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ТАКТИКО-ТЕХНИЧЕСКИЕ АСПЕКТЫ У БОЛЬНЫХ ЭХИНОКОККОЗОМ

АННОТАЦИЯ

На основании анализа историй болезни 327 пациентов с эхинококкозом печени (ЭП) разработана тактика хирургического лечения с учетом оптимального доступа в зависимости от локализации кисты; определены показания для декомпрессии желчных путей, в том числе и с применением эндоскопической техники.

Ключевые слова: эхинококкоз, эхинококкэктомия, ЭРПХГ, папиллосфинктеротомия.

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ЖИГАР ЭХИНОКОККОЗИ БИЛАН КАСАЛЛАНГАН БЕМОРЛАРДА ЖАРРОҲЛИК ТАКТИКАСИ

АННОТАЦИЯ

Жигар эхинококкози (ЖЭ) билан касалланган 327 беморда касаллик анамнезини таҳлил қилиш асосида кистанинг локализациясига боғлиқликка оптимал кириш имкониятини ҳисобга олган ҳолда жарроҳлик даволаш тактикаси ишлаб чиқилди; эндоскопик усуллардан фойдаланган ҳолда, ўт йўлларини декомпрессиялаш кўрсаткичлари аниқланди.

Калит сўзлар: эхинококкоз, эхинококектомия, ЭРПХГ, папиллосфинктеротомия.

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TACTICAL AND TECHNICAL ASPECTS IN PATIENTS WITH LIVER ECHINOCOCCOSIS

ANOTATION

Based on the analysis of the case histories of 327 patients with liver echinococcosis (LE), surgical treatment tactics were developed considering optimal access depending on the location of the cyst; indications for biliary tract decompression, including using endoscopic techniques, were determined.

Key words: echinococcosis, echinococcectomy, ERPH, papillosphincterotomy.

Echinococcosis is a dangerous natural focal parasitic disease of domestic animals and humans, occurring sporadically and endemically. Areas that are endemic for echinococcosis include Mountainous areas, echinococcosis is included in the who list of diseases requiring radical eradication. The problem of echinococcosis remains relevant, since the disease is quite common, and treatment issues are becoming debatable. Among the lesions of various organs and tissues with echinococcosis, the frequency of liver damage is 44-84 % [1,2,3,4,5]. Prevalence of echinococcosis inabout all of them the incidence of echinococcosis in the region is 1 per 10,000 inhabitants, in the Republic of Uzbekistan 0.39 per 1000 inhabitants (2017). the Incidence of echinococcosis in the region is 4 times higher than the incidence in the Republic of Uzbekistan [7,8,9,10]. The problem of surgical treatment of liver echinococcosis still remains relevant in many regions of Uzbekistan [8,9,10,11,12,13,14]. 483 patients with echinococcosis were operated on in the 1st clinic of Samgmi from 2005 to 2018, 327 of them were diagnosed with LE. the difficulties of effective surgical treatment are due to the lack of a generally recognized optimal treatment option, depending on the location of the cyst, the condition of the cyst. fibrotic capsule and the lack of a single view on the methods of treatment of the fibrotic bed after removal of the cyst [16,17,18,19,20,21,22]. Improvement of modern diagnostic methods and introduction of new high-tech methods of surgical treatment did not give the expected results [24,25,26,27]. There is no consensus among surgeons about the scope of operations for liver echinococcosis complicated by bile duct damage. Postoperative complications in the form of retention of residual cavities, their suppuration, development of cholangitis, prolonged bile flow, often with the formation of an external biliary fistula, are still frequent and relapse of the disease [26,28,30]. The main reason for the development of these complications is inadequate treatment of the fibrous cyst capsule and its capitonage. to increase the effectiveness of these key stages of surgery, pre-and intraoperative detection of bile ducts opening into the cyst cavity is very important [28,29,30,31]. The aim of the study was to determine a method for improving the immediate results of surgical treatment of liver echinococcosis, and to develop the most rational tactics of surgical treatment.

