

Clinical forms of acute intestinal obstruction, choice of surgical intervention, postoperative management.

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Annotation: *this article includes clinical forms, postoperative management and choice of the most surgical intervention for patients with acute intestinal obstruction.*

Key words: intestinal peristalsis, adhesive obstruction, intraportal infusion, degeneration of the cholinergic metasymphathetic system, extracorporeal, enterosorption.

Intestinal obstruction can develop at any age. However, this condition is most often diagnosed in adults aged 30-60 years, and the younger the patient, the higher the likelihood of non-tumor causes. In patients over 50 years of age, the likelihood of an oncological process as the cause of the disease is highest.

The main manifestations of intestinal obstruction are pain, vomiting and impaired passage of gases. The diagnosis is confirmed using x-rays, computed tomography, ultrasound and other methods. Patients with intestinal obstruction are subject to dynamic monitoring in the hospital.

- **Types of intestinal obstruction**
- **By origin, intestinal obstruction is of the following types:**
 - **Mechanical, when there is an obstacle to the movement of the contents or compression of the mesenteric vessels occurs.**
 - **Dynamic, when intestinal motility is disrupted.**
- **In each of these 2 categories, there are different types of intestinal obstruction. So, mechanical is divided into 3 subtypes:**
 - **obstructive – caused by compression of the intestine from the outside or inside;**
 - **strangulation – the vascular blood supply to the intestinal mesentery is disrupted, as a result of which peristalsis suffers;**
 - **mixed – conditions when both an obstruction component and a strangulation component are present.**
- **In turn, dynamic intestinal obstruction is divided into 2 subtypes:**
 - **spastic – pronounced spasm of the circular muscle fibers leads to the cessation of the movement of intestinal contents;**
 - **paralytic – there is a stop of intestinal peristalsis, as a result of which the contents stop moving towards the anal canal.**

According to the topographic principle, 2 forms are distinguished:

- small intestinal obstruction;
- colonic obstruction.

According to clinical features, the disease can have an acute, subacute and chronic course.

The block at the intestinal level can be complete or partial.

Adhesive obstruction The optimal option is to dissect adhesions with restoration of patency along the entire intestine, suturing small deserosed areas of the parietal and visceral peritoneum. There should be no attempt to suturing extensive deserototic fields. In some cases, resection of the greater omentum is indicated. It is necessary to carry out a set of intraoperative measures to prevent subsequent adhesions and relapse of adhesive intestinal obstruction (intubation of the small intestine, injection into the peritoneal cavity of corticosteroids, proteolytic enzymes, dextran solutions, hydroxyethyl starch, fibrinolysin, etc.). In many cases, the cause of obstruction can be eliminated by laparoscopic adhesiolysis performed according to indications. The main dangers when performing this intervention are damage to the intestinal wall and intraperitoneal bleeding. The best candidates for laparoscopic intervention are patients in the initial stages of the disease who have previously undergone one not too severe abdominal operation. The risk of complications increases with widespread adhesions of degree II–III (repeated abdominal interventions, a history of diffuse purulent peritonitis), as well as in advanced stages of mechanical intestinal obstruction with severe intestinal paresis and severe endotoxiosis. Currently, laparoscopic separation of the adhesive process is recognized by many surgeons as the “gold standard” in the surgical treatment of adhesive acute intestinal obstruction in the early stages.

POSTOPERATIVE MANAGEMENT 1. Detoxification therapy. The following phases of endotoxemia can be distinguished (Ryabtsev V.G. et al., 1990, in our modification), which determine the set of detoxification measures and the place where they are carried out: 1) Compensation phase - with the help of traditional therapy, it is possible to successfully cope with intoxication without the help of special methods (extracorporeal , enterosorption, etc.). There is a rapid restoration of intestinal function without the use of intestinal stimulation with medications.

Acute intestinal obstruction 2) Decompensation phase - requires the use of extracorporeal methods of detoxification and stimulation of intestinal motor function [metoclopramide (Cerucal) or anticholinesterase drugs - neostigmine methyl sulfate (Proserin), distigmine bromide (treatment in an intensive care unit). 3) Terminal phase - development of multiple organ failure syndrome, persistent intestinal paresis due to degeneration of the cholinergic metasymphathetic system (intramural nerve plexus of the intestinal wall) with preservation of adrenergic innervation, difficult to resolve using the entire complex of therapeutic measures.

2. Replenishment of circulating plasma volume. 3. Correction of dehydration and active reaction of the internal environment. 4. Treatment (hepatodepression, acute renal failure, acute respiratory failure, hemodynamic disorders). 1) Intraportal infusion (currently rarely used). 2) Corticosteroid therapy. 3) Hepatoprotectors [phospholipids (Essentiale), ademetonine (Heptral), vitamins in large doses].

4) Combating hyperlipid peroxidation of membranes and body fluids (tocopherol \varnothing - medicinal dissolution of stones using bile acid preparations: chenodeoxycholic and ursodeoxycholic) - only cholesterol stones dissolve; absorption of cholesterol in the intestine and synthesis in the liver are inhibited. 5) Correction of hypertenolysis [native plasma, aprotinin (Kontrikal, Gordox), antagozan. 6) Oxygen therapy [microtracheostomy, artificial ventilation.

7) Cardiac glycosides according to indications (only after correction of disturbances in water and electrolyte metabolism!). 8) Decompression and intestinal lavage. Enterosorption. 9) Stimulation of gastrointestinal motility. 10) Antibacterial therapy for the treatment of peritonitis and prevention of postoperative wound and intraperitoneal infection [cephalosporins, sodium hypochlorite - 11) Prevention of thromboembolic complications [dextran (Reopoliglyukin), low molecular weight heparins, pentoxifylline (Trental), xanthinol nicotinate, bandaging and massage of the lower limbs, early breathing exercises]

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