

REPEATED RECONSTRUCTIONS OF THE DIGESTIVE TRACT IN THE SURGERY OF THE OPERATED STOMACH

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Abstract: Reconstruction of the digestive tract following stomach surgery poses unique challenges, particularly in cases of repeated procedures. This study investigates the intricacies and outcomes of repeated reconstructions in surgically treated stomachs. Patients undergoing multiple surgeries due to complications or disease progression necessitate careful consideration of surgical techniques, perioperative management, and long-term outcomes. Factors such as tissue viability, functional integrity, and patient nutritional status profoundly influence the choice and success of reconstruction methods. Advanced surgical approaches, including revisional procedures and innovative reconstruction techniques, have emerged to address these complexities. This review evaluates current literature, emphasizing strategies for optimizing outcomes and minimizing complications in the context of repeated digestive tract reconstructions post-stomach surgery

Keywords: Stomach surgery, Digestive tract reconstruction, Repeated procedures, Revisional surgery, Surgical techniques, Perioperative management, Long-term outcomes, Tissue viability, Nutritional status.

ПОВТОРНЫЕ РЕКОНСТРУКЦИИ ПИЩЕВАРИТЕЛЬНОГО ТРАКТА В ХИРУРГИИ ОПЕРИРОВАННОГО ЖЕЛУДКА

Аннотация: Реконструкция пищеварительного тракта после операций на желудке представляет собой уникальную задачу, особенно в случае повторных процедур. В этом исследовании изучаются сложности и результаты повторных реконструкций желудка, подвергнувшегося хирургическому лечению. Пациенты, перенесшие несколько операций из-за осложнений или прогрессирования заболевания, требуют тщательного рассмотрения хирургических техник, периоперационного ведения и долгосрочных результатов. Такие факторы, как жизнеспособность тканей, функциональная целостность и состояние питания пациента, глубоко влияют на выбор и успех методов реконструкции. Для решения этих сложностей появились передовые хирургические подходы, включая ревизионные процедуры и инновационные методы реконструкции. В этом обзоре оценивается современная литература, особое внимание уделяется стратегиям оптимизации результатов и минимизации осложнений в контексте повторных реконструкций пищеварительного тракта после операций на желудке.

Ключевые слова: хирургия желудка, реконструкция пищеварительного тракта, повторные процедуры, ревизионная хирургия, хирургические методы, периоперационное ведение, отдаленные результаты, жизнеспособность тканей, статус питания.

INTRODUCTION

Repeated reconstructive stomach surgeries traditionally constitute a separate section of surgical gastroenterology. Today, these open, technically complex and often unique operations have not lost their practical significance. In the modern literature, dissatisfaction with the functional results of standard options for gastric resection and gastrectomy is still emphasized.

Severe digestive disorders after primary operations on the stomach lead about 25% of patients to permanent disability and in 100% require medical rehabilitation. The pathogenesis of post-gastro-resection disorders is based on the loss of reservoir function, pyloric mechanism and duodenal passage of food. The cumulative damage to digestion exceeds its compensatory capabilities and inevitably leads to the development of pathological conditions: dumping syndrome, syndrome of malabsorption, agastral asthenia, cachexia, etc. The only radical method of treating diseases of the operated stomach and recurrent cancer is reoperation.

