CHOICE OF DRAINING LIGATION METHOD IN THE TREATMENT OF ACUTE PARAPROCTITIS

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Abstract: Severe inflammation is considered the most common pathology in urgent coloproctology. The issue of the development of fistulas of the immediate interior after the tense paraproctitis has been carried out remains unfinished at the present time. Primary radical actions in paraproctitis reduce the frequency of formation of fistulas of the immediate interior, but the presence of this method of healing surprises the muscular fibers of the locking unit of the immediate interior, which can cause anal incontinence. The significance of the draining ligature (loose set-on) in the treatment of fistulas of the immediate interior is widely popular and also well researched, which should not be noted regarding the use of this method in the treatment of strained paraproctitis.

Keywords: inflammation, drainage ligature, fistulas, immediate viscera, LIFT, incontinence.

ВЫБОР МЕТОДА ДРЕНИРУЮЩЕЙ ЛИГАТУРЫ В ЛЕЧЕНИИ ОСТРОГО ПАРАПРОКТИТА

Аннотация: Сильный воспаление считается наиболее зачастую встречаемой патологией в срочной колопроктологии. Вопрос развития свищей непосредственный внутренности уже после вынесенного напряженного парапроктита остается незаконченной в настоящий период. Первично-радикальные действия присутствие парапроктите уменьшают частоту формирования свищей непосредственный внутренности, но присутствие этом способе излечения удивляются мускульные волокна запирательного агрегата непосредственный внутренности, то что способен послужить причиной к заднепроходной инконтиненции. Значимость дренирующей лигатуры (loose set-on) в излечении свищей непосредственный внутренности обширно популярна а также хорошо исследована, чего же не следует отметить касательно использовании этого способа в излечении напряженного парапроктита.

Ключевые слова: воспаление, дренирующая лигатура, свищи непосредственный внутренности, LIFT, инконтиненция.

INTRODUCTION

Severe inflammation (anorectal congestion) is considered to be one of the most well-known diseases in emergency coloproctology [1]. Anorectal congestion is formed with representatives of the stronger sex 2 times more than with girls, the presence of this is more tormented by the society of the able-bodied year from the twentieth to the sixty years. In 90% of the situation, the appearance of paraproctitis is explained by the widely popular cryptoglandular concept, the other 10% are created as a result of injuries, inflammatory diseases of the intestinal tract, thin neoplasms of the immediate viscera, and other factors [2–6].

Operational detection and drainage of the acute purulent source is considered the only appropriate way to cure anorectal abscess [7]. The main problems of treatment are the elimination of the recurrence of the disease, as well as the healing of the scratch in the absence of the development of a fistulous pace [8–11]. The result of the action, the presence of a sharp

paraproctitis, largely depends on the ability of the pathology of the anatomical relationship among the cavity of the abscess and also the stricken anal crypt.

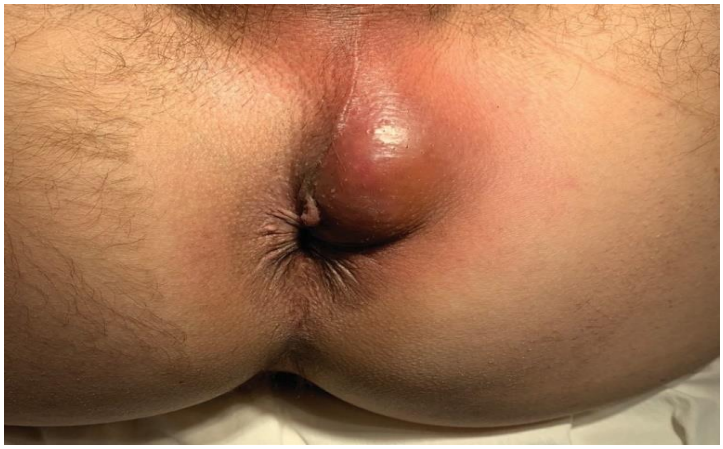

FIGURE 1. **Before incision and drainage of the paraproctitis**

The involvement of the immediate viscera in the acute inflammatory course of the muscle fibers of the obturator unit, as well as the chance of iatrogenic defects in the fibers of the anal sphincter, the presence of a spacious anatomy of the anal abscess, does not make it possible to use the rule of acute purulent surgery "where the pyosalpinx, then the incision" in the absolute verge. The necessary rational prudence in the presence of a decisive cure for tense paraproctitis leads to the formation of a relapse of the disease in approximately 44% of patients, which will require timely secondary interventions [12, 13]. Thus, the development of fistulas in the immediate viscera after the endured intense paraproctitis in the works of various creators can be traced in 26–87% of the situation [14–22].

