

**SURGICAL APPROACH IN TREATMENT
RECURRENT GOITER DIVING FOR THE TRACHEA**

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D.A CHOICE OF SURGICAL TACTICS IN THE TREATMENT

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Abstract: the review article describes 41 recurrences of complications that were observed in the postoperative period after 426 strumectomy performed over the past 10 years. A complex technique for performing surgical interventions in the form of the formation of the thyroid gland (nodule or cyst) behind the trachea in various forms, mostly recurrent with these complications.

Much attention is paid to the description of the operation technique. At the same time, when mobilizing the thyroid gland, taking into account the anatomical features of the neck, it is important to consider what is important when separating each layer. Measures taken to avoid injury to adjacent organs due to complications that may occur during surgery are described in detail.

The procedures and recommendations received by patients in the postoperative period are described in detail, conclusions and recommendations are described.

Key words: goiter recurrence, thyroid gland, strumectomy.

For recurrent diving goiter, the main treatment for recurrent goiter is surgery (2, 6). The danger of respiratory disorders due to compression, movement behind the trachea and displacement of the trachea, the threat of asphyxia make surgical intervention vital (1, 4). As a rule, 45 can usually be removed from a wide Kocher incision on the neck. Internal capsular removal is easy and safe. After suturing and pulling on the lower pole, the knots can be exposed into the wound and removed (5, 7). In this case, it is necessary to take precautions so as not to damage the blood vessels, recurrent nerves, which can lead to various complications.

Material and methods

From 2012 to 2022, 426 patients with various forms of goiter were hospitalized and operated on at the surgical department of the Andijan Regional Multidisciplinary Medical Center. Among them, 41 patients with recurrent goiter, previously operated in various medical institutions. In all, the clinical picture

proceeded under the guise of broncho-obstructive syndrome. The frequency was 10.1 of the total number of patients operated on for various forms of benign diseases of the thyroid gland (TG). There were 6 (20.0%) men, 35 (80.0%) women, age from 19 to 71 years. Among the observed patients, 70.2% were women of reproductive and working age. Out of 41 patients, 5 (17.7%) had manifestations of thyrotoxicosis, 36 (82.3%) were euthyroid. All patients in the postoperative period for a long time (from 1 to 10 years) were examined and treated by various specialist

One of the most difficult and controversial issues in the surgical treatment of 41 patients with recurrent tracheal diving goiter is the choice of an operative approach and its extraction, which is determined by the depth of the goiter.

All 41 patients with recurrent diving for tracheal goiter were operated on through a cervical incision under general anesthesia. Benign thyroid diseases were detected in 36 (80.7%) patients, thyroid cancer - in 5 (19.3%) patients. Recurrent nodular and multinodular euthyroid colloid goiter was detected in (3.8%) patients, nodular toxic goiter in (1.4%) patients.

In case of recurrent nodular and multinodular goiter, subtotal resection of one lobe and extirpation of the isthmus were performed in 30 patients, subtotal resection of both lobes with extirpation of the isthmus in 11 patients. In all cases of clinical thyrotoxicosis, a histological examination of the drug was performed during surgery to assess the state of the functional activity of the thyroid parenchyma. The severity of lymphoid infiltration and the state of the extrafollicular epithelium of the thyroid gland were taken into account. At the same time, the assessment of the volume of thyroid tissue left in each patient was strictly individual. In 5 patients, mild, in 2 - the average degree of functional activity of the gland. After extraction the part of the thyroid gland that dived behind the trachea, the further course of the operation continued according to the chosen method of thyroid resection. With subtotal resection of one lobe, the volume of thyroid tissue left is approximately 2.0 x 2.5 cm.

After subtotal resection of both thyroid lobes with prophylactic hypothyroidism isthmus extrusion, Mercozolil was prescribed 1 tablet 2 times a day for a month. Patients with subtotal resection of one lobe with isthmus extraction did not require replacement therapy. The diagnosis was established during the operation, when the appearance of the lobe of the thyroid gland with a hard nodule aroused suspicion of its morphological structure. An urgent histological examination was carried out to determine the severity of the autoimmune component (lymphocytes, lymphoid tissue infiltration against the background of follicular epithelial cells). In all cases, the data (urgent) histological examination coincided with the results of postoperative histological examination

