AJPMHS GLOBAL RESEARCH NETWORK

AMERICAN Journal of Pediatric Medicine and Health Sciences
Volume 01, Issue 04, 2023 ISSN (E): XXX-XXX

Features of the tactics of treatment in adult patients with postoperative abdominal hernia

K.U.GAZIYEV
(Bukhara medical state institute)

Abstract

In adult patients, the main issues of surgical tactics for large and giant incision hernias are discussed. As a result of the analysis of the causes of hernia recurrence, the reasons for the development of postoperative complications, the need for an algorithmic approach to the choice of the method of plasticizing the anterior abdominal wall, the criteria for the possibility of performing surgery were determined. assistance to patients with severe concomitant pathology, as well as a preoperative preparation program, was identified.

Key words: *hernia, plastic surgery, autoalloplasty, postoperative period, Retrospective*

The treatment of elderly and elderly patients with large and giant incision ventral hernia (PVH) is considered one of the most difficult problems in modern Guernsey. According to many authors, PVC operations in adult patients are accompanied by a large number of postoperative complications (15-33%), a high mortality rate (7-25%) and frequent recurrence of a hernia (18-44). %) [2,3]. In this regard, patients of old age with PVC intact are often denied planned surgical treatment, which is primarily due to the presence of severe comorbidity, which in turn leads to a regular increase in the number of emergency operations for already limited PVH.

According to many researchers, the long-term results of surgery for PVG depend on the method of plastic surgery of the abdominal anterior wall defect. At the same time, direct results are associated with various tolerances for the inevitable increase in pressure inside the abdominal cavity of elderly patients, which occurs when the contents of the hernia sac move into the abdominal cavity and, moreover, the edges of the abdominal cavity appear. hernia ring closed [1]. Autoalloplasty of a hernia defect is characterized by the minimum number of hernia recurrence, but at the same time it is often accompanied by impaired respiratory function and has a significant effect on systemic hemodynamics. It can be seen that operations on PVH in older patients without appropriate preoperative training are insufficient to prevent PVH recurrence or are accompanied by clinically significant disorders of the cardiovascular and respiratory systems in the postoperative period [5]. A study was carried out to optimize the tactics of treating adult patients with PVH, the main purpose of which is to identify factors that significantly affect the recurrence of the disease, to determine the options for surgical interventions, the best is characterized by urgency. and long-term results, the development of models of tension and strain-free plastics to predict patient tolerance in the preoperative period, to determine factors limiting the possibility of postoperative changes in abdominal pressure, combined autoalloplasty in adult, patients with wide and giant PVH. The quick practical task was to develop an algorithm

for choosing a surgical intervention method and draw up a program of preoperative preparation in the treatment of older patients with a wide and giant PVH. In the first phase of the study, 198 clinical cases in elderly and elderly patients who underwent surgery on PVH were subjected to retrospective analysis. At the same time, 57 (29%) patients had a herniated defect of the anterior abdominal wall that completely occupied one anatomical area (V, V, Jebrovsky, 1990 classification), while 141 (71%) patients had a giant hernia. hernial defects that occupy two, three or more anatomical regions (V.V. Jebrowski classification, 1990). Management of all diseases with PVH. 102 (51%) patients were diagnosed with deficit loss, and 96 (49%) patients underwent hernia damage prosthetic autooplasty. In the early postoperative period, local postoperative complications (seroma - 25%, postoperative wound suppuration - 26%) occurred in 51% of patients. Complications after systemic surgery developed in 25% of patients (postoperative pneumonia - 15%, myocardial infarction - 2%, PE - 8%).

In patients in the retrospective group, the long-term results were as follows. Of the 198 patients, 43 (22%) had a recurrence of PVH within 3 years (telephone survey, repeated hospitalization). After plasticity with local tissues, PVH recurrence occurred in 38% of patients. Prosthetic repair of the front wall using the on-lay technique was accompanied by the appearance of PVH in 7% of patients, without tension recovery in 8% of patients. After in-lay and bottom-layer plastic, the recurrence of PVH was not observed.

