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# JOURNAL OF HEPATO-GASTROENTEROLOGY RESEARCH

## ЖУРНАЛ ГЕПАТО-ГАСТРОЭНТЕРОЛОГИЧЕСКИХ ИССЛЕДОВАНИЙ

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### PERCUTANEOUS PUNCTURE-DRAINAGE PROCEDURES UNDER ULTRASOUND CONTROL FOR FLUID ACCUMULATIONS IN ACUTE PANCREATITIS


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**ABSTRACT**

The objective of the study was to improve the results of treatment of patients with fluid collections in acute pancreatitis with a minimally invasive method. Material and methods. Results of percutaneous-puncture interventions under ultrasound in 62 patients with acute pancreatitis in the presence of fluid clusters were analyzed. In the first day from the moment of the disease, 39 % of patients admitted during the second and the third days - 31 % and more than three days - 20 % of patients. Results. Diagnostic punctures of fluid collections under ultrasound control were performed. In 49 (79 %) of 62 patients, the puncture was effectively transformed into percutaneous drainage. In 13 of 49 patients were further operated. Lethal outcomes after puncture-draining interventions were in 5 cases. Among 44 patients operated with a minimally invasive method of acute pancreatitis, recovery was noted in 24, recurrence of fluid collections - in 7, 13 patients were operated on. Conclusion. Thus, early diagnosis and timely implementation of conservative and minimally invasive methods of treatment contributed to improving the immediate results of treatment of patients with fluid collections in acute pancreatitis.

**Keywords:** acute pancreatitis, fluid collections, minimally invasive puncture-draining interventions

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### ПЕРКУТАННЫЕ ПУНКЦИОННО-ДРЕНАЖНЫЕ ПРОЦЕДУРЫ ПОД УЛЬТРАЗВУКОВЫМ КОНТРОЛЕМ ПРИ ЖИДКОСТНЫХ СКОПЛЕНИЯХ НА ФОНЕ ОСТРОГО ПАНКРЕАТИТА

**АННОТАЦИЯ**

Цель. Улучшение результатов лечения пациентов с жидкостными скоплениями при остром панкреатите мини-инвазивным способом. Материал и методы. Проанализированы результаты чрескожных пункционных вмешательств под ультразвуковым (УЗ) контролем у 62 больных острым панкреатитом при наличии жидкостных скоплений. В 1-е сутки от начала заболевания поступили 39 % больных, на протяжении 2-х и 3-х суток - 31 % и свыше 3 суток - 20 % пациентов. Результаты. Выполнены диагностические пункции жидкостных скоплений под УЗ-контролем. У 49 (79 %) из 62 пациентов пункция была эффективно трансформирована в чрескожное дренирование. 13 из 49 больных в дальнейшем были оперированы. Летальные исходы после пункционно-дренирующих вмешательств имелись в 5 случаях. Среди оперированных малоинвазивным способом 44 больных острым панкреатитом выздоровление отмечено у 24, рецидив жидкостного

скопления - у 7, оперированы 13 больных. Заключение. Таким образом, ранняя диагностика и своевременное проведение консервативных и мини-инвазивных методов лечения способствуют улучшению непосредственных результатов лечения больных с жидкостными скоплениями при остром панкреатите.

**Ключевые слова:** острый панкреатит, жидкостные скопления, мини-инвазивные пункционно-дренирующие вмешательства

**Introduction.** Acute pancreatitis (AP) is one of the most complex and unresolved problems in emergency abdominal surgery [1-3]. Despite the introduction of modern methods of diagnosis and treatment of AP into clinical practice, the results, unfortunately, remain unsatisfactory, with mortality averaging 15-25%, and in cases of pancreatic necrosis - 30-40% [4, 5]. OP is often accompanied by the formation of fluid accumulations of various mechanisms and development times, characterized by the blurring of clinical manifestations and the masking of infection symptoms [6-8]. At the same time, reducing the trauma of surgical interventions is very relevant. It is necessary to study and clarify the timing, indications, and contraindications for puncture and drainage of fluid collections (FC) in OP.

**The aim** of the study is to improve treatment outcomes for patients with fluid accumulations in acute pancreatitis.

**Materials and Methods.** Over the past 5 years in the clinic, percutaneous interventions under ultrasound (US) guidance were performed on 62 patients with acute pancreatitis (AP) and the presence of gallstones. There were 29 men (46.8%) and 33 women (53.2%). The patients' ages ranged from 29 to 84 years. The predominant factors for the development of AP were complications of gallstone disease or concomitant biliary pathology in 76% of cases, and alcohol consumption in 24% of cases.

