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GASTROINTESTINAL COMPLICATIONS DURING TREATMENT: NON-STEROIDAL ANTI-INFLAMMATORY DRUGS ARE USED IN TREATMENT.

Achilov Shokhrukh.
Faculty of Medicine, International University of Asia, Uzbekistan

ABSTRACT

To date, the world medical literature presents a huge amount of data on the side effects of NSAID therapy, primarily on their toxic effects on the gastrointestinal tract (GIT). It is known that NSAID-induced erosive and ulcerative damage can be localized in almost any part of the digestive tract. However, traditionally the subject of discussion is NSAID-induced damage to the mucous membrane of the gastroduodenal zone . Nevertheless, the toxic effects of NSAIDs on the small intestine (NSAID-induced enteropathy), despite the relatively rare discussion in the literature, is much more common than is commonly believed.

Methods. Analysis of treatment outcomes in 275 patients with acute gastrointestinal bleeding from the urgent surgical department of Bukhara branch of the Republican cientific Center for Emergency Medical Care

Results. Patients of the main group were performed along with endoscopic diathermocoagulation, infiltration of the bleeding site was performed by injection and irrigation with 96% alcohol. In the same group of patients, according to indications, other methods of injection hemostasis could be used. In this case, 96% ethyl alcohol is injected 1 mm directly from the source of bleeding at 4 points. The amount of alcohol administered per injection is not more than 0.5 ml, the total volume is 1.0 - 1.5 ml and should not exceed 2.0 ml. Patients in the control group 130 patients who used endoscopic methods to stop bleeding monopolar diathermocoagulation. The control group consisted of patients who, by the nature of the cause that caused the bleeding, as well as by age, gender and the presence of concomitant diseases, were comparable with the main group. Traditional conservative treatment includes hemostatics, angioprotectors, PPIs, H2 blockers, antacids, blood substitutes, blood components according to indications, and endoscopic diathermocoagulation. Patients in the control group 130 patients who used endoscopic methods to stop bleeding monopolar diathermocoagulation. All patients simultaneously received conservative treatment. When using the methods of endoscopic hemostasis mentioned above in patients with bleeding from upper gastrointestinal tract the efficiency was achieved in 87.9% of cases. It was the highest when using combined endoscopic methods. Recurrent acute bleeding was diagnosed in 30 (7.1%) cases.

Conclusion. There were no deaths in the main group of patients. Conducting a combined method of hemostasis and correction of impaired liver functions in CDLD together with cytoprotective therapy, it is possible to reduce the number of recurrences of bleeding and avoid risky and pathogenetically unjustified surgical interventions. This tactic made it possible

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to reduce the number of operations in the main group in only 1 (0.7%) patients, against 6 (4.6%) in the control group.

Keywords: upper gastrointestinal tract, bleeding, endoscopic hemostasis, surgical treatment, conservative therapy.

INTRODUCTION

One of the urgent problems of practical health care is acute gastrointestinal bleeding that requires emergency surgical care. Gastrointestinal bleeding is not only a public health problem, but it also remains an economic problem. Thus, in the United States, the cost of treating patients with bleeding ulcers is more than $2 billion per year [11]. Acute gastrointestinal bleeding (GIB) is one of the most common causes of emergency hospitalization in hospitals. Mortality in this pathology has not decreased for 30 years and ranges from 5 to 14, in people over 60 years old it can reach 40% [1,2,12]. GCC can be detected in patients at any age from 18 to 89 years, 2-3 times more often in men than in women. Mortality rates are the same in both sexes [3,4]. The causes of acute GCC of non-ulcerative origin are: esophageal varices due to portal hypertension, Mallory-Weiss syndrome, polyps of the stomach and esophagus, erosive gastroduodenitis, erosive lesions of the esophageal mucosa, cancer of the esophagus and stomach and other causes. The cause of bleeding can also be medical ulcers and erosions, which are localized in any part of the gastrointestinal tract. From 42% to 60% of patients indicated prior gastrointestinal bleeding aspirin, non-steroidal anti-inflammatory drugs (NSAIDs), anticoagulants, antiplatelet agents. Some patients took 3 drugs per day: antiplatelet agents, anticoagulants and non-steroidal anti-inflammatory drugs [5,6,7]. Non-steroidal anti-inflammatory drugs (NSAIDs) are one of the most popular classes of drugs. The high effectiveness of non-steroidal anti-inflammatory drugs (NSAIDs) in pain, inflammation and fever, the possibility of purchasing drugs without a prescription explain their "popularity" among different population groups [8,9, 10.]. In the United States, about 30 billion NSAID tablets are sold annually; in developed countries, these drugs are received by 20–30% of the elderly, among whom about 30% are forced to take these drugs, despite the presence of risk factors for the development of adverse events from the gastrointestinal tract (gastrointestinal tract) and the cardiovascular system. To date, the doctor's arsenal has a huge number of NSAIDs that differ in chemical structure, but have the same effect. In the study of J.P. Hreinsson et al. it was found that the incidence of gastroduodenal bleeding in patients taking non-steroidal anti-inflammatory drugs (NSAIDs) is 371 per 100,000, which is 4 times higher than in the general population. According to world statistics, more than 30 million people daily take non-steroidal anti-inflammatory drugs (NSAIDs) [11,12]. The use of these drugs in routine clinical practice is progressively increasing both due to the aging of the population, and due to the growing prevalence of degenerative diseases of the musculoskeletal system, due to the peculiarities of the lifestyle of a modern person (prolonged forced sitting position, lack of adequate physical activity, nutritional etc.)

