THERAPEUTIC AND SURGICAL MEASURES CARRIED OUT IN THE CASE OF SIMULTANEOUS PATHOLOGIES (COMBINATION OF GYNECOLOGICAL AND SURGICAL PATHOLOGY) IN WOMEN

Ganiev Fakhriddin Istamkulovich
Assistant, Department of Obstetrics-Gynecology №2
Samarkand State Medical University

Abstract. Numerous studies in recent years indicate not only the widespread occurrence of simultaneous diseases of the abdominal organs, but also unsatisfactory results of their treatment. In addition, simultaneous surgical treatment of patients with two or three diseases of the abdominal organs is a complex and not fully resolved problem [1,2].

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

Introduction: 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 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. The widespread use of endoscopic surgery has provided a unique opportunity to redefine the boundaries of two specialties - gynecology and surgery, since operative laparoscopy is not only equivalent, but also preferable to classical treatment [5,6]

Information about this is rare in the literature, although in practice many gynecologists and surgeons note the need to perform such operations.

In this regard, the goal of our work was to improve the methods of combined surgical treatment of diseases of the pelvic organs and abdominal cavity.

Materials and methods of research. The study is based on the analysis of the results of surgical treatment of 200 patients with various combined diseases of the

abdominal organs, who underwent simultaneous surgery. The patients were divided into two main groups: the first 107 patients who underwent laparoscopic and traditional simultaneous operations (main group), the second - 93 patients with traditional surgery (control group), who underwent one isolated operation.

The comparison of the surgical approaches used in performing simultaneous operations was made.

The average age in the main group was 38.6±6.6, and in the control group 41.3±5.9 years. It should be noted that all patients were of the most working age.

In the main group of 107 patients who underwent simultaneous laparoscopic interventions, 47 (43.9%) had calculous cholecystitis - chronic calculous cholecystitis was in 40 (85.1%), acute - in 7 (14.9%). In chronic calculous cholecystitis, cholecystectomy by minilaparotomy access was performed in 40 patients (37.4%), in case of complete and incomplete uterine prolapse, transvaginal extirpation of the uterus was performed in 20 (18.7%). Laparoscopic simultaneous stage of the operation was uterine myoma in 47 patients. In addition, the main group is characterized by the performance of a combination of minilaparotomy and traditional operations. Thus, the simultaneous traditional stage of the operation to calculous cholecystitis was uterine myoma of various localizations in 40 women, and in transvaginal extirpation of the uterus, the simultaneous stage was herniotomy for umbilical hernia in 20 patients.

The control group (comparison) consisted of 93 patients with gynecological and surgical pathology, who underwent one operation (hysterectomy, ventroplasty, cholecystectomy) for benign diseases (uterine myomas, endometriosis, vaginal wall prolapse, chronic cholecystitis or umbilical hernias). All patients were examined and prepared for surgery on an outpatient basis. Clinical examination of patients included a general blood and urine test, biochemical blood test, ECG, chest X-ray, ultrasound of the pelvic organs, liver and gall bladder. Ultrasound of the gall bladder and liver was performed to exclude gallstones, echinococcal cysts and other liver formations. Particular attention was paid to the degree of vaginal cleanliness, which should correspond to I-II degree.

Results of the study and their discussion. In 2010-2015, 5120 laparoscopic operations were performed, of which 107 (2.1%) were simultaneous.

Volume of operations	number of seats больных	в %
Laparoscopic cholecystectomy + laparoscopic hysterectomy	47	43,9
Minilaparotomic cholecystectomy + laparotomic hysterectomy	40	37,4
Transvaginal hysterectomy +umbilical herniotomy	20	18,7
Total	**107**	**100**

In the control group, all patients underwent only isolated operations: hysterectomy in 33 (42.3%) patients, transvaginal hysterectomy in 21 (26.9%), cholecystectomy in 11 (14.1%), and ventroplasty in 13 (16.7%), i.e. the same as those performed in the main group and also using classical methods, but one operation in each patient.

The decision on conducting simultaneous operations was made by a council with the participation of attending physicians, heads of departments, as well as with the participation of professors, associate professors and assistants of the Department of Surgery of the Faculty of Advanced Medical Studies and the Department of Obstetrics and Gynecology of the Pediatric Faculty of SamMI.

