GASTRECTOMY FOR GASTRIC DISEASES BLEEDING

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ANNOTATION: This paper presents the results of 17 gastrectomies (over the past 15 years) regarding acute gastric bleeding. To improve immediate functional results of treatment of patients, as well as to reduce the frequency of postoperative purulent-septic complications, reduce the exclusion of a large section of the small intestine, in the clinic a gastrectomy technique was developed. 5 (29.5%) patients were operated using this method. patients, with favorable results. Formation of esophagojejunostomy according to the developed technique allows for effective reduce intraduodenal pressure and the risk of developing failure esophagojejunostomy and thereby improves the immediate results of treatment of patients with bleeding stomach cancer.

Key words: gastric cancer, bleeding gastric cancer, gastrectomy, gastric Bleeding

Relevance: Despite significant progress in the diagnosis and treatment of surgical diseases stomach, their complicated forms, requiring urgent surgical interventions, are still observed to this day [1-3]. Among them, the most severe and life-threatening for patients are acute gastric bleeding (AGB), which often require gastrectomy [2,3]. Gastrectomy is an extremely complex and dangerous procedure. surgical intervention, which even in planned surgery is accompanied by a large number of postoperative complications and mortality, reaching 20%. The development of anesthesiology and resuscitation, the improvement of gastrectomy techniques in recent years have allowed in a number of cases significantly reduce the incidence of postoperative complications and mortality up to 2.5-5% [1,3]. It should be noted that in urgent surgery, gastrectomy is an urgent and at the same time forced surgical intervention, to which Most surgeons are extremely cautious about it because of the high risk it poses to the untrained patients. The literature provides extremely scanty information and a few reports of progress emergency gastrectomy [1,2].

The aim of the study is to improve the immediate results of surgical treatment of patients with acute gastric bleeding.

Material and methods. Over the past 15 years, the clinic surgical diseases №1 TSMU gastrectomy by 17 patients underwent OZHK. Among them There were 12 (70.5%) men and 5 (29.5%) women. The age of the patients ranged from 39 to 72 years. The nature of

diseases for which the procedure was performed gastrectomy, shown in Table 1.

As can be seen from the table presented, in 5 observations the cause of the acute gastritis was gigantic callous ulcer of the cardiac part of the stomach, in 4 – malignancy of the ulcer in the subcardium, in 4 cases - ulcerative-infiltrative form of cancer of the body of the stomach, in 2 cases ulcerative- infiltrative form of cancer of the stomach grew into the head of the pancreas and more in 2 cases - into the mesentery of the transverse colon intestines.

To diagnose the causes of gastroduodenitis, all patients underwent fibrogastroduodenoscopy and clinical and laboratory studies of red blood cell counts.

blood.

Results and their discussion. Upon admission patients in the clinic in all observations (n=17) noted the serious condition of the patients, caused by severe blood loss. Complex Conservative therapy using blood components was temporarily effective in 6 patients. Conservative and endoscopic methods in 11 observations. In our view, resistance to conservative therapy and endoscopic hemostasis was due to the fact that that the source of profuse gastric bleeding was the large branches of the left gastric and

TABLE 1. Diseases stomach , complicated sharp gastric bleeding (n=17)

Name of the disease	Number of patients	%
Giant callous ulcer of the cardiac part of the stomach	5	29.6
Suspected malignant ulcer of the subcardial part of the stomach	4	23.5
Ulcerative-infiltrative form of gastric body cancer	4	23.5
Ulcerative-infiltrative form of gastric cancer with	2	11.7

invasion into the pancreas		
Infiltrative form of gastric cancer with invasion into the mesentery of the transverse colon	2	11.7
Total	17	100

TABLE 2. Character operational interventions at sharp gastric bleeding (n=17)

Name of surgical interventions	Quantity	%
Gastrectomy according to Graham-Petrovsky	8	47.1
Gastrectomy using an improved technique	5	29.5
Combined gastrectomy with resection of the transverse colon	2	11.7
Gastrectomy with splenectomy and left-sided pancreatectomy	2	11.7
Total	17	100

pancreatoduodenal arteries. Nature of urgent surgical interventions performed is given in Table 2. At the height of profuse gastric bleeding 11 patients underwent surgical interventions out of 17. Moreover, all of them were operated on the first 2-4 hours from the onset of profuse gastric bleeding after a failed attempt at endoscopic hemostasis, the remaining patients (n=6) were operated on within 2 days after stopped by conservative measures bleeding. These patients had a high risk recurrence of bleeding or it has recurred, but was not profuse. Surgical interventions these patients were performed in a calmer environment environment, after a certain preoperative preparation. It should be noted that 3 patients were operated on in a delayed manner: two - if a diagnosis of adenocarcinoma has been established refused to be transferred

to the oncology center, third - a false negative result was obtained from the histological examination and intraoperative The discovery of a cancerous tumor was unexpected. Emergency gastrectomy according to Graham-Petrovsky performed on 8 patients with acute gastrointestinal tract infection. Combined Gastrectomy with resection of the mesentery of the transverse colon for invading gastric cancer performed on 2 patients, another 2 patients underwent gastrosplenectomy with left-sided resection of the pancreas. Possibility of establishing morphological structures of malignant tumors during interventions were available only for delayed (n=6) operations. Express biopsy to be performed also did not seem possible. In such cases the question of the scope of the operation was decided on the basis intraoperative assessment of local changes. In the postoperative period in 4 observations complications in the form of insolvency were noted esophagogastric anastomosis (n=1) and duodenal stump failure (n=1), which ended in death in one case. The presence of a cancerous tumor in 11 cases was established by microscopy of the removed stomach. In two cases, subhepatic abscess in patients with recurrent gastric bleeding. To improve immediate functional treatment results for patients, as well as to reduce frequency of postoperative purulent-septic complications, reducing the shutdown of the large section of the small intestine, a gastrectomy technique was developed in the clinic. In developing this methodology we relied on the following principles:

1. Formation of an esophagojejunostomy on a long loop of the small intestine accompanied by a significant increase in frequency failure of the duodenal stump intestines and enterointestinal reflux, due to high intraduodenal pressure;

2. The observed significant exclusion of small intestine sections during the formation of the esophagojejunostomy with the interintestinal anastomosis causes severe enteral nutrition disorders. According to the developed technique, great importance was attached to each stage of the operation, especially the mobilization of the duodenum and the isolation of the jejunum in the area of the duodenojejunal junction. For this purpose, the transitional fold of the peritoneum from the duodenum to the lateral abdominal wall was dissected, the hepatic flexure of the colon was separated from the anterior semicircle of the duodenum, the pancreatoduodenal complex was displaced from the inferior vena cava, the vessels of the mesentery of the transverse colon and the aorta. Additionally, the peritoneum was dissected over the elements of the hepatoduodenal ligament in the supraduodenal part. As a result, the angles of the transition of the upper horizontal section of the duodenum to the descending and descending to the lower horizontal are sutured, which makes it possible to lengthen the duodenal stump and perform its reliable treatment. The stomach is mobilized together with the ligaments, greater and lesser omentums. The esophagus is transected above the esophagogastric junction no closer than 4-5 cm from the upper border of the tumor, then the stomach is dissected approximately 1 cm distal to the

pyloric sphincter. The stomach is resected distally by 7-8 cm below the palpable tumor, then an end-to-side esophagojejunostomy is formed using the intussusception method (Fig. 1, 2). Subsequently, the anastomosis line is covered using a short afferent loop of the small intestine. Formation of esophagojejunostomy according to the proposed method allows to effectively reduce intraduodenal pressure and the risk rate of esophagojejunostomy failure, as well as significant exclusion of a section of the small intestine from the digestion process. Five patients were operated on using this method, with a favorable result. Histological examination of the preparation along the line of resection of the stomach and duodenal bulb did not reveal tumor growth, there were no complications or lethal outcomes, when measuring intrajejunal pressure using the open catheter method on days 3-4 and 6, no increase in intraintestinal pressure was noted. After two

weeks after surgery with esophagoenteroscopy, pathologies in the mucous membrane of the esophagus and small intestine did not reveal any subjectively expressed signs. dumping syndrome was not observed. Thus, in case of cardioesophageal pathology areas complicated by profuse gastric bleeding, it is possible to perform it according to indications emergency gastrectomy.

Conclusions

1. In case of bleeding stomach cancer, surgery intervention should be aimed at elimination of its source even during germination tumors in neighboring organs.

2. Gastrectomy for bleeding gastric cancer can be performed in compliance with all modern oncological principles, including number and using improved methods.

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