SURGICAL TACTICS IN COMBINED GYNECOLOGICAL AND SURGICAL PATHOLOGY

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Abstract. The problem of surgical treatment of combined diseases of the abdominal organs has long attracted the attention of specialists in various fields.

The combination of diseases of the abdominal organs and female genital organs is quite common and, according to various authors, ranges from 2.8 to 63%, in particular, diseases of the appendix accompany gynecological pathology in 3.1 - 3.3%, gallbladder - in 3.1 - 15% [4,6,7,8]. Simultaneous surgery is the simultaneous performance of two or more independent operations for various diseases for which surgical treatment is indicated [5].

Key words: gynecological and surgical pathology, appendix, simultaneous surgical, treatment, abdominal organs.

Improvement of the diagnostic capabilities of practical medicine, improvement of anesthesiology and resuscitation assistance during surgical interventions, introduction of new minimally invasive technologies into medical practice allow performing surgical interventions less traumatically, with minimal blood loss, significantly reducing the duration of the postoperative period. This creates real conditions for expanding the indications for simultaneous operations, reducing the number of intra- and postoperative complications, reduces the time the patient stays in hospital and the duration of temporary disability, and presents broad prospects for improving the results of surgical treatment of patients with combined diseases [1,3].

The idea of examining the abdominal organs by inserting lighting devices into it was first implemented in practice by the outstanding Russian obstetrician-gynecologist Dmitry Oskarovich Ott back in 1901. Since then, his method has been continuously developed, and today it is widely known as laparoscopy. Currently, laparoscopic access is widely used in all areas of surgery, and gynecology is no exception. According to some data, more than 90% of all gynecological operations in the world are currently performed laparoscopically [1].

One of the first triumphs of modern laparoscopic surgery was the performance of laparoscopic cholecystectomy by Ph. Mouret in 1987. The number of operations

on the biliary tract is steadily increasing every year, which is associated with the widespread increase in the incidence of cholelithiasis. According to summary statistics, in European countries the incidence of cholecystolithiasis has increased from 10.8 to 18.5% [4, 8].

Research objective: Improving the methods of combined surgical treatment of diseases of the pelvic and abdominal organs.

Material and methods: We examined 185 patients with various diseases of the abdominal and pelvic organs at the City Medical Association (endoscopic center) and in the 3rd maternity complex of Samarkand. All patients were divided into two main groups. The first group included 107 patients who underwent laparoscopic and traditional simultaneous operations (main group), the second - 78 patients with traditional surgery (control group), who underwent one isolated operation. In the main group of 107 patients, laparoscopic hysterectomy + laparoscopic cholecystectomy were performed in 47 (43.9%) patients with uterine myoma up to the size of 12 weeks of pregnancy; chronic calculous cholecystitis was performed in 40 (85.1%) patients, and acute calculous cholecystitis was performed in 7 (14.9%) patients. In addition, the main group is characterized by a combination of traditional and minilaparotomic operations. Laparotomy hysterectomy and cholecystectomy as a simultaneous stage for chronic calculous cholecystitis via minilaparotomic access were performed in 40 (37.4%) patients with uterine myomas larger than the size of 12 weeks of pregnancy. Also, in cases of complete and incomplete prolapse of the uterus, transvaginal extirpation of the uterus and, as a simultaneous stage, herniotomy for umbilical hernia was performed in 20 patients (Table 1).

Table 1. Nature of gynecological and surgical pathology in the main group

Gynecological pathology	**Surgical pathology**			**Total number of patients**
	Acute calculous cholecystitis	Chronic calculous cholecystitis	Umbilical hernia	
Uterine fibroids up to 12 weeks of pregnancy	7	40		47
Uterine fibroids larger than 12 weeks of pregnancy		40		40
Complete and incomplete prolapse of the uterus			20	20

The control comparison group consisted of 78 patients with gynecological and surgical pathology who underwent one operation (hysterectomy, ventroplasty, cholecystectomy). Indications for surgery were uterine myoma, endometriosis, chronic cholecystitis, and umbilical hernia.

To perform endovideosurgical operations, we used endovideosurgical equipment kits from Karl Storz.