Given the complexity and adhesive processes, all patients underwent general endotracheal anesthesia, a collar-shaped incision (according to Kocher) was performed on the anterior surface of the neck along the lower skin fold. We believe that the level of the incision and its dimensions can vary widely depending on the shape of the neck, its thickness, the size of the goiter and the depth of its occurrence. As a rule, an incision was made 1.5-2.0 cm above the jugular notch. After the incision of the skin, subcutaneous tissue and muscles, hemostasis was performed, novocaine was injected into the sternocleidomastoid muscles with selection of the sides and into the space between the second fascia of the chest and the chest-hyoid muscle (10 ml), then absorbed from the layer of the upper part of the flap. The size of the upward detachment of the skin-subcutaneous flap depends on the size and level of the goiter. The lower flap, as a rule, does not exfoliate, since after the operation this leaves a non-drainable cavity. The intersection of the sternohyoid and sternothyroid muscles with recurrent goiter is not performed. Surgical access during operations on the thyroid gland, when recurrent goiter diving behind the trachea of a low degree with a single node (adenoma) or cysts, in which there is no need for wide access to all areas behind the trachea. When the dimensions of the recurrent diving goiter are large, the goiter lies deep within one lobe with the presence of one or many excretion nodes, we continue on the side of the altered lobe and access is made between the sternohyoid and sternothyroid muscles. Separating the muscles in a sharp and blunt way, we take them to the sides with Farabef hooks, having previously mobilized them along the entire length of the longitudinal line, dissecting the facies. In the case of an unaltered lobe of the thyroid gland, in the presence of one or many nodes extending from it on a stalk, access is made between the anterior edge of the sternocleidomastoid and the outer borders of the sternothyroid muscle. Before dissection of the fascia along the midline, we inject a solution of novocaine (10-20 ml) between the layers of the fourth fascia. With this solution of novocaine, it envelops the entire protective gland, and its subfacial direction is planned to disappear. Before dissection of the fascia along the midline, we introduce a solution of novocaine (10-20 ml) between the layers of the fourth fascia. In this case, the novocaine solution envelops the entire thyroid gland, and the need for its subfacial administration is eliminated. The intersection of the lateral veins, the lobe becomes mobile, then it moves slowly forward, which makes it possible to differentiate the recurrent laryngeal nerve and thyroid arteries. The main stage of the operation for recurrent diving goiter, we begin with the intersection of the isthmus of the thyroid gland. This is especially important, since it provides a wide release of the anterior surface of the trachea and allows you to release the thyroid lobe after clamping, crossing and ligating the vessels of the upper and lower poles of the gland lobe. To do this, we cross the median thyroid-hyoid ligament formed between the parietal

layer 1V of the 1V cervical fascia and the cricoid cartilage. Then we raise the isthmus and with a curved clamp along the lower edge we penetrate into the space between the trachea and the posterior surface of the isthmus. We dissect the isthmus, we start isolating the lobe from the upper pole and subfascially, while we apply a clamp to the proximal end of the vessels of the upper pole and the distal part. We apply the clamps from the outside inward, the ends of the clamps should reach the side wall of the trachea, then we cross the pole between them. At the next stage, we introduce a solution of novocaine 10-15 ml, mobilize the lower pole as close as possible to the parenchyma of the gland, preserving the vessels, which prevents the removal or exsanguination of the parathyroid glands, which are known to be in close proximity to the vessels of the lower pole. This allows to bring the lobe of the gland completely into the wound and facilitate further manipulation.

Then a visual and palpatory assessment of the parenchyma of the lobe and the diving part of the gland is performed. At the same time, we determine the localization, size and consistency of the node, the clarity of the boundaries, the involvement of the capsule in the process, the depth of the goiter. In the presence of cysts, it is necessary to have an idea about their contents, the state of the walls, the presence of growths on them. We remove visually altered areas of the gland to healthy tissue, the scope of the operation for each specific case is different. With an altered thyroid gland, we perform a subtotal subfascial resection of the lobe with the removal of the diving part. If the lobes are not changed, then the selection is by the presence of the posterior pole along with the stem. After ligation of the thyroid artery, we select the posterior surface of the gland and skip the clamp under the control of the fingers. Next, we separate the gland into a circular one between the trachea and the anterior edge of the sternocleidomastoid muscle and take it on a holder, thereby first separating the lower pole from the trachea. Then we separate the lower pole and the diving part of the gland with clamps, cross, bandage, which eliminates bleeding during the isolation and removal of the gland. We form a stump from the lateral parts of the lobe of the gland, which are the most dangerous from the position of possible removal or damage to the parathyroid gland, as well as damage to the recurrent nerve. The blood supply to the stump is carried out at the expense of the parietal vessels of the tracheal wall. The optimal volume of thyroid tissue left is 2.0 x 2.5 cm. The stump is not closed. Next, we perform drainage with a rubber strip, drainage through the lower part of the surgical wound, directly above the jugular notch, we bring it out. Next, we stitching the fascia of the prethyroid muscles and the superficial muscle of the neck transversely with thin interrupted sutures. We suture the subcutaneous tissue and skin.

Results and its discussion

In the immediate postoperative period, 4 patients with diving goiter developed unilateral impaired mobility of the vocal fold, 2 patients developed hoarseness due to paresis of the recurrent laryngeal nerve. In all cases, an inflammatory process was caused, which resumed after the operation. non-compliance with the recommendations of the attending physician. After the outpatient complex anti-inflammatory treatment with antibiotics, prozerin according to the scheme, the corpus vitreum, of 2 ml, absorbable therapy and physiotherapy as electrophoresis with 1% sodium iodine hydrocortisone, the mobility of the vocal folds was completely restored in 5 patients. In 1 patient, restoration of treatment 3 months after resolving treatment. Long-term results were studied in 32 patients (80.4%) in terms of 1 to 5 years. Of these, 24 (75.3%) patients were operated on with diving nodular and multinodular goiter, 5 (13.5%) after surgery for nodular toxic goiter, with thyroid adenoma -2 (8.5%), with thyroid cancer in 1 (2.7%) patient. 38 (17.8) examined patients were in a state of euthyroidism. In the late period after surgery, clinical hypothyroidism was detected in 1 (2.7) patients operated on for thyroid cancer (after thyroidectomy). These patients are on lifelong thyroid hormone replacement therapy.

Conclusion 1. The experience of treating 41 patients with recurrent diving goiter showed that (diving) goiter - a method extraction and resection of the thyroid gland allows you to plan optimal treatment tactics, predict the amount of intervention and reduce the trauma of surgery with a minimum number of postoperative complications. 2. Postoperative complication can be treated with absorbable therapy (as electrophoresis with 1% iodine followed by hydrocortisone)

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