Materials and methods. The work is based on the analysis of medical records of 327 patients. The main group included 152 patients. There are 85 women and 67 men among them. Damage to the right lobe was detected in 102 patients, the left lobe in 14, damage to both lobes in 11 patients, and 24 patients had combined liver and other organ damage. Indications for surgery and the choice of optimal access for them were made considering the location of the cyst and the nature of complications. The choice of access depended on the topical location of the cyst. When cysts were localized in the second and third segments, echinococcectomy was performed from the upper end of the spine. – median access [28], if the first, fourth, fifth, and sixth segments were affected – from the subcostal segment [24], if they were located in the seventh and eighth segments, thoracotomy with diaphragmotomy was performed [23]. one patient had a combined access (thoracotomy, laparotomy), considering echinococcal lesion of the left lung and right lobe of the liver. Giant cysts, multiple cysts of both lobes of the liver in 9 cases required transverse laparotomy or total median laparotomy. laparoscopic surgery was performed in five patients. One patient underwent videothoracoscopic surgery. operation for echinococcosis of the right lung and right lobe of the liver the diagnostic Algorithm included clinical laboratory examinations, ultrasound examination of the liver, computed tomography, chest x-ray, ERPHG. Several patients (10) underwent liver MRI. This complex of examinations allowed us to obtain an accurate segmental localization of cysts, their size, number, and signs of a complicated course of the disease, such as mechanical jaundice, suppuration of the cyst, connection of the cyst with the bile ducts, and cyst breakthrough into the biliary system. In complex diagnostic cases with the goal of for the differential diagnosis of echinococcosis and liver cancer in 3 patients, an angiographic study was performed. Only the information received in full allowed us to solve the tactical issues of the upcoming surgical intervention. The comparison group consisted of 175 patients. Of these, 103 are women, 72 are men. In this group, the right lobe was affected in 126 patients, the left lobe in 22, both lobes in 12 patients, and combined liver and other organ damage in 15 cases. The main operative approach in this group of patients was the right subcostal one, and ERCP was performed for the purpose of follow-up examination. only in the presence of jaundice.

Research results. We believe that determining the most rational surgical approach and timely detection of cystobiliary fistulas (CBF) is a key factor in reducing the likelihood of postoperative complications. One of the most severe complications of EP is the rupture of cyst contents into the bile ducts, which occurs in 6-63% of cases [2,8,9,10]. According to our study, this complication occurred in 73 people, which was 22.3%. The clinical picture of getting the contents of an echinococcal cyst into the bile ducts is due to the diameter of the CBS and its level a breakthrough in the biliary tract. Depending on the severity of the clinical picture, we distinguish three degrees of manifestation of CBF. The first degree was diagnosed in 22 patients (6.7%) with severe mechanical jaundice and cholangitis, which

occurred due to the breakthrough of the cyst contents into the large lobar hepatic ducts. All patients in this group showed signs of liver failure with severe intoxication, pain, chills, and hyperthermia. The second degree was detected in 23 patients (7%). in this group of patients, symptoms of inflammation predominated due to the formation of CBF with segmental duct, suppuration of the echinococcal cyst, the development of cholangiogenic abscesses. We assigned 28 patients (8.6%) to the third degree, who did not have clinical manifestations of echinococcal cyst communication with the bile ducts, which was explained by the small size of the perforation opening (no more than 1.5 mm) and, as a rule, the integrity of the chitinous membranes was preserved. The main group included 29 patients with varying degrees of cyst breakthrough manifestations (8 patients with severe mechanical jaundice and cholangitis, 11 patients with inflammatory manifestations of CBF, and 10 patients with a mild clinical course of this complication). The diagnostic algorithm in patients of this group included clinical and laboratory, ultrasound, x-ray, and endoscopic examination methods. Special attention was paid to ultrasound and computed tomography, which specified the location, size, nature of the cyst contents, its relation to the surrounding organs, large vessels and liver ducts. ERPHG was used in all patients, with 25 patients diagnosed with CBS before surgery. in patients of the main group, the tactics and scope of treatment measures depended on the degree of damage to the bile ducts. for the treatment of patients with the first degree of communication with the bile ducts we apply a three-stage tactic of conducting therapeutic measures. The first (preoperative) stage includes methods aimed at decompression of the biliary tract and treatment of acute cholangitis. All patients underwent endoscopic papillosphincterotomy (EPST) after EPCG, and 7 of them managed to extract fragments of the chitinous membrane from the common bile duct. six patients underwent nasobiliary drainage of the biliary tract with rehabilitation of the bile ducts and administration of antibiotics after EPST and removal of chitinous membranes. The second stage of treatment is open surgery with the definition of the most rational access, ensuring optimal treatment of the cyst cavity. Argon-enhanced electrocoagulation was used at the main stages of the operation (thoracophrenolaparotomy, laparotomy, cystotomy, excision of the fibrous capsule, hemo and cholestasis). all 22 patients underwent echinococcectomy. For antiparasitic and antibacterial treatment of the cyst cavity, 80-100% glycerin or 3% hydrogen peroxide solution was used. Our experience, as well as literature data, show that glycerol or a solution of hydrogen peroxide have a rapid destructive effect not only on protoscolexes, but also on acephalocysts of hydatid Echinococcus, while the shells of live echinococcal cysts are impermeable to these substances, which eliminates their toxic effect on the body. The fistula opening was sutured from the side of the fibrous capsule with atraumatic suture material. In order to maximize the reduction of the residual cavity, the fibrous capsule was excised along the border with unchanged liver tissue, followed by its capitonage or suturing with turning the cyst wall into its cavity. Capitonage of the residual cavity was carried out mainly by vertical pouch seams, which allowed evenly bring together the walls of the fibrous capsule, without interfering with the separation of exudate. Sutures were applied in several rows, along the liver ducts along the wall of the fibrous capsule to the bottom and on the opposite side in the opposite direction until the residual cavity was closed. Open echinococcectomy was performed in 2 patients with signs of suppuration of the cyst cavity, semi-closed echinococcectomy with capitonage of the residual cavity on thin drainage was performed in 2 patients, and closed echinococcectomy with drainage of the abdominal cavity was performed in the remaining patients. In 8 patients, echinococcectomy was supplemented with biliary drainage. of the Central nervous system, considering the pronounced phenomena of cholangitis. drainage of the choledochus according to Vishnevsky was performed in 4 patients, according to Ker – in 2 patients, separate drainage of the right and left hepatic ducts was performed in 2 patients. the third stage of treatment was drug correction in the postoperative period, aimed at correcting hyperbilirubinemia and bacterial complications. Patients with second-degree cystobiliary fistulas in the presence of cholangiogenic abscesses and suppuration of the echinococcal cyst underwent open (16) and semi-closed (7) echinococcectomy with opening and drainage of cholangiogenic cysts. abscesses (2), treatment was performed in one stage, as in patients with the third degree of manifestation of CBF. In recent years, in addition to the listed methods for diagnosing bile duct lesions in EP, the method of chromatic intraoperative visualization of cystobiliary fistulas has been used by puncturing an aqueous solution of methylene blue into the biliary tract, which allowed 5 patients to detect small (up to 1.5 mm in diameter) cystobiliary fistulas during surgery. Discussion. So, patients with second and third degree CBF underwent one-stage treatment, which consisted of autopsy, rehabilitation and antiparasitic treatment of the residual cavity, elimination of the biliary fistula from the fibrous capsule by electrocoagulation or suturing with atraumatic suture material and elimination of the residual cavity. In case of prolonged bile flow in the postoperative period (more than 5 days), which was noted in 6 patients of the main group, PST was performed, against which bile flow stopped on 6-7 days. In the main group, 107 patients had uncomplicated echinococcosis, they underwent closed echinococcectomies (89), 5 of them laparoscopically, liver resection (1), and perfect echinococcectomy (8), 14 have a semi-closed echinococcectomy. Postoperative complications were registered in 27 patients (17.76%). Among the patients of the main group, 29 patients (23.01%) were admitted and treated with recurrent cysts. 10 patients were diagnosed with rare complications of EP in the form of cyst bursting into the abdominal and pleural cavities, diaphragm necrosis, etc. (table 1). Fatal outcome was recorded in three patients of the main group, which was 1.97%. Of the 175 patients with EP in the comparison group, 64 cases of complicated course were noted (36.6%). 87 of them underwent closed echinococcectomy, 17-semi-closed and 71 patients underwent open echinococcectomy.

