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Article/Review

IMPROVING SURGICAL TREATMENT OF ESOPHAGAL-GASTRIC BLEEDING IN LIVER CIRRHOSIS

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Annotation. RELEVANCE. Liver cirrhosis (LC) affects the function of the gastrointestinal tract and is associated with hemodynamic abnormalities in the portal system. The pathological processes that occur in the duodenum and stomach are influenced by reciprocal humoral effects and strong functional links between the liver and the organs of the gastrointestinal system. Some causes of bleeding from the upper gastrointestinal tract, their pathogenesis and mechanisms of occurrence are discussed above. Apparently, it is known that the cause of bleeding from the upper gastrointestinal tract is not only pathological changes in the mucous membrane, but also diffuse changes in the liver. There is a lot of information about ulcers (acute and chronic), erosive gastritis, the mechanism of bleeding from PG, clinical course, but information based on scientific research about the combined course of this pathological process is rare. No information about this pathological process, which is one of the pressing problems of medicine, was found in the literature we examined. To date, more than 200 methods of surgical intervention have been proposed, which is explained by the extreme complexity of the problem, the variety of clinical manifestations of the disease and the lack of absolutely reliable methods of surgical treatment.

PURPOSE. Improving the results of surgical tactics in patients with ulcer bleeding combined with liver cirrhosis by choosing the most optimal methods of diagnostic and treatment tactics

MATERIAL AND METHODS. Considering cirrhosis in combination with duodenal and gastrointestinal ulcers, we examined the results of treatment of 83 patients with bleeding from pg. The age of the patients ranged from 25 to 79 years. The majority of patients (71.1%) with this pathology are of working age (40-60 years). Men made up 67.5% of the population and women 32.5%. The source of bleeding was arrosion of varicose veins (bpb) of the esophagus and gastric cardia in 41 patients (49.4%); gastric and duodenal ulcers in 31 patients (37.3%); in eight of these patients, the source of bleeding was giant gastric and duodenal ulcers; in 11 patients (13.3%) both bpb and gastric and duodenal ulcers were observed simultaneously.

RESULTS. Of the 83 patients who underwent surgical treatment, 71 (85.5%) had bleeding from gastric and duodenal ulcers, 24 from arrozed BPB of the esophagus and stomach, and 11 patients had bleeding from both sources at the same time, which led to the need for suturing the BPB of the esophagus, stomach, and duodenum ulcers. 39 (54.9%) unwell patients underwent urgent and urgent surgery (table). B 24 (33.8%) patients had emergency surgery between two hours and one day, during the peak of their bleeding (between two and six hours — 18 ill Eleven patients had bleeding ulcers and eleven had two sources of bleeding (from BPBP and F) at 4–20 hours. Of them, 15 patients (up to 2-3 days) or 21.1% had recurrence bleeding at 4 sick, indicating the need for emergency operational measures. In 32 (45.1%) patients with stable hemostasis.

Keywords. cirrhosis liver, portal hypertension, bleeding, ulcer stomach And duodenum, varicose veins of the esophagus and stomach.

Introduction. Hemodynamic abnormalities in the portal system, which are observed in patients with liver cirrhosis (LC), have a significant impact on the function of the gastrointestinal tract. The liver and the organs of the gastrointestinal tract have strong functional connections, and the reciprocal hormonal effects between them contribute to the pathological processes that occur in the duodenum and stomach.

Variceal hemorrhage is a severe medical emergency and a fatal complication of cirrhosis. It poses an even greater risk to patients who have already experienced clinical decompensation, such as ascites, encephalopathy, previous episodes of hemorrhage, or jaundice. It is particularly dangerous in patients with advanced liver disease, classified as Child-Pugh B or C, where bleeding ceases spontaneously in only about 50% of cases. In order to decrease morbidity and mortality, it is crucial to promptly and effectively manage these patients.

The mortality rate for cirrhosis patients who experience variceal bleeding is generally between 10% and 20%. However, since the 1980s, when the mortality rate was nearly 40%, there has been a gradual decrease in mortality. Various factors have contributed to this decline, including aggressive resuscitation in intensive care units, increased use of vasoactive medications, therapeutic endoscopy, and antimicrobial prophylaxis. However, among patients with advanced liver disease (Child-Pugh C), early mortality within the first six weeks remains significant, at approximately 40%. It is important to note that effective variceal bleeding therapy in cirrhosis patients involves both managing acute bleeding and preventing rebleeding. Failure to seek treatment after the initial bleeding stops can result in a 60% recurrence rate

and a fatality rate of 33%.

According to several studies, hepatogenic ulcers in patients with diffuse liver diseases occur in approximately 9.5-16.7% of cases and can reach up to 23.5-27% in some instances. Among patients with ulcerative gastroduodenal bleeding, cirrhosis is detected in approximately 1.8-6% of cases. Chronic ulcer of the stomach or duodenum is found to be the cause of bleeding in 13.8% of cirrhosis patients. Unfortunately, the results of treatment for these ulcers are often unfavorable. The presence of portal hypertension, as indicated by the presence of varicose veins in the stomach and liver veins, is believed to be one of the pathogenic mechanisms that contribute to ulcer formation and worsen the disease course. Measures aimed at reducing portal pressure have been shown to be effective in improving tissue microcirculation in the portal organs.

The liver's functional status plays a significant role in the frequency of hepatogenic ulcers and the outcomes of surgical interventions. When cirrhosis is decompensated, approximately 38% of patients develop ulcers. Additionally, the presence of venous