Laparoscopy technique. To perform laparoscopic operations in the small pelvis, the patient was placed in the Trendelenburg position - an elevated pelvic end with an angle of 200-300. With these tilts, the intestinal loops are displaced into the upper abdominal cavity under the action of gravity and the pressure of the insufflated gas, which significantly improves the view of the recto-uterine cavity and facilitates access to the uterus and appendages, and laparoscopic cholecystectomy was performed in the Fowler position with the head end of the operating table raised by 200-250 and tilted by 150-200 to the left.

After processing the surgical field, pneumoperitoneum was applied. Carbon dioxide was introduced, which is easily and quickly resorbed, does not cause patients a feeling of pain or discomfort and does not form emboli, has a certain effect on the respiratory center and increases the vital capacity of the lungs.

In typical cases, the optimal place for insufflation of gas into the abdominal cavity is a point located in the area of intersection of the midline of the abdomen with the lower or upper edge of the umbilical ring. Carbon dioxide insufflation was performed using a Veress needle with a spring mechanism. A longitudinal skin incision of 10-11 mm in length was made along the midline of the abdomen, starting from the edge of the umbilical ring. The needle was inserted only by hand movement. The needle was tractioned with constant force, without interruption, until the sensation of the "falling through" effect and the appearance of a click of the spring mechanism. The optimal pressure for introducing carbon dioxide into the abdominal cavity is 12-14 mm Hg. After creating pneumoperitoneum, an 11 mm trocar was inserted, then a laparoscope. All patients underwent similar general anesthesia with the use of artificial ventilation against the background of the use of non-depolarizing muscle relaxants, based on multicomponent modern anesthesia with the use of central analgesics with a combination of neuroleptics, ketamine. Some patients received spinal anesthesia. The drugs were used in standard calculated dosages taking into account age and concomitant pathology.

Results and discussion. In the main group, all patients underwent simultaneous operations: laparoscopic hysterectomy + laparoscopic cholecystectomy in 47

(43.9%), laparotomic hysterectomy + minilaparotomic cholecystectomy in 40 (37.4%), transvaginal hysterectomy + umbilical hernioplasty in 20 (18.7%) patients. In the control group, only isolated operations were performed: hysterectomy in 33 (42.3%), transvaginal hysterectomy in 21 (26.9%), cholecystectomy in 11 (14.1%) and ventroplasty in 13 (16.7%) patients. Laparoscopic extirpation of the uterus with appendages due to myoma was performed in 47 patients, and laparoscopic cholecystectomy was a simultaneous stage of the operation. For such operations, patients were carefully selected (uterine size no more than 12 weeks of pregnancy, history of uncomplicated urgent deliveries, no previous laparotomies, no inflammatory process in the gallbladder and genital organs). For uterine myomas up to 12 weeks of pregnancy, we used the standard technique of laparoscopic extirpation of the uterus: laparocentesis up to 1 cm long was performed along the lower edge of the umbilical ring. CO2 gas was insufflated into the abdominal cavity using a Veresh needle, pneumoperitoneum was created with pressure reaching 15 mm Hg, after which the Veresh needle was replaced with a 10 mm trocar and a 10 mm laparoscope was inserted. After entering the abdominal cavity, two additional 5 mm trocars were inserted in the left and right iliac regions. Fixation of the cervix and expansion of the cervical canal were performed using the Claremont-Ferrand uterine manipulator (which has an "anatomical zone" of varying length depending on the length of the cervix) in order to ensure the position of the uterus in anteversio and a certain position of the posterior vaginal fornix between the uterosacral ligaments.

The ureters were isolated transparietally on both sides in the middle part of the posterior leaflet of the broad uterine ligament. This was done in order to safely cross the infundibulopelvic ligaments.

The uterine arteries were isolated transparietally and coagulated using the high-frequency coagulator AVTOKON 350 by monocoagulation in the "aerosol coagulation" mode with a coagulation effect of t3 (stage 3). The intersection of the round ligaments of the uterus, the infundibulopelvic and sacrouterine ligaments was also performed using monocoagulation.