According to the classification adopted in 1992 in Atlanta [9], PN was represented by acute fluid accumulation in 41 (66.1%) cases, acute pseudocyst in 14 (22.6%) cases, and pancreatic abscess in 7 (11.3%) cases. Patients with PN were divided into 3 groups. The 1st group included 40 patients with non-infected PN and cysts, the 2nd group consisted of 15 patients with infected PN and cysts, and the 3rd group included 7 patients with pancreatic abscess.

The main method of treating AP at the early stage of the disease was intensive conservative therapy, which included catheterization of central veins and the urinary bladder, infusion-transfusion therapy, pain relief, antiseptic and anti-enzyme therapy, as well as antibacterial therapy to prevent purulent complications.

For the diagnosis of acute cholecystitis in patients with pancreatitis, the full range of examinations was performed, including clinical and biochemical blood tests, as well as ultrasound and computed tomography (CT).

**Results.** Analysis of the clinical manifestations of pancreatitis showed that the typical clinical picture was observed in 72% of patients. In the remaining cases (28%), isolated or other symptoms were observed in the clinical picture of the disease. A mild degree of endogenous intoxication was detected in 42% of patients, a moderate severity in 51% of patients, and severe in 7% of patients. When studying the signs of systemic inflammatory response (body temperature over 38 °C, leukocyte count over  $12 \times 10^9/L$ ), the differences between the groups with infected and non-infected gallbladders and cysts were insignificant. In 53% of observations, signs of infection were found in the aspirate. It should be noted that in 27.2% of cases, based on ultrasound results, a false-negative conclusion about gallbladder infection was made. Considering the above, CT scans were performed in 12% of cases. To select the most pathogenetically justified method of treating acute pancreatitis (AP) and pancreatic pseudocysts (PC), in the absence of reliable clinical-laboratory and ultrasound criteria, it was deemed reasonable to perform diagnostic puncture under ultrasound guidance of the PC, supplementing the procedure with drainage if there were no contraindications. Percutaneous diagnostic punctures in 49

(79%) of 62 patients were effectively transformed into percutaneous drainage.

Indications for percutaneous drainage of PC in AP were considered to be the presence of fluid collections according to ultrasound and CT near the pancreas, in the omental sac and abdominal cavity in the early stages of the disease; enlarging PCs according to dynamic ultrasound and the presence of signs of infection; large and medium-sized fluid collections according to ultrasound.

Contraindications for the drainage of fluid collections were considered to be small hypoechoic fluid collections in the projection of the pancreas, the absence of their increase over time and pronounced signs of intoxication, and the interposition of the spleen, intestines, lung, kidney, or large vessels.

Percutaneous puncture-drainage procedures under ultrasound guidance were performed along the shortest path from the body surface to the boundary of the fluid formation. The distance from the puncture site to the boundary of the fluid collection averaged  $(47.1 \pm 2.4)$  mm. In 38 (61.3%) cases, the Seldinger method was used for drainage, in 11 (17.7%) - drainage with stylet catheters and through a trocar.

Subsequently, 14 patients who underwent puncture-drainage percutaneous interventions for liver cysts were operated on. Indications for surgery included leakage of cyst contents into the peritoneal cavity with the development of peritonitis (n=4), ineffectiveness of drainage (n=4), migration of the drainage from the cyst cavity (n=3), and erosive bleeding (n=3).

Fatal outcomes after puncture-drainage interventions occurred in 5 cases. The causes of these fatal outcomes were multiple organ failure (n=2), erosive bleeding (n=2), and acute myocardial infarction (n=1). Among the 44 patients discharged after conservative treatment, recovery occurred in 24 (38.7%), recurrence of liver cysts in 7 (11.2%), and 13 (20.9%) patients were operated on. Thus, early diagnosis and timely implementation of conservative and minimally invasive treatment methods contribute to improving the immediate treatment outcomes in patients with liver cysts during conservative treatment.

**Discussion.** At present, the diagnosis and treatment of acute pancreatitis (AP) continue to remain among the most complex and debatable areas of emergency abdominal surgery. At the same time, AP is a fairly common condition in emergency abdominal surgery. It should be noted that in recent years interest in the treatment and management of patients with localized fluid collections in AP has increased.

In our opinion, the development of a differentiated, individually active approach, based on the achievements of modern surgery, makes it possible to regulate (taking into account the specifics and capabilities of the medical institution) the scope of examination, the establishment of a diagnosis, the content of intensive therapy, and indications for surgical treatment with the determination of the surgical technique and scope of the operation, in particular, minimally invasive percutaneous drainage under ultrasound guidance. This approach significantly contributes to improving the quality of treatment for patients with AP in the presence of fluid accumulations.

**Conclusions.** Dynamic ultrasound combined with the assessment of clinical and laboratory indicators in acute pancreatitis allows effective monitoring of the nature of local changes and timely determination of indications for puncture-drainage interventions under ultrasound guidance. Percutaneous puncture-drainage interventions under ultrasound guidance are effective methods for treating fluid collections in acute pancreatitis.

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