations on the thyroid and parathyroid glands are known to have a high risk of damage to the recurrent nerves responsible for voice formation.

For a patient, early detection of impaired mobility of the vocal cords may be a reason for timely consultation with a phoniatrician and subsequent, possibly complete recovery of vocal function. As for a surgeon, understanding the presence or absence of problems with the "vocal" nerves in patients can help to choose the right amount of surgery, and also helps to determine the need for neuromonitoring or optical techniques during surgery.

Currently, laryngoscopy is considered to be the most accurate method of diagnosing of impaired mobility of the vocal cords. However, its routine use is limited by the need for additional equipment and its disinfection, the presence of an ORL-doctor or endoscopist, as well as the risk of complications, including anaphylactic reactions when using local anesthetics. Also an important problem of subjectively unpleasant sensations in some patients, due to which it is impossible to