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INTESTINAL OBSTRUCTION.

***Abstract:** this article provides information about intestinal obstruction and its treatment*

***Key words:** abdominal, endotoxiosis, gastrointestinal tract, detoxification therapy.*

A patient with suspected acute intestinal obstruction should only be examined, monitored and treated in a surgical hospital. If there is a suspicion of the presence of an abdominal cavity, it is necessary to take all measures for emergency hospitalization. At the pre-hospital stage, symptomatic therapy is carried out, which may be necessary to compensate for the functions of vital systems in severe forms of endotoxiosis and dehydration.

In the emergency room, the patient is examined, and in the case of a diagnosis of acute mechanical intestinal obstruction, the issue of treatment tactics is resolved.

1. Decompression of the gastrointestinal tract;
2. Replacement therapy;
3. Treatment of intestinal insufficiency;
4. Endotoxiosis treatment.

For decompression of the gastrointestinal tract, various probes are used. The simplest and most common method is nasogastric drainage - it allows you to permanently evacuate the contents of the stomach. In addition to the action of decompression and detoxification, it allows you to slightly reduce the secretion of the stomach and intestines. Methods other than nasogastric drainage have

been proposed for conservative drainage of the upper parts of the small intestine. It is necessary to hold the probes behind the pyloric pulp using an endoscope or rely on the independent development of peristalsis. Distal placement of the probe in the pulp of the pyloric increases the efficiency of decompression of the gastrointestinal tract.

In a number of cases, it is advisable to do this if the suffocation was short-lived and not all of these signs were expressed. measures to restore blood circulation in the intestine. To do this, the intestine is heated by wrapping it with a handkerchief moistened with a warm saline solution, a Novocain solution is injected at the root of the handle. (0.25% - 80-100 ml.) ... The appearance of pink color, peristalsis and pronounced pulsation of the mesenteric arteries indicate the restoration of blood circulation in the intestinal wall. All doubts about the viability of the intestine should be interpreted in the same way in favor of resection. Unfortunately, there is currently no generally accepted method of objective diagnosis of intestinal viability.

Sometimes with sticky intestinal obstruction, the intestine is deformed as a result of cicatrice adhesions to the extent that its isolation is impossible or dangerous. Even in similar situations, cicatrice changes in the intestine must be resected.

Emptying the Joint parts of the intestine provides decompression of the intestine, intraoperative eliminating toxic substances from its lumen (detoxification effect) and improving conditions for manipulation - resection, intestinal suture, anastomosis. It is indicated in cases where the intestine is significantly stretched by fluid and gas... Before opening the lumen, it is preferable to evacuate the contents of the adductor ring. The best option for such decompression is the nasal drainage of the small intestine according to Vangenshtin... A long probe that passes from the nose to the small intestine, spilling it along its entire length. After removing the contents of the intestine, the probe can be left for longer decompression.

Sometimes it is impossible to open the intestine without opening its lumen. In such cases, enterotomy is opened, and the contents of the intestine are evacuated using electric suction. To prevent infection with the help of this manipulation, it is necessary to carefully distinguish the opening of enterotomy from the abdominal cavity.

Prolonged decompression of the gastrointestinal tract is indicated for viscous obstruction, when isolated from adhesions, with pronounced symptoms of intestinal trauma, small intestinal obstruction, hypextension of the intestinal wall, its swelling, venous stasis and lymphostasis (especially if the small intestine is involved in paralytic changes) and anastomosis with forms of colon obstruction should be placed). Main functions of extended decompression:

- Removal of toxic content from the intestinal cavity;
- * Intestinal detoxification therapy;
- Effect on the intestinal mucosa, restoration of its barrier and functional viability;
- * Early enteral nutrition of the patient.

There are 5 main types of small intestine drainage.

1. Transnasal drainage of the small intestine.

This method is often referred to by the name Vangenstin or T.Miller and W. Although there is evidence that Abbot was the forerunners of transnasal intestinal intubation with Abbott-Miller (1934) during the operation. G.A.Smith (1956) and J.C. Turner (1958). This decompression method is most optimal due to its minimal invasiveness. The probe is transferred to the small intestine during surgery and is used both for the operation of the small intestine and for extended decompression. The disadvantage of this method is a violation of nasal

breathing, which can lead to a deterioration in the condition of patients. chronic diseases provoke the development of pulmonary or pneumonia.

2. The proposed method is J.M. Ferris and G.K.Smith was described in detail in 1956 and in Russian literature by YM Dederer(1962), intubating the small intestine through a gastrostomy tube, devoid of this defect and showing it to patients who for some reason were unable to pass a probe through the nose or had nasal breathing as a result of an examination. risk of postoperative lung complications.

3. Drainage of the small intestine through enterostomy, I.D. Zhitnyuk was widely used in emergency surgery before the appearance of commercially available probes for nasogastric intubation. This involves retrograde drainage of the small intestine through a suspended ileostomy.

(There is an antegrad drainage method through jejunostomy J.W.Baker(1959), separate drainage of the small and proximal intestine through suspended enterostomy White (1949) and many of their modifications). These methods seem to be the least preferred due to possible complications from the enterostomy side, the risk of developing a small Intestinal Fistula at the site of the enterostomy, etc.

4. Retrograde drainage of the small intestine through microchecostomy (G.Shayde, 1965) can be used in cases where antegrad intubation is not possible.

Perhaps the only drawback of the method is the difficulty of passing the probe through the Bauhinia valve and dysfunction of the ileosecal valve. After removing the probe, cecostomy usually heals on its own. A variant of the previous method is proposed I. S. Mgaloblishvili (1959) method of drainage of the small intestine through appendicostomy.

5. Transrectal drainage of the small intestine is used only in pediatric surgery, although it has been successfully used in adults.

Many combined methods of drainage of the small intestine have been proposed, which include both closed elements (not related to opening the lumen of the stomach or intestines) and open methods.

Usually a probe is removed from the small intestine 4-5 days after surgery. When adhesive obstruction occurs as a result of adhesive processes, it is recommended to extend decompression for 7 days, since in this case the probe plays the role of a frame that prevents the formation of new stenosing adhesions.

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