Dissection and lowering of the plica vesico-uterina was performed by sharp and blunt means with scissors until the vagina was identified. The cervix was cut off from the vaginal vaults on the “anatomical zone” of the Claremont-Ferrand uterine manipulator. After this, the uterus with appendages was removed through the vagina and sutured from the outside with interrupted vicryl sutures. Peritonization was not performed. Upon completion of the operation, the abdominal cavity was sanitized, the surgical field was thoroughly examined and hemostasized, and it was drained.

The postoperative period in 1 (0.5%) patient was complicated by bile leakage from the stump of the cystic duct. Relaparoscopy was performed with the application of an additional titanium clip. There were no fatal outcomes.

After completion of the laparoscopic hysterectomy, the laparoscope was rotated by 1800, the patient was transferred from the Trendelenburg position to the Fowler position, and the abdominal organs, in particular the liver and gallbladder, were examined. During the simultaneous stage of the laparoscopic cholecystectomy, two additional 5 mm and one 10 mm trocars were inserted into the abdominal cavity in the right hypochondrium along the anterior axillary, midclavicular, and midline. The cystic duct and artery were isolated with an L-shaped monopolar coagulator, and titanium clips were applied to them. The gallbladder was completely isolated from its bed using mono-bipolar coagulators and removed from the abdominal cavity through a midline incision. Initially titanium clips were applied to a.cysticus, but our further studies showed that with a powerful coagulator such as AVTOKON-350 there is no need for its clipping.

All patients operated on for calculous cholecystitis, after the main stage of the operation, underwent thorough sanitation and drainage of the subhepatic space.

Laparotomic extirpation of the uterus for uterine myoma larger than 12 weeks of pregnancy and as a simultaneous stage minilaparotomic cholecystectomy for calculous cholecystitis were performed in 40 patients. Laparotomic extirpation of the uterus was performed using the standard technique with a Joel-Kohen incision. A set of surgical instruments developed by M.I. Prudkov was used to perform the simultaneous stage of minilaparotomic cholecystectomy. The set of instruments for minilaparotomy includes: a support circle for fixing retractor mirrors (retractors), mobile narrow mirrors, one of which is equipped with a point light source connected to the illuminator using a fiber optic light guide. The set of instruments also includes specially designed clamps, dissectors and scissors, as well as other devices that facilitate manipulations in the abdominal cavity through a minilaparotomy approach. Minilaparotomy cholecystectomy was performed with access through a pararectal incision, while the incision length did not exceed 6 cm, which was sufficient for safe manipulations in the hepatoduodenal ligament area. The duration of the operation increased by 20 ± 1.2 min compared to laparoscopic surgery. Blood loss was within 120-150 ml. In the postoperative period, 1 (0.5%) patient had parenchymatous bleeding from the vaginal stump in the early postoperative period. Relaparotomy was performed - ligation of the internal iliac arteries. The postoperative period was uneventful. There was no lethal outcome.

Of greatest interest is the combination of transvaginal hysterectomy and umbilical hernia. This pathology was present in 20 patients. The indication for these operations was complete prolapse of the uterus, as well as stress urinary incontinence, vaginal prolapse, and the presence of an umbilical hernia. The operation began with herniotomy, since the presence of infection in the umbilical wound in the postoperative period can lead to a relapse of the hernia. The skin above the navel was dissected in a semicircle above or below the navel. Then, with a scalpel, the skin of the navel was separated from the surrounding tissues and the hernial orifice was isolated. The contents of the hernia were resected (most often, this was the tissue of the greater omentum) and the hernial orifice was closed with interrupted sutures. Then they proceeded to perform a hysterectomy through the vagina. Many gynecologists underestimate vaginal hysterectomy and avoid performing it because they are convinced that the same thing can be done better and safer with an abdominal approach. A gynecologist experienced in vaginal operations has a good understanding of the anatomy of the area being operated on and sees it no less clearly than with abdominal operations. The operation began with the introduction of a vasoconstrictor solution to reduce vaginal tissue bleeding. After this, the anterior lip of the cervix was grasped with bullet forceps, the uterus was pulled back. A circular incision was made through all layers of the vagina, at a distance of about 3 cm from the external os of the uterus with a scalpel. By pulling the uterus toward the symphysis, the rectouterine space was exposed with a swab and opened with scissors and the left and right uterosacral ligaments were ligated alternately. After these manipulations, the uterus became more mobile and the plica vesico-uterina was opened with scissors. In this case, in order to prevent injury to the bladder, the scissors were held perpendicular to the uterus. Then, the uterine arteries, round ligament and infundibulopelvic ligaments were successively ligated and crossed. After checking hemostasis, the infundibulopelvic ligaments and round ligaments of the uterus were sutured together in order to form a strong, supporting suture under the peritoneum. The vagina was sutured with a continuous vicryl suture.