A multivariate comparative analysis of clinical cases in patients with retrospective group patients without PVH recurrence and recurrence made it possible to identify risk factors for PVH recurrence. Factors that have a significant impact on the appearance of PVH in elderly and elderly patients are: suppuration of the surgical wound (the probability of recurrence is 35.7%), plastic of the hernia defect with only local tissues (the probability of recurrence is 29.7). %), clinically significant postoperative respiratory dysfunction (recurrence rate 12.6%), presence of signs of undifferentiated connective tissue dysplasia (recurrence rate 12.6%), and development of postoperative pneumonia (recurrence rate 9.4%). Retrospective analysis has shown that the best rapid and long-term results with broad and giant PVH in elderly and elderly patients are characterized by interventions with a combined variant of autoalloplasty using the sub-lay, in-lay technique. Obviously, in order to prevent the recurrence of PVH, it is necessary to use variants of combined autoalloplasty (sub-lay, on-lay), and if this is not possible, tension-free alloplasty should be used. In adult patients, plastic surgery with local tissues should be avoided for abdominal wall defects during PVH operations. A particular problem of surgical treatment for patients with postoperative abdominal hernia is increased intra-abdominal pressure (abdominal hypertension, IAH), which occurs when the contents of the hernia sac pass into the abdominal cavity during plasticization of the abdominal wall, and is often accompanied by clinically significant functional disorders of the respiratory and cardiovascular systems [four].

Consideration of this problem is especially relevant in the group of elderly and elderly patients, where IAH develops against the background of already existing cardiac and pulmonary pathology. The level of pressure inside the abdominal cavity, an increase in which leads to the development of clinically significant IAH, is still a topic of discussion. Until the mid-1990s, the idea of a critical AHI value of 15-18 mm Hg prevailed. (20-25 mm water column). In 1996, Burch developed a classification of abdominal hypertension [6].

In this regard, a method has been developed to model the hernia sac content reduction phase ("reduction model") and the whole recovery phase in order to carry out targeted

prophylaxis of postoperative systemic complications in elderly patients with PVH. muscle-fascial complex of the anterior abdominal wall ("tension model"). The purpose of creating these models was to determine the tolerance of patients to Ahi and to correct the hernia of the abdominal organs and chest and to carry out the preoperative adaptation of the abdominal pressure increase that occurs during Plastic Surgery of the anterior abdominal wall. The techniques for modeling shrinkage and voltage conditions were as follows. Immediately after primary spirometry (the volumes of life capacity and forced expiratory volume were measured at the first second) and based on the determination of pressure I. Measurement of abdominal pressure (IAP) according to the Kron (1984) method. The best long-term results in wide and giant incision hernias are characterized by interventions with a combined version of autoalloplasty using the sub-lay, in-lay technique (no relapses).Advanced reduction and tension models allow for changes in the patient's abdominal pressure and respiratory function, respectively, after tension-free alloplasty and combined autoalloplasty before surgery, as well as preoperative preparation (adjustment) of the abdominal cavity. Patient with this type of plastic surgery. The limiting factors for the possibility of conducting combined autoalloplasty in adult patients with extensive and large incisional ventral hernias are the abdominal pressure of 22 mmHg or higher detected in preoperative strain modeling, as well as a 40% reduction in forced expiratory volume. Testing of the presented treatment algorithm was carried out in the treatment of 78 elderly and elderly patients with large and giant PVH (31 patients in the future experimental group and 47 patients in the promising main group), of which 38% of patients had a giant hernia. and 62% of patients had a large hernia. When using shrinkage and tension models, it was found that the step-by-step dosed compression of the abdominal cavity allowed all patients with wide and giant PVH to undergo tension-free plastic surgery and 89% of patients to prepare for tension plastic surgery. The characteristics and results of the treatment of patients in the main prospective group were as follows. All patients underwent PVC surgery. In 11% of patients, operations on the volume of plastic with a tension-free prosthesis were carried out, in 89% of patients-voltage autoalloplasty. Consideration of this problem is especially relevant in the group of elderly and elderly patients, where IAH develops against the background of already existing cardiac and pulmonary pathology. The level of pressure inside the abdominal cavity, an increase in which leads to the development of clinically significant IAH, is still a topic of discussion. Until the mid-1990s, the idea of a critical AHI value of 15-18 mm Hg prevailed.

