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OBJECTIVES OF ONPARK, INTERACTIVITY, AND RESULT OF PATIENTS TREATMENT WITH BLEEDING OF THE STOMACH AND 12 DUO FROM NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

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Acute gastrointestinal bleeding (GIB) is one of the most common causes of emergency hospitalization in hospitals. Mortality in this pathology has not decreased for 30 years and ranges from 5 to 14, in people over 60 years old it can reach 40% [1,2,21]. GCC can be detected in patients at any age from 18 to 89 years, 2-3 times more often in men than in women. Mortality rates are the same in both sexes [3,4,20]. The causes of acute GCC of non-ulcerative origin are: esophageal varices due to portal hypertension, Mallory-Weiss syndrome, polyps of the stomach and esophagus, erosive gastroduodenitis, erosive lesions of the esophageal mucosa, cancer of the esophagus and stomach and other causes. The cause of bleeding can also be medical ulcers and erosions, which are localized in any part of the gastrointestinal tract. From 42% to 60% of patients indicated prior gastrointestinal bleeding aspirin, non-steroidal anti-inflammatory drugs (NSAIDs), anticoagulants, antiplatelet agents. Some patients took 3 drugs per day: antiplatelet agents, anticoagulants and non-steroidal anti-inflammatory drugs [5,6,7,23]. Non-steroidal anti-inflammatory drugs (NSAIDs) are one of the most popular classes of drugs. The high effectiveness of non-steroidal anti-inflammatory drugs (NSAIDs) in pain, inflammation and fever, the possibility of purchasing drugs without a prescription explain their "popularity" among different population groups [8,9, 10.24]. In the United States, about 30 billion NSAID tablets are sold annually; in developed countries, these drugs are received by 20–30% of the elderly, among whom about 30% are forced to take these drugs, despite the presence of risk factors for the development of adverse events from

the gastrointestinal tract (gastrointestinal tract) and the cardiovascular system. To date, the doctor's arsenal has a huge number of NSAIDs that differ in chemical structure, but have the same effect. In the study of J.P. Hreinsson et al. it was found that the incidence of gastroduodenal bleeding in patients taking non-steroidal anti-inflammatory drugs (NSAIDs) is 371 per 100,000, which is 4 times higher than in the general population. According to world statistics, more than 30 million people daily take non-steroidal anti-inflammatory drugs (NSAIDs) [11,12,13]. The use of these drugs in routine clinical practice is progressively increasing both due to the aging of the population, and due to the growing prevalence of degenerative diseases of the musculoskeletal system, due to the peculiarities of the lifestyle of a modern person (prolonged forced sitting position, lack of adequate physical activity, nutritional etc.) [14,15,16,25]. NSAID-gastropathy occurs in the early stages from the start of taking *medications* (1-3 months). Unlike ordinary peptic ulcer disease, when the duodenal bulb is the predominant localization of ulcers, with NSAID gastropathy, gastric ulcers are detected more often - in a ratio of approximately 1: 1, 5. A typical localization of NSAID-induced ulcers and erosions is the antrum of the stomach, while ulcers are often single, relatively small and shallow, and erosions are often multiple [17,18,19,26]. Very often, with NSAIDs - gastropathy, there is no subjective symptomatology (the so-called silent ulcers). It should be noted that this phenomenon is often determined not by the true absence of symptoms, but by its moderate severity (the severity of pain is erased due to the analgesic effect of NSAIDs) or by the fact that complaints associated with the underlying disease bother the patient much more than complaints from the gastrointestinal tract. However, even the complete absence of complaints does not rule out the presence of a serious pathology. Therefore, endoscopic examination is the only timely and accurate method for diagnosing NSAID gastropathy. Risk factors for the development of NSAID gastropathy are: advanced age, a history of peptic ulcer disease, simultaneous use of glucocorticosteroids, high doses of NSAIDs or the use of several NSAIDs, simultaneous use of anticoagulants [27,28]. The success

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of treatment is based on early and accurate diagnosis of the causes of bleeding and the timeliness of a set of therapeutic measures, including conservative, endoscopic and, if necessary, surgical methods of treatment. Much depends on the timing of the patient's request for medical care from the onset of the disease, the timing of hospitalization, the timing of the diagnostic stage in the surgical department, as well as the severity of the patient's condition admitted to the hospital. According to the opinion of the Association of Rheumatologists of Russia, none of the existing non-steroidal anti-inflammatory drugs (NSAIDs) in the course of numerous randomized clinical trials has shown a significant advantage in the therapeutic effect. In this regard, the choice of NSAIDs, based on the nature, duration and severity of adverse drug effects during therapy, becomes relevant [29,30].

THE AIM OF

Our work was to improve the results of treatment of patients with bleeding from NSAIDs induced by OENP of the stomach and duodenum 12 and to develop a therapeutic and diagnostic algorithm for this category of patients.

Analysis of the treatment results in patients with gastrointestinal bleeding with the use of endoscopic and surgical methods of hemostasis. The cause of bleeding can also be medical ulcers and erosions, which are localized in any part of the gastrointestinal tract. From 42% to 60% of patients indicated prior gastrointestinal bleeding aspirin, non-steroidal anti-inflammatory drugs (NSAIDs), anticoagulants, antiplatelet agents. Some patients took 3 drugs per day: antiplatelet agents, anticoagulants and non-steroidal anti-inflammatory drugs . Non-steroidal anti-inflammatory drugs (NSAIDs) are one of the most popular classes of drugs.

Methods. Analysis of the treatment results in 275 patients with acute gastrointestinal bleeding from the urgent surgical department of Bukhara branch of the Republican cientific Center for Emergency Medical Care

Results. The patients were divided into groups II. The first group was studied retrospectively by studying 130 medical histories of patients with bleeding from NSAIDs induced by OEJP, who took traditional conservative treatment (hemostatics, angioprotectors, PPIs, H2-blockers, antacids) and underwent endoscopic diathermocoagulation. The second group conducted a prospective study, which included 145 patients of the main group taking drugs (traditional + omeprazole 20 mg + rebamipide 300 mg intravenously (slow drip) in 0.9% sodium chloride solution, 1.2-2.4 g 1 once a day and combined methods of endoscopic hemostasis) improving the quality of treatment and aimed at eliminating recurrence of bleeding.

Patients of the main group were performed along with endoscopic diathermocoagulation, infiltration of the bleeding site was performed by injection and irrigation with 96% alcohol. In the same group of patients, according to indications, other methods of injection hemostasis could be used. In this case, 96% ethyl alcohol is injected 1 mm directly from the source of bleeding at 4 points.

Conclusion. There were no deaths in the main group of patients. Conducting a combined method of hemostasis and correction of impaired liver functions in CDLD together with cytoprotective therapy, it is possible to reduce the number of recurrences of bleeding and avoid risky and pathogenetically unjustified surgical interventions. This tactic made it possible to reduce the number of operations in the main group in only 1 (0.7%) patients, against 6 (4.6%) in the control group .

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