MATERIAL AND METHODS

In the period 2010-2020. In the 1st clinic of SamMI, 52 reoperations were performed on patients who had previously undergone resection, drainage and antireflux interventions on the stomach. As a primary surgical intervention, distal gastrectomy in the Billroth II modification was performed in 21 (41.3%) patients, gastrectomy in 12 (23.5%) patients. 11 (21.6%) patients had previously undergone proximal gastrectomy. There were 5 (9.6%) patients after gastric drainage surgery (including gastric bypass), and 3 (5.8%) patients after Nissen fundoplication. Indications for reoperation in 27 (51.9%) patients were diseases of the operated stomach, in 25 (48.1%) patients with recurrent cancer in the anastomosis and cancer of the gastric stump. The average age of patients was 55 years, there were 30 men (57.7%), and 22 women (42.3%). As a reoperation, gastric resection with Billroth I reconstruction was performed in 5 (9.6%) patients, Hofmeister - in 1 (1.9%) patient. Reconstruction on Rupetl was performed in 4 (7.7%) patients after extirpation of the gastric stump. Ejunogastroplasty was used in 30 (57.7%) cases, of which in 8 (15.4%) after distal resection, in 6 (11.5%) after extirpation of the gastric stump, in 2 (3.8%) after resection of esophagojejunoanastomosis ... Another 3 (5.8%) patients underwent inversion of the abduction loop in the duodenum, in 2 after gastrectomy with loop reconstruction and 1 after gastric resection according to the Hofmeister method. Esophagogastric anastomosis resection and Merendin oDillard operation were performed in 11 (21.2%) patients. The segment of the transverse colon was used as a plastic material in 2 (3.8%) patients: in 1 after extirpation of the gastric stump, in 1 after resection of esophagojejunoanastomosis. Esophagectomy with plastic surgery of the left half of the large intestine was performed in 8 (15.4%) patients, of which 5 (9.6%) with esophagojejunoanastomosis resection, and 3 (5.8%) with gastric stump extirpation. Another 1 (1.9%) patient, who had previously undergone gastric bypass surgery, extirpated the tumor-affected small stomach and thoracic esophagus, and the "turned off" part of the stomach was used as an isoperistaltic tube for subtotal esophagoplasty. Only 1 (1.9%) patient did not undergo reconstruction due to a deficiency of visceral reserve after multivisceral resection for recurrent cancer in the area of esophagojejunoanastomosis. who had previously undergone gastric bypass surgery, the tumor-affected small stomach and the thoracic esophagus were extirpated, and the "off" part of the stomach was used as an isoperistaltic tube for subtotal esophagoplasty. Only 1 (1.9%) patient did not undergo reconstruction due to a deficiency of visceral reserve after multivisceral resection for recurrent cancer in the area of esophagojejunoanastomosis. who had previously undergone gastric bypass surgery, the tumor-affected small stomach and the thoracic esophagus were extirpated, and the "off" part of the stomach was used as an isoperistaltic tube for subtotal esophagoplasty. Only 1 (1.9%) patient did not undergo reconstruction due to a deficiency of visceral reserve after multivisceral resection for recurrent cancer in the area of esophagojejunoanastomosis.

RESULTS

Postoperative complications occurred in 5 (9.6%) patients. Partial failure of esophagojejunoanastomosis developed at 2 (3.8%), duodenojejunostomy in 1 (1.9%) patient. All of them are arrested by adequate drainage and vacuum aspiration. Only 1 (1.9%) patient needed a relaparotomy due to necrosis of the colonic graft, which was resected with the removal of the nutritive colo and esophagostomy. There was one death on the 1st day after surgery from the progression of multiple organ failure. Hospital mortality was 1.9%. An important criterion for assessing the immediate result of re-reconstruction was its completeness, achieved in 96.2% of cases. In 2 patients (3.8%), the reconstruction remained incomplete. The long-term result of reconstructive surgery was assessed using a three-point modified Visick scale, taking into account the patient's well-being, the dynamics of his nutritional status, and the presence of certain digestive disorders. At the time of the end of the study, there were 44 (86.2%) out of 51 the patient. Examination of the patients revealed that 26 (59.9%) good, 12 (27.4%) satisfactory result. Only 6 (13.7%) patients received relief from the repeated operation.

Findings. Evaluation of the results obtained demonstrates the relief of pathological syndromes of the operated stomach in most cases, which indicates the advisability of repeated operations with gastropasty and restoration of the duodenal passage.

CONCLUSION

Repeated reconstructions of the digestive tract following surgery on the stomach represent a challenging aspect of surgical management. The complexities inherent in these cases demand a nuanced approach that considers both patient-specific factors and surgical techniques. Through an exploration of the literature, it is evident that successful outcomes hinge on a thorough understanding of the underlying pathology, meticulous surgical planning, and vigilant postoperative care.

While the need for repeated procedures may arise due to complications or disease progression, advancements in surgical techniques and perioperative management offer promise for improved patient outcomes. Novel approaches, including revisional procedures and innovative reconstruction techniques, demonstrate potential for addressing the challenges associated with repeated reconstructions.

However, it is essential to acknowledge the limitations and risks inherent in these complex cases. Patient selection, careful consideration of tissue viability, and proactive management of nutritional status remain critical aspects of surgical decision-making.

Moving forward, interdisciplinary collaboration, ongoing research efforts, and the dissemination of best practices will be instrumental in further refining strategies for optimizing outcomes and minimizing complications in patients undergoing repeated reconstructions of the digestive tract following stomach surgery. By embracing innovation while prioritizing patient safety and well-being, the field can continue to advance towards more effective and personalized surgical interventions.

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