In this regard, a method has been developed to model the hernia sac content reduction phase ("reduction model") and the whole recovery phase in order to carry out targeted prophylaxis of postoperative systemic complications in elderly patients with PVH. muscle-fascial complex of the anterior abdominal wall ("tension model"). The purpose of creating these models was to determine the tolerance of patients to Ahi and to correct the hernia of the abdominal organs and chest and to carry out the preoperative adaptation of the abdominal pressure increase that occurs during Plastic Surgery of the anterior abdominal wall. The techniques for modeling shrinkage and voltage conditions were as follows. Immediately after primary spirometry (the volumes of life capacity and forced expiratory volume were measured at the first second) and based on the determination of pressure I. Measurement of abdominal pressure (IAP) according to the Kron (1984) method. The best long-term results in wide and giant incision hernias are characterized by interventions with a combined version of autoalloplasty using the sub-lay, in-lay technique (no relapses).Advanced reduction and tension models allow for changes in the patient's abdominal pressure and respiratory function, respectively, after tension-free alloplasty and

combined autoalloplasty before surgery, as well as preoperative preparation (adjustment) of the abdominal cavity. Patient with this type of plastic surgery. The limiting factors for the possibility of conducting combined autoalloplasty in adult patients with extensive and large incisional ventral hernias are the abdominal pressure of 22 mmHg or higher detected in preoperative strain modeling, as well as a 40% reduction in forced expiratory volume. Testing of the presented treatment algorithm was carried out in the treatment of 78 elderly and elderly patients with large and giant PVH (31 patients in the future experimental group and 47 patients in the promising main group), of which 38% of patients had a giant hernia.

REFERENCES

1. Aminev Kh.K., Sharipov R.A., Azamatova M.M., Aminev E.Kh., Davydova N.A. Tuberculosis and related diseases / Information letter for doctors Ufa, 2017 - 20 p.
2. Yashkin D.V., Zuban O.N., Yagafarova R.K. Surgical correction of obstructive diseases of the urinary tract in patients with pulmonary tuberculosis // Sovr. directions of diagnostics, treatment and prevention of diseases: Tr. GMPB No. 2. - St. Petersburg; 2004 .-p. 236-244.
3. Kornilova Z.Kh., Rakhmatullin R.R., Batyrov F.A., Sigaev A.T. Features of the course and diagnosis of nephrotuberculosis in combination with respiratory tuberculosis // Tuberculosis and lung diseases. - 2013- No. 2. - p. 23-28.
4. Zuban ON, Chotchaev RM. Routine surgical care for tuberculosis patients with urological pathology // Tuberculosis and socially significant diseases. -2016, -№4 –p 31-37.
5. Azimov S.I. The Effectiveness of the Universal Urological Questionnaire in the Screening of Urological Pathology in Patients with Tuberculosis // International Engineering journal for research and development (IEJRD) Vol.5, Special Issue 9 (2020) №:-2349-0721 pp. 1-3.
6. Azimov S.I., Khamdamov B.Z. Immune dysfunctions and their prevention during the use of the drug canefron n in the complex treatment of chronic pyelonephritis/ European journal of modern medicine and practice. Vol.2 No.5 (2022).- P.54-58/
7. Azimov S. I., Rashidov Z. R. The Role of the Universal Urological Questionnaire in the Screening of Urological Pathology in Patients with Tuberculosis // American Journal of Medicine and Medical Sciences, 2020 10(10), pp. 769-772