THE AIM OF THE STUDY

Was to improve the results of treatment of patients with bleeding from NSAIDs induced by OEJAP of the stomach and duodenum 12 and to develop a therapeutic and diagnostic algorithm for this category of patients.

METHODS.

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The dissertation research included an analysis of patients who were treated in the surgical departments of the Bukhara branch of the RRCEM for the period from 2015. to 2021 with bleeding from NSAIDs induced by OEJP. During this time, 275 patients with bleeding from OEJP of the stomach and duodenum were treated after taking various types of NSAIDs. The study included only patients taking NSAIDs. The study did not include patients with tumors of the upper gastrointestinal tract, bleeding from the veins of the RVV, Malore-Weiss syndrome and other pathologies.

RESULTS.

The patients were divided into groups II. The first group was studied retrospectively by studying 130 medical histories of patients with bleeding from NSAIDs induced by OEJP, who took traditional conservative treatment (hemostatics, angioprotectors, PPIs, H2-blockers, antacids) and underwent endoscopic diathermocoagulation. The second group conducted a prospective study, which included 145 patients of the main group taking drugs (traditional + omeprazole 20 mg + rebamipide 300 mg intravenously (slow drip) in 0.9% sodium chloride solution, 1.2-2.4 g 1 once a day and combined methods of endoscopic hemostasis) improving the quality of treatment and aimed at eliminating recurrence of bleeding.

Patients of the main group were performed along with endoscopic diathermocoagulation, infiltration of the bleeding site was performed by injection and irrigation with 96% alcohol. In the same group of patients, according to indications, other methods of injection hemostasis could be used. In this case, 96% ethyl alcohol is injected 1 mm directly from the source of bleeding at 4 points. The amount of alcohol administered per injection is not more than 0.5 ml, the total volume is 1.0 - 1.5 ml and should not exceed 2.0 ml. Patients in the control group 130 patients who used endoscopic methods to stop bleeding monopolar diathermocoagulation. The control group consisted of patients who, by the nature of the cause that caused the bleeding, as well as by age, gender and the presence of concomitant diseases, were comparable with the main group. Traditional conservative treatment includes hemostatics, angioprotectors, PPIs, H2 blockers, antacids, blood substitutes, blood components according to indications, and endoscopic diathermocoagulation. Patients in the control group 130 patients who used endoscopic methods to stop bleeding monopolar diathermocoagulation.

The second, main group (prospective study), which included 145 patients, included in addition to the traditional drugs described above, rebamipide, glutathione solutions, and combined methods of endoscopic hemostasis (bipolar diathermocoagulation, injection method using 96% ethanol and irrigation) were used.

The patients of the main group were performed along with endoscopic diathermocoagulation, the bleeding site was infiltrated by injection and irrigation with 96% ethyl alcohol.

For endoscopic hemostasis, we used endoscopes with a wide working channel for adequate evacuation of gastric contents and the implementation of diverse intragastric manipulations. Having found the cause of bleeding, injections were carried out in the immediate vicinity of the source of bleeding (arrosed vessel) into the submucosal layer of the stomach or duodenum from 4 points until a drug infiltrate appeared.

