



CHOICE OF SURGICAL TACTICS FOR THE TREATMENT OF PATIENTS WITH ACUTE PARAPROCTITIS

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Abstract

303 patients with various clinical forms of acute paraproctitis were treated. All observed patients underwent radical surgery. Therapeutic 52 the tactics and choice of surgical treatment in patients with various clinical forms of acute paraproctitis depend on the localization of the abscess, the location of the primary purulent passage in relation to the fibers of the anal sphincter, the degree of development of the cicatricial process in the pararectal tissue, the rectal wall. The developed complex of tactical and therapeutic measures allows to reduce the length of the patient's stay in the hospital, significantly reduce the percentage of relapses of the disease, and improve the functional results of treatment.

Keywords: acute paraproctitis, diagnosis, therapeutic tactics, surgical treatment, disease outcomes.

Introduction

The relevance of the problem of treating patients with complex forms of acute paraproctitis is currently due to the fact that the issues of instrumental topical diagnosis of complex forms of acute paraproctitis have not been resolved [1, 3, 7, 12]. There is no detailed classification of complex forms of acute paraproctitis, guided by which, it is possible to determine the indications and type of treatment. A unified tactic for the treatment and postoperative management of patients with complex forms of acute paraproctitis has not been developed [2, 4, 6, 11, 14]. Relapses of the disease and complications in the postoperative period with the use of modern methods of surgical treatment account for 9-17% of cases [1, 7, 9, 13]. As a result, many patients undergo repeated operations, longer hospitalization periods, sometimes disability, reduced quality of life due to the chronic course of an untreated purulent process or the occurrence of severe cicatricial deformity in the perianal region with insufficient anal sphincter. Considering that acute paraproctitis in 70% of cases affects the able-bodied category of the population, most of them are men, then this problem is nationwide 53 acquires not only medical, but also socio-economic significance.





Purpose of the study. To improve the results and choice of a radical method of surgical treatment of patients with acute paraproctitis

Material and Methods

We analyzed the results of treatment of acute paraproctitis in 303 patients who were treated in the proctology department of the Bukhara Regional Medical Association for the period 2016-2020. Of these, 67 women (22%), men 236 (78%), aged 16 to 74 years. The time from the moment of illness to hospitalization ranged from 3 to 12 days, on average 4 days. By localization, subcutaneous-submucosal forms of paraproctitis were in 162 (53.4%), ischiorectal in 83 (27.5%), pelviorectal in 14 (4.6%), retrorectal in 25 (8.2%) and intermuscular in 19 (6.3%) patients. Developed differentiated approaches to the choice of surgical tactics. Radical surgery for acute paraproctitis involves the opening of a pararectal abscess, taking into account the degree of its complexity, its relation to the sphincter fibers and the elimination of its internal opening in the rectum.

In general surgical hospitals, most often, a simple opening and drainage of the abscess is performed without eliminating the hole in the intestine, which in a large percentage of cases leads to the formation of rectal fistulas. In case of subcutaneous-submucosal, ischiorectal, intrasphincteric proctitis with intrasphincteric communication with the lumen of the rectum, we perform opening and drainage of the abscess with excision of the purulent tract into the lumen of the rectum according to Ryzhykh-Bobrova. With ischiorectal paraproctitis with a transsphincteric purulent passage passing through the superficial portion of the anal sphincter, i.e. capturing less than 1/3 portion of the anal sphincter, we open and drain the abscess with dissection of the purulent passage into the intestinal lumen. In ischiorectal and retrorectal forms with streaks, as well as pelviorectal abscesses with transsphincteric (more than 1/3 portion of the anal sphincter) purulent tract, in all paraproctitis with extrasphincteric communication, we perform opening and drainage of the abscess, cryptectomy. With additional incisions (if it is not possible through the main access), we open the streaks, drain them, draw a ligature through the inner hole, and tighten it.

The ligature is pulled up after the inflammatory process in the wound has stopped, on average after 4-5 days. As a rule, 3 ligature lifts are enough, after which it leaves on its own, or we remove it on the 12-16th day. In these forms, in rare cases, when it is not possible to clearly identify the affected crypt, one has to limit oneself to a wide opening and drainage of the purulent cavity. In the future, if a fistula is formed, we operate in a planned manner in 2-3 months.





With recurrent paraproctitis, if possible, we excise all scar tissue, with an extremely careful attitude to the sphincter fibers. Tightening the ligature for such patients is advisable after the bottom of the wound has been filled with granulations.

In all forms, we perform intraoperative contrasting by puncturing the abscess and injecting a dye with H₂O₂ to determine the affected crypt. At the end of the operation, we perform the wound with tampons with Vishnevsky ointment or levomikol.

Dressing next day. We wash the wound with antiseptic solutions, drain with ointment turundas.

Antibiotics for purulent paraproctitis are prescribed for common processes with leakage into pararectal tissue

Results

The results of treatment in 245 operated patients in the proctology department were monitored for 1, 2 and 3 years after surgery. After radical operations for paraproctitis with intrasphincteric and transsphincteric purulent course (245 cases 80.8%) 55 there was no fistula formation. After operations for paraproctitis with extrasphincteric purulent course (58 cases, 19.2%), a fistula formed in two cases (3.4%), and a recurrence of acute paraproctitis in the area of the postoperative scar was noted in one case (1.7%). All patients with fistulas and acute paraproctitis were successfully operated on in our department. Postoperative insufficiency in acute paraproctitis most often occurs when using a ligature, with recurrent paraproctitis. According to our data, there were 5 (1.6%) cases, while providing radical surgical interventions. In any case, surgical correction of pulp insufficiency was not required.

Thus, as evidenced by the data, despite the undoubted success, many more issues related to the management of patients with acute paraproctitis remain not fully resolved, which makes it advisable to continue research on the development of new highly effective and low-traumatic methods of treating this pathology.

Conclusions:

1. Operations for acute paraproctitis should be carried out taking into account the location of the purulent passage to the fibers of the rectal sphincter, with the elimination of the internal opening.
2. Treatment in a specialized department of patients with acute paraproctitis leads to their radical cure without turning into chronic paraproctitis.
3. Whenever possible, surgery for acute paraproctitis should be performed by a surgeon trained in proctology



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