Table 1

The nature of identified complications in patients with liver echinococcosis

Complications	Main group		Comparison group	
	n = 152	%	n = 175	%
Breakthrough of an echinococcal cyst into the pleural cavity	2	1,3	1	0,57
Necrosis of the diaphragm	1	0,66	-	-
Cystobiliary fistulas of the first degree	8	5,3	14	8
Second-degree cystobiliary fistulas	11	7,2	12	8
Third-degree cystobiliary fistulas	10	6,6	18	10,3
Cyst breakthrough into the abdominal cavity	4	2,6	5	2,8
Exudative pleurisy	2	1,3	1	0,57
Suppuration of an echinococcal cyst	6	4	11	6,3
Breakthrough in the tracheobroncheal tree	1	2,8	-	-
Total	45	29,6	64	36,6

46 patients (26.28%) were admitted with recurrent cysts. the mortality rate in the comparison group was 4 people, which was 2.28%. In the postoperative period, EP patients developed complications (table 2).

Table 2

Complications in the early postoperative period in patients of both groups with liver echinococcosis

Complications	Main group		Comparison group	
	n = 152	%	n = 175	%
Bile discharge	6	3,95	16	9,14
Residual cavity	9	5,92	17	9,71
Subhepatic abscess	1	0,66	3	1,72
Intraoperative anaphylactic reaction	1	0,66	-	-
Hepatopleural and peritonopleural fistulas	1	0,66	-	-
Pleural empyema	2	1,32	3	1,72
Postoperative wound suppuration	7	4,6	10	5,71
Total	27	17,76	49	28

The analysis revealed that the development of postoperative complications in the form of residual cavities, prolonged bile flow is primarily associated with inadequate surgical access, ineffective capitonage, and incomplete revision of the cyst cavity. Improvement of diagnostic methods and surgical tactics allowed us to reduce the number of postoperative complications in the form of residual cavities by 10.24 %.

Conclusion. thus, the problem of preventing the development of complications after echinococcectomy can be solved by a full-fledged preoperative diagnosis, which includes a full range of clinical, laboratory and instrumental examinations. Choosing the most rational surgical approach for each patient allows you to perform a thorough visual control, clarify the configuration of the cyst, its connection with the ducts, and eliminate them. Reliable capitonage of the residual cavity by vertical sutures and decompression by endoscopic papillosphincterotomy in the pre-or postoperative period this period allows you to achieve a full recovery of patients.

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