Using the classification of the degree of blood loss according to Gostishchev V.K., Evseev M.A. (2005), patients were divided into 2 groups. It was found that more than half of the patients with bleeding from NSAIDs induced by OEJP, 157 (57.3%) were admitted with a

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mild degree of blood loss to the hospital department, 69 (25%) patients - with an average degree of blood loss, 47 (17%) patients - with a severe degree of blood loss. blood loss, 2 (0.7%) patients - with extremely severe blood loss, post-hemorrhagic shock II degree. Table 1.1.

More than half of patients in groups I–II had mild blood loss 72(55.4%) and 85(58.6%), respectively. The dynamics of the patients' condition was amenable to conservative therapy and endoscopic method of stopping bleeding, and no special difficulties in treatment were observed. There was also no evidence of recurrent bleeding.

Our attention was directed to identifying the causes of early relapse in patients with moderate, severe, and extremely severe blood loss.

In both groups, statistically significantly every fourth patient was admitted with moderate blood loss, every fifth with severe blood loss. In extremely serious condition in both groups, 1 patient with hemorrhagic shock of II degree was admitted.

When using the above methods of endoscopic hemostasis in patients with bleeding from the upper digestive tract, efficiency was achieved in 87.9% of cases. It was highest with the combined use of various endoscopic methods. According to our study, recurrence of acute bleeding was diagnosed in 30 (7.1%) patients. It should be noted that the majority of patients with recurrent bleeding were with gastric and duodenal ulcers (21 patients). All 30 patients with recurrent bleeding underwent surgical interventions. 9 patients died.

With gastric bleeding in patients in serious condition, with inoperable tumors, only palliative operations are justified, such as suturing a bleeding vessel after gastrotomy, excision of an ulcer, ligation of the main vessels throughout, etc. After such operations, our patients developed recurrent bleeding. In order to stop and prevent recurrence of gastric bleeding and necrosis of the gastric wall, we proposed a method for the surgical treatment of gastric bleeding [7].

The goals are achieved by ligating the branches of the small and large perigastric arches in the area of the source of bleeding and immediately adjacent areas under the control of blood pressure in the intramural vessels - until it is firmly established at the level of 40–45 mm Hg. at the edge of the bleeding site. The method is carried out as follows. Prior to the start of laparotomy, a fibrogastroscope is inserted into the stomach, through which blood is removed from the stomach, clots are washed, and a bleeding site is established. Then, under general anesthesia, through a mini-incision in the transmitted light of a fibrogastroscope, the surgeon fixes the position of the source of bleeding and the intramural vessels associated with it.

Reveal perigastric arches - small, large and vessels directed from them to the anterior and posterior walls of the stomach. Bandage direct vessels in the projection of the source of bleeding (tumors, ulcers). In the course of ligation, the method of angiotensometry determines the blood pressure in the vessels of the submucosal layer, in the sections adjacent to the bleeding focus from the side of the lesser and greater curvature. The ligation of the vessels going to the tumor is continued until the arterial pressure in the intramural vessels is established in the indicated sections at the level of 40–45 mm Hg. Depending on the position and length of the focus of bleeding, the pressure is bandaged in the areas of the stomach wall adjacent to the pathological focus and thereby stop bleeding from tumors, ulcers, erosions of the stomach.

When the pressure in the intramural vessels is below 40–45 mm Hg. destructive changes in the gastric wall develop. At pressures above 40–45 mm Hg. does not provide a reliable stop bleeding. The proposed method is characterized by simplicity, low trauma, asepsis of the operation, since the lumen of the stomach is not opened. The method can be the operation of choice for an inoperable tumor of the stomach, as well as for gastric bleeding in elderly patients

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with severe concomitant diseases, when more extensive operations are accompanied by an increased risk.

CONCLUSIONS

There were no deaths in the main group of patients. Conducting a combined method of hemostasis and correction of impaired liver functions in CDLD together with cytoprotective therapy, it is possible to reduce the number of recurrences of bleeding and avoid risky and pathogenetically unjustified surgical interventions. This tactic made it possible to reduce the number of operations in the main group in only 1 (0.7%) patients, against 6 (4.6%) in the control group. For bleeding FIa, FIb, in order to treat bleeding and prevent bleeding, combined endoscopic hemostasis (clipping and injection methods) is recommended; rebapimide and glutathione.

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