FIGURE 2. **After incision of the parapractitis and application of a ligature**

In accordance with the writer's information collected to date, the identification and drainage of the abscess in the composition, together with the main fistulotomy, exactly reduces the threat

of fistula development. The key criteria in order to perform the main fistulotomy, in accordance with medical advice, are considered to be an opening in the stricken crypt identified in the absence of additional checks, and in addition, the determination in this that the part of the sphincter to be crossed will become insignificant for the purpose of the proper functioning of the obturator unit of the immediate viscera (less than 1 /3 sphincter thickness). In other embodiments, the therapy of an abscess, the acute purulent process of which includes a significant portion of the sphincter must be dispensed with by the usual opening and drainage, or by holding a draining ligature through a blindfolded crypt [7, 22, 23]. One of the main criteria for the security score of the dissection of a portion of the muscle sphincter, and also, in accordance with this, the selection of a method of treatment in the direction of the primary radical action is considered to be the doctor's skill, that, unfortunately, it establishes a largely individual form of solving these problems.

Taking into account the foregoing, it is possible to come to the conclusion that so far there are no elements and algorithms that allow you to clearly make your choice along with the use of this or other timely technology for the treatment of tense paraproctitis. The objective of the study: to evaluate the effectiveness of the draining ligature in a two-stage treatment of patients with paraproctitis.

MATERIALS AND METHODS

Sixty patients with acute ischiorectal paraproctitis were included in the retrospective study. Without exception, all patients were cut on an urgent basis at the basis of the multidisciplinary hospital of the Samara State Medical University, the Department of Proctology, between March 2022 and April 2023.

An important aspect of the introduction to the study was considered to be the highest (more than 1/3 portion) transsphincteric placement of the acute purulent pace, which was confirmed during the intraoperative verification process. All patients, without exception, were divided into 2 categories according to 30 individuals in any and also cut on an urgent basis under parenteral anesthesia in the state of Lloyd-Davies. Patients from category A underwent identification and drainage of the abscess. Patients from the Letter category were opened and drained an acute purulent depression, then, together with the support of the dye and a bellied probe, a shocked crypt was determined, by means of which a draining sign (“loose seton”) was placed in the scratch in the variant of a narrow and limited disinfected silicone tube (grass. 1 , 2). After the action, the patients were given daily dressings along with disinfectant solutions and liniments. Already after the healing of the perineal scratch, patients of the Letter category were hospitalized for the purpose of the 2nd stage of treatment, thus, as well as the establishment of a draining ligature, it inevitably led to the formation of a fistula in the immediate entrails for anyone in the study team. In 22 patients with category A, already after the opening of intense paraproctitis, an anorectal opening also developed, which caused a planned action. Short-term intervals among 2-stage cures in the usual cumulative 4.5 months in Team A and 4.3 months in Team Letter. Before a planned operation, patients of two companies underwent TRUS to remove the presence of streaks and cavities, which are an aspect of non-inclusion in the study, and also to measure the portion of the sphincter through which the fistula process proceeded. In addition, an individual and fair analysis of the function of the obturator assembly of the immediate viscera was made in accordance with this, along with the support of the questionnaire according to the Wexner scale and sphincteromanometry, together with the support of the Gastroscan SF-01 sphincterometer. With absolutely all patients, the meaning of sphincter pressure in calmness, as well as the presence of

sthenic contractile effort, settled down in the reference meanings of generally recognized measures.

By another stage, 22 patients with category A and 30 patients with category Letter were cut together with the use of combined LIFT technology and laser destruction of the fistulous pace. In the course of the action, through the external opening of the fistulous pace, the entire length of the end was carried out by a beam electrolaser light guide installed to the silicone leader. Already after the activation of the laser emission, the light guide moved back and forth with a speed of 1 mm/sec according to the direction from the inner hole of the fistulous pace to the outer one. Wave length - 1470 nm, emission power - 13 watts. Then the usual LIFT procedure was done. By means of a month after the action in patients, the role of the obturator unit in the immediate viscera was also assessed along with the support of the methods described above.