Laparoscopic cholecystectomy + laparoscopic extirpation of the uterus was performed in 47 patients. Laparoscopic cholecystectomy was performed using the standard technique: one 10 mm trocar was inserted through the navel, after which, under the control of the laparoscope, two 5 mm and one 10 mm trocars were inserted in the right hypochondrium along the anterior axillary, middle clavicular and midline. Using a monopolar coagulator, the cystic duct and cystic artery were isolated, hemostasis was performed using a bipolar coagulator and the preparation was removed from the abdominal cavity through a midline incision. After completion of the cholecystectomy operation, the laparoscope was rotated by 1800, the patient was transferred from the Fowler position to the Trendelenburg position, and the pelvic organs were examined. Laparoscopic extirpation of the uterus with appendages due to myoma in 47 cases was a simultaneous stage to laparoscopic cholecystectomy. For such operations, the selection of patients was carried out

carefully (uterine size no more than 12 weeks of pregnancy, history of uncomplicated urgent deliveries, absence of previous laparotomies and, as a consequence, the presence of a pronounced adhesive process, absence of an inflammatory process in the gallbladder and genital organs). Fixation of the cervix and expansion of the cervical canal were performed using the Claremont-Ferrand uterine manipulator 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 ligament of the uterus. 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 methods with scissors until the vagina was identified. The cervix was cut off from the vaginal vaults in the "anatomical zone" of the Claremont-Ferrand uterine manipulator. After that, the uterus with appendages was removed through the vagina and sutured from the outside with interrupted catgut sutures. Peritonization was not performed. At the end 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 and application of an additional titanium clip were performed. There were no fatal outcomes. Minilaparotomic cholecystectomy for calculous cholecystitis and, as a simultaneous stage, laparotomic extirpation of the uterus were performed in 40 patients. A set of surgical instruments developed by M.I. Prudkov was used for these operations. 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. Minilaparotomic 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 area of the hepatoduodenal ligament. Laparotomic extirpation of the uterus was performed using the standard technique with a Pfannenstiel incision. 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, parenchymatous bleeding from the vaginal stump occurred in 1 (0.5%) patient in the early postoperative period. Relaparotomy was performed -

ligation of the internal iliac arteries. The postoperative period was uneventful. There were no fatal outcomes.

Of greatest interest is the combination of transvaginal extirpation of the uterus and umbilical hernia. This pathology was present in 20 patients. The indication for these operations was complete prolapse of the uterus, as well as urinary incontinence during stress, 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. Then they proceeded to performing a hysterectomy through the vagina using the Steckel method.

In the control group, all patients underwent isolated surgeries: hysterectomy in 33 (35.4%) patients, transvaginal hysterectomy in 21 (22.5%), anterior colporrhaphy and posterior colpoperineoplasty in 15 (16.3%), cholecystectomy in 11 (11.8%), and ventroplasty in 13 (13.9%), i.e. the same as those performed in the main group and also using classical techniques, but one operation per patient.

A comparative study of two statistically comparable groups of patients who underwent simultaneous and single surgeries, according to clinical and laboratory studies, showed that no significant changes occurred in the patient's body associated specifically with simultaneous interventions.

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 ml, 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.

Our experience of laparoscopic gynecological single-stage operations performed entirely laparoscopically and in combination with traditional approaches reveals the advantages of this method, primarily due to low trauma and cosmetic effect. Therefore, when choosing an approach, we have recently been based on the ability to perform any operation or stage in any low-traumatic way, be it laparoscopic or mini access.

When comparing the sizes of 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 when performing both stages of the operation laparoscopically. When performing simultaneous operations by laparotomy access in the main and control groups, the incision length was identical (12-13 cm).

The total duration of the operation in the main group was 87.13±13.2 min, and in the control group 77.13±11.1 min. When performing laparoscopic simultaneous operations, the total duration of the operation decreased by an average of 21 minutes.

Conclusion. Thus, with high professionalism and accumulated experience of operators, as well as highly qualified anesthesiology and resuscitation support, simultaneous operations in gynecology and surgery through classical and combined approaches can take a worthy place in the practice of departments, since, subject to the above conditions, they do not pose a great danger to patients, and are perceived positively by them.

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