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USE OF PRIMARY INTESTINAL ANASTOMOSIS IN A PATIENT WITH WITH DAMAGE TO THE DUODENUM

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Introduction. In patients with severe trauma, the incidence of duodenal injuries ranges from 0.2 to 0.6%, while in patients with abdominal trauma, the prevalence is between 3 and 5%. Penetrating trauma, which is frequently linked to vascular and nearby organ damage, accounts for about 80% of these instances. Determining the optimal surgical treatment protocol is therefore still up for debate. Currently, primary repair and straightforward surgical methods are used to treat mild to moderate duodenal injuries. However, serious injuries have necessitated sophisticated surgical methods with little chance of success, which has led to a rise in death rates. Despite more than a century of treatment experience, duodenal damage (DID) remains one of the most pressing issues in emergency surgery, due not only to the rarity of DID but also to the development of frequent, life-threatening complications.

PDPC accounts for 0.93-10% of cases in open and closed abdominal injuries[1379], and 0.43-6.5% among gastrointestinal injuries[12345]. In recent years, according to literature data, there has been an increase in the frequency of injuries to the perineum, which is associated with an increase in road injuries, falls from heights, and abdominal injuries from cold and firearms.

In 25-30% of cases, the postoperative period for PID is accompanied by early complications. The most frequent and dangerous postoperative complication is suture failure of the deciduous colon. The mortality rate for PID remains very high and ranges between 11-30%[1379].

To clarify the most optimal treatment and diagnostic program and ensure the continuity of specialized surgical care for patients with PID, we utilized the generally recognized classification of E. Mooreetal (1990):

Grade I lesions: small hematoma or incomplete rupture of the GI wall without mucosal damage.

Grade II injuries: large hematoma or a tear less than 50% of the perimeter of the GI wall.

Grade III lesions: a large transverse tear of 50-70% or 50-100% of the perimeter of the GI wall.

IV degree of damage: very large - up to 75-100% rupture, rupture of the ampulla and distal part of the GI tract.

V degree of damage: massive pancreato-duodenal wound with hepatic devascularization.

However, serious injuries have necessitated complicated surgical procedures (pancreatoduodenectomy, pyloric exclusion with or without gastrojejunostomy, and duodenal diverticulization) with negligible positive results and consequently higher mortality rates. By developing a useful and efficient algorithm that incorporates fundamental concepts of damage control surgery (DCS), this article seeks to describe the experience gained in the surgical management of penetrating duodenal injuries. The idea of "Less is Better," which refers to a minimalistic approach to all duodenal injuries, has been previously documented. In the current manuscript, which is a sequel, we reaffirm the significance of this idea and suggest a novel surgical management algorithm to that end [8].

The main purpose of the submitted manuscript is based on the results of authoritative scientific works advantages of the Use of primary intestinal anastomosis in a patient with

with damage to the duodenum consists of a brief analysis of

Result and discussion.

Patient Ergashev Abubakr, 17 years old, i/b No. 18054/1100, was admitted to the Namangan branch of RSCEMP with complaints of abdominal pain, nausea, and general weakness. From the medical history: the patient sustained an abdominal injury about 30 minutes before being admitted to the hospital while under the rubble of a collapsed wall. The patient's general condition upon admission is severe, conscious, passive, and pale. The patient enters into contact reluctantly. Breathing chest-type, 22 times per minute. Arterial blood pressure 80/70 mm Hg, pulse 100 beats per minute, satisfactory tension and filling. The tongue is moist, the abdomen is oval-shaped upon examination, there are transverse abrasions on the skin in the meso- and epigastric regions, and abdominal delay in breathing is noted. On palpation: no sharply pronounced widespread pain throughout the abdomen, passive tension, and no peritoneal symptoms. Upon ultrasound examination immediately after the patient's admission to the admissions department: no signs of abdominal organ damage or free fluid were detected. During the examination, no signs of musculoskeletal injuries or craniocerebral trauma were found. After a short preoperative preparation (catheterization of the subclavian vein with anti-shock fluid connection, necessary biochemical analyses) with a preliminary diagnosis of "Closed abdominal trauma, closed abdominal organ damage, peritonitis?" Traumatic shock" diagnostic laparoscopy was performed, during which approximately 100 ml of dark brown liquid resembling bile was detected in the abdominal cavity under the liver and in the right lateral canal, along with emphysema of retroperitoneal tissues and their imbibition into dark fluid and conversion. During laparotomy, emphysema of retroperitoneal area tissues and their imbibition with dark fluid are identified in the projection of the descending and lower-horizontal parts of the GI. Mobilization of the GI tract was performed according to Kocher, and during the revision, a circular tear of the lower-horizontal part of the GI tract was detected, with the integrity of only 1 cm of its posterior wall remaining intact, which corresponds to the 3rd degree of damage according to E. Mooreetal's classification.

The ruptured area of the perineum was sutured with double-row knotted sutures using non-traumatic polypropylene thread No. 3.0, and an anterior gastro-enteroanastomosis and an entero-enteroanastomosis according to Brown were applied. Two probes, one of which for enteral nutrition is transferred through an entero-entero anastomosis to the drainage compartment, and the other through the pyloric canal to the lower-horizontal part of the mediastinum for its subsequent decompression. The postoperative period proceeded smoothly.

In the early postoperative period, antibacterial, infusion-corrective treatment, transfusion of blood components, and parenteral nutrition preparations are prescribed. Regular active decompression was performed using a "Gomco" apparatus through a duodenal probe. Starting from the 4th day after surgery, enteral probe feeding has been initiated. On the 7th day after surgery, an X-ray contrast (triombrast) examination of the GI tract was performed: patency was not impaired, and no contrast extravasation was detected. After this, the decompression probe is removed. The last safety drainage was removed on the 9th day after an ultrasound examination of the abdominal cavity.

On the 11th day after surgery, the patient was discharged for further outpatient treatment in a satisfactory condition.

Conclusions.

1. When admitting patients with suspicious signs of abdominal organ damage, it is recommended to use diagnostic laparoscopy rather than limiting themselves to instrumental examination data.

2. During diagnostic laparoscopy.

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