RESULTS

In 1 patient from category A, as well as 3 patients from the category Letter, already after pulling out the tampon on the 1st day, blood flow was formed from a postoperative scratch, which was blocked by tamponing with a collagen sponge in the circumstances of an auto-dressing office. In 4 patients from category A, already after opening the abscess, a repetition of intense paraproctitis was formed; according to the patients, there was a secondary detection and drainage of the abscess.

Already after the implementation of the 2nd stage of minimally invasive treatment, the final places of study were established. Thus, the cure was fixed if the external as well as the spiritual fistulous holes were completely closed. The recurrence was the recanalization of the fistulous pace after the previously fixed absolute healing of the fistula.

Pathology of the retention function already after the 2nd stage of treatment did not exist in any way;.

DISCUSSION

At present, there is no general view in the relationship of conditions and events aimed at lowering the notch of the formation of a relapse of intense paraproctitis and the subsequent development of a fistula in the immediate viscera. Undoubtedly, the fact that primary-radical actions exactly reduce the proportion of the formation of relapses of the disease and its transformation into a protracted configuration, but it is not always possible to implement them in the absence of intersection of a highly functionally important portion of the sphincter. In such cases, the doctor needs to meet with the issue of selecting the appropriate size of the cure: to carry out an elementary detection of the abscess along with the risk of recurrence of the course and the development of a difficult fistula, or to carry out a draining ligature, dooming the patient in advance to the formation of a fistula, however, the presence of this to keep the obturator device intact and also organize the patient to another period of treatment, a constant figure of paraproctitis [24–26].

The use of setons in the treatment of tense paraproctitis contributes to the removal of an abscess sawn off from the cavity and also prevents the formation of streaks and recurrences of an acute purulent course. In addition, tension-free ligatures have every chance of being used as fibrosis stimulators in the preliminary period before the minimally invasive treatment of fistulas directly inside, along with support for the LIFT, Filac, Fistula-plug methods. In the line of the situation, the draining sign perfects the results of the mentioned more minimally invasive actions, something that has been proven in our work. The sign, determined in the initial period of healing,

was intended with a pencil and also as a guide in finding the fistulous pace during the minimally invasive stage of healing, which reduced the period of action.

CONCLUSIONS

The results obtained in this work, without claiming to be unconditional, demonstrate that the use of a draining ligature in a two-stage treatment of paraproctitis makes it possible to implement decisive supervision over the drainage of the abscess, to develop a combined fistula process in the absence of spurs and streaks, to organize the patient for another period of surgical treatment and also in total to reduce the proportion of recurrence formation after minimally invasive treatment of fistulas of the immediate viscera in the absence of loss of function of the anal sphincter. The results of the 2nd stage of the cure of the patients introduced in our time study are considered to be confident in the future in the project of further possibilities of using the combined LIFT technology and laser destruction of the fistulous pace.

REFERENCES:

1. Абдуллаев С. А. и др. Хирургические тактики лечения сепсиса при сахарном диабете //наука и инноватsii в XXИ веке: актуальные вопросы, открытия и достижения. – 2019. – С. 190-194.
2. Yakhshiboyevich, S.Z., Isrofulovich2.Z., Shukhratovich, N.S. and ugli , K.N.B. 2023. Surgical Care for Injuries to the Duodenum. Central Asian Journal of Medical and Natural Science. 4, 1 (Feb. 2023), 177-181. DOI:https://doi.org/10.17605/OSF.IO/9VJMU.
3. Saydullaev Zayniddin Yakhshiboyevich, Murtazaev Zafar Isrofulovich, Narzullaev Shokhrukh Shukhratovich and Khaidarov Numonzhon Bazar ugli 2023. Surgical management of injuries to the small and large intestine. World Bulletin of Public Health. 19, (Feb. 2023), 31-34.
4. Shonazarov I. et al. Analysis of the results of surgical tactics and treatment in patients with acute necrotic pancreatitis //European Journal of Molecular & Clinical Medicine. – 2020. – Т. 7. – №. 3. – С. 3130-3135.
5. Нарзуллаев Ш. Ш. и др. Функциональное состояние остаточной тиреоидной ткани после операции диффузно-токсического зоба у пожилых и лиц старческого возраста //Наука, образование и культура. – 2021. – №. 2 (57). – С. 23-26.
6. Карабаев А. и др. Один из механизмов нарушения гипоталамо-гипофизарной системы в период постреанимационной болезни //Журнал проблемы биологии и медицины. – 2013. – №. 1 (72). – С. 44-46.
7. Джалолов Д. А., Карабаев А. Г., Карабаев Ж. А. Взаимотношения реактивности вегетативной нервной системы, показателей эндогенной интоксикации, и базофильных клеток аденогипофиза белых крыс //Вестник современных исследований. – 2018. – №. 4.2. – С. 47-49.
8. С.А. Абдуллаев, С.Т. Хужабаев, М.М. Дусияров, И.М. Рустамов. Тактика хирургического лечения гнойно-некротических осложнений мягких тканей у больных сахарным диабетом и диабетической стопы //Research Focus. – 2023. – Т. 2. – №. 1. – С. 399-404.
9. Хакимов Э. А. и др. Полиорганная недостаточность и исследование почек при ожоговой болезни //Академический журнал Западной Сибири. – 2013. – Т. 9. – №. 3. – С. 42-43.
10. Шеркулов К.У., Рустамов И.М., Усмонкулов М.К. Результаты лечения больных острым гангренозно некротическим парапроктитом //Research Focus. – 2023. – Т. 2. – №. 1. – С. 483-486.