The total duration of the operation in the main group was 87.13 ± 13.2 minutes, and in the control group 77.13 ± 11.1 minutes. When performing laparoscopic simultaneous operations, the total duration of the operation decreased by an average of 21 minutes. When comparing the sizes of the surgical access, the use of laparoscopic technology made it possible to reduce the trauma of the access - the length of the surgical incision to 1 cm with laparoscopic performance of both stages of the operation.

Determination of the degree of blood loss in the main and control groups showed that in the main group, when performing simultaneous operations, blood loss was 94.4 □ 11.7, and in the control group, blood loss during surgery was 85.4 □ 16.4 ml. The above clearly shows that the difference in blood loss during simultaneous and isolated operations is insignificant.

When comparing the data of the postoperative period, the advantages in the main group were expressed in the fact that the need for pain relief was the same as in the control group.

The next indicator of the advantages of the main and control groups is the timing of patient activation and elimination of postoperative intestinal paresis and the beginning of feeding patients. In both groups, patients were activated on the 1st day, and oral feeding occurred on the 2-3rd day after the operation.

Conclusion. Thus, comparison of parameters indicating the trauma of the operation such as the total duration of the operation, the degree of blood loss, the need for pain relief and its duration in the postoperative period, the beginning of the patient's activation and the beginning of food intake showed that simultaneous operations do not differ in comparison with isolated operations.

REFERENCES:

1. Adamyan L. V. Endoscopic methods for performing simultaneous operations in gynecology / Adamyan L. V., Panin A. V., Kozachenko A. V. // Endoscopy in gynecology. - M., 1999. - P. 135-148.

2. Aleksandrov L. S., Ishchenko A. I., Vedernikova N. V. Combined operations in gynecology. Obstetrics and Gynecology. 2003; 4: 11-4.

3. Akhtamov J.A., Negmadzhanov B.B., Narzullaev H.B., Azimov S.A., Ganiev F.I., - Laparoscopy in gynecology and surgery // VI Congress of obstetricians and gynecologists of the Republic of Uzbekistan. Tashkent. October. 2003. Art. 245-246.

4. Bakov V.S. Simultaneous laparoscopic surgeries for combined diseases of the abdominal cavity and pelvic organs. Abstract of Cand. Sci. (Medicine) dissertation. Ryazan. 2000. -24 p.

5. Gordeev S.A. - Simultaneous laparoscopic surgeries http://www.cetl.ru/articles/surgery/art 31.phtml.

6. Emelianov S.I., Protasov A.V., Rutenburg G.M. Endosurgery of inguinal and femoral hernias. — SPb., 2000.

7. Zaporozhtsev D.A., Lutsevich O.E., Gordeev S.A., Prokhorov Yu.A. — New possibilities of operative laparoscopy in treatment of diseases of pelvic organs in combination with cholelithiasis // Endoscopic surgery.№6,2001,P.10-14.

8. Korkan I.P., Aldangarova G.A. Simultaneous operations in obstetrics and gynecology.// Clinician.- 1995,- №1, -P.30-34.

9. Puchkov K.V., Bakov V.S., Ivanov V.V. Simultaneous laparoscopic surgical interventions in surgery and gynecology. — M., 2005.

10. Rutenburg G.M., Protasov A.V. // Endoscopic surgery. - 1997. - No. 4. - P. 40-41.

11. Rozhkov A.G., Dronov V.I., Fomenko A.V., Petrov V.P. Combined laparoscopic operations.// Annals of surgical hepatology. M., 1996.- No. 1.- P. 60-61.

12. Sedov V.M., Strizheletsky V.V. Complications in laparoscopic surgery and their prevention. —34 Pacific Medical Journal, 2007, No. SPb.: St. Petersburg Medical Publishing House, 2002.