EFFECTIVENESS OF MILESTONE SURGICAL INTERVENTIONS CONSIDERING SEVERITY OF ACUTE PURULENT CHOLANGITIS

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Abstract. The results of surgical treatment of 144 patients with acute purulent cholangitis as a consequence of cholelithiasis have been analyzed. In the main group of patients (83), staged surgical treatment taking into account the severity of acute purulent cholangitis with the use of minimally invasive decompressive interventions made it possible to arrest the phenomena of cholestasis and purulent intoxication, and significantly improve the results of radical operations. Excessive sanitation of the biliary tract with 0.06% activated sodium hypochlorite solution contributed to the early relief of cholangitis. Achieved a decrease in postoperative complications from 24.5% to 12.1% mortality from 8.2% to 2.4%.

Introduction. Acute purulent holangitis (APH) has now acquired the status of an independent problem. It is believed that from 11 to 60% of patients with impaired passability of bile ducts are suffering from purulent cholangitis.

The continued interest in cholangitis is largely determined by unsatisfactory treatment results over the past 20 years, which is confirmed by high figures of lethality - from 11% to 64% even with timely surgical operations. In this case, the highest percentage of fatalities is given by emergency operations in combination with acute destructive cholecystitis and peritonitis due to the extreme severity of the operated patients. Without surgical permission, acute purulent cholangitis is thought to lead to death in 100% of cases.

As a rule, surgical treatment of patients with severe forms of purulent cholangitis is carried out in 2 stages. The first stage involves bile duct decompression by minimally invasive methods-endoscopic papillosfincterotomy or percutaneous cholangiostomy. As the second stage, patients undergo laparoscopic cholecystectomy (LCE) or cholecystectomy through mini-access with external drainage of choledoch. At the same time, 55% of patients need to perform single-step open operations due to the presence of destructive cholecystitis or peritonitis.

Dissatisfaction with the results of the treatment of purulent cholangitis, associated with the development of biliary sepsis, 6.5-30% of patients, dictates the need to optimize the tactical and technical aspects of the complex surgical treatment of this pathology. Progress in this area is possible with the combined use of mininvasive operations with percutaneous intrabilar procedures to sanitize bile ducts, prevent the formation of cholangiogenic abscesses in the liver and septic conditions.

Research objective. Improve results of treatment of patients with APC by optimizing tactical and technical aspects of complex surgical treatment.

Material and methods. 010-2019. in the surgical departments of the clinic of
the Samarkand Medical Institute, 144 patients of APC developed as a complication of housing and communal services were operated on. The age of patients ranged from 28 to 81 years, an average of 53 + 13 years. Male 53 (36.8%), female 91 (63.2%).

APC as a complication of LCD developed due to choledocholithiasis and chronic calculous cholecystitis in 82 (56.9%), acute calculous cholecystitis and choledocholithiasis in 62 (43.1%) patients, with acute destructive cholecystitis complicated by various forms of peritonitis in 29 patients (spilled-7, local-22).

Comorbidity was detected in 97 (67.3%) patients, mainly cardiovascular disease in 59 (40.9%), chronic obstructive pulmonary disease in 2 (14.5%), obesity in 48 (33.3%), diabetes mellitus in 12 (8.3%).

Diagnosis of APC was carried out on the basis of a clinical picture (Sharko triad, Reynolds pentad), laboratory and instrumental research methods (sonography, RPHG, MRI-cholangiography). The final diagnosis was established by characteristic changes in the walls of the bile ducts and bile with the definition of microflora.

Results and discussion. All patients were divided into 2 groups. The comparison group was 61 (42.4%) patients operated in the clinic from 2010 to 2014, the main one - 83 (57.6%), who were under treatment 2015-2019. In the main group of patients, treatment was carried out taking into account the severity of APC proposed at the conciliation conference in Tokyo (2006). In accordance with these criteria, the mild severity of APC is stated in 54 (65%), the average in 18 (21.6%), severe in 11 (13.2%) patients.

Patients with APC were subjected to various minimally invasive and open surgical interventions, taking into account the proposed severity criteria, as well as the presence of a clinic for acute destructive cholecystitis and peritonitis.

In the main group of patients with moderate severity (n = 18) and severe APC (n = 11), miniinvasive decompressive interventions were applied to 20 patients in the first stage of treatment. In 9 patients with acute destructive cholecystitis, gallbladder decompression was performed by transdermal-transhepatic microcholecystomy (PMCS) under ultrasound control. Endoscopic papillosphincterotomy (EPST) and nasobiliary drainage (NBD) were then performed on 5 of them. In the remaining 4 patients, ChMHC significantly stopped the clinical manifestations of APC. In 11 patients with APC without an acute cholecystitis clinic, the first stage was endoscopic transduodenal intervene- EPST with lithoextraction and NBD choledoch. The second step in these 20 patients on day 7-12 was cholecystectomy-LHE-13, MLKhE-7, with 4 MLHE supplemented with choledocholithotomy.

In 4 patients with a peritonitis clinic, laparotomy, CE, choledocholithotomy and abdominal sanitation were performed according to emergency indications. Another 5 patients with a progressive APC clinic with an unsuccessful attempt at EPST were treated with choledocholithotomy from an open miniaccess.

Thus, a two-stage surgical treatment was performed on 11 (61.1%) patients with moderate severity and 9 (81.8%) with severe APC. In mild-severity APC, a two-stage surgical treatment was performed on 13 (24.1%), a one-stage radical surgery was performed on 41 patients.

61 patients from the comparison group underwent surgery for the correction of APC due to housing and communal services - performed one stage - performed CE with choledocholithotomy from minia- 13, from a wide laparotomy access - 48 patients. At the same time, patients are operated with APC and acute destructive cholecystitis in 15, with a complication of acute destructive cholecystitis peritonitis in 12 cases. 34 patients were operated on for APC due to choledocholytiasis and chronic calculous cholecystitis.
The most formidable complications in the control group were cholangiogenic abscesses of the liver and biliary sepsis, which caused deaths in 4 patients. Continued peritonitis in another 1 observation resulted in an adverse outcome. Lethality was 8.2%. Purulent septic complications in the postoperative period were observed in 15 patients (24.5%) (Fig. 1).

In the main group, postoperative complications developed in 10 patients (12.1%), 2 (2.4%) patients died (1 - postoperative pancreatitis, 1 - ongoing peritonitis). Attention is drawn to the postoperative cupping of cholangiogenic abscesses of the liver and biliary sepsis.

**Conclusions.**

1. Step surgical treatment with decompressive interventions was carried out in 81.8% of patients with severe severity, 61.6% of moderate severity and 24.1% of patients with mild severity of APC. Optimization of the tactical and technical aspects of surgical interventions taking into account the severity of APC allowed to stop the phenomena of cholestasis and purulent intoxication, to improve the results of radical operations.

2. Percutaneous rehabilitation of the biliary tract contributed to the early cupping of cholangitis, the prevention of the formation of cholangiogenic abscesses and the development of biliary sepsis. Reduced postoperative complications from 24.5% to 12.1%, mortality from 8.2% to 2.4%.

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