11. I.M. Rustamov, J.A. Karabayev. Modern approach to the treatment of patients with acute gangrenous-necrotic paraproctitis //Research Focus. – 2023. – Т. 2. – №. 1. – С. 469-472.
12. РУСТАМОВ М. И. и др. Современная тактика лечения острого парапроктита //Журнал биомедицины и практики. – 2022. – Т. 7. – №. 2.
13. Rustamov M.I., Rustamov I.M., Shodmonov A.A. Optimising surgical management of patients with acute paraproctitis //Frontline Medical Sciences and Pharmaceutical Journal. – 2022. – Т. 2. – №. 02. – С. 36-42.
14. Кан С. А., Рустамов И. М., Шербекова Ф. У. Хирургическая тактика у больных с послеоперационной недостаточностью анального сфинктера //Молодежь и медицинская наука в XXI веке. – 2017. – С. 361-362.
15. Рустамов М.И, Давлатов С.С, Сайдуллаев З.Я, & Рустамов И.М. Хирургическое лечение больных гангреной фурнье //Журнал гепато-гастроэнтерологических исследований. – 2020. – Т. 1. – №. 2. – С. 69-71.
16. Рустамов И.М., Кан С.А., Рустамов М.И., Шербеков У.А., Дусияров, М. М. Анализ результатов хирургического лечения больных гангреной фурнье //Современные технологии: актуальные вопросы, достижения и инновации. – 2017. – С. 83-86.
17. Рустамов М. и др. Результаты хирургического лечения больных острым гангренозно-некротическим парапроктитом //Журнал гепато-гастроэнтерологических исследований. – 2020. – Т. 1. – №. 2. – С. 65-68.
18. Дусияров М.М., Рустамов И.М., Муртазаев Х.Ш., Шербекова Ф.У. Выбор оптимального метода лечения эпителиалъно-копчикового хода //Молодежь и медицинская наука в XXI веке. – 2017. – С. 358-358.
19. Дусияров М.М., Рахматова Л.Т., Рустамов И.М. Результаты хирургического лечения сложных свищей прямой кишки //Молодежь и медицинская наука в XXI веке. – 2017. – С. 358-359.
20. Рустамов М. И., Гафаров Р. Р. Хирургическая тактика в лечении больных с острым парапроктитом //Тюменский медицинский журнал. – 2011. – №. 2. – С. 17.
21. Рустамов М. И. и др. Обоснование хирургического метода лечения острого парапроктита //Национальная ассоциация ученых. – 2016. – №. 1 (17). – С. 9-10.
22. Isomiddinovich R. M. et al. The analysis of surgical treatment results in patients with Fourniers gangrene //European science review. – 2018. – №. 9-10-2. – С. 148-150.
23. УА Шербеков, МИ Рустамов, КУ Шеркулов, ШУ Байсариев. Диагностика и хирургическое лечение острых гнойных проктологических заболеваний// Молодежь и медицинская наука в XXI веке. – 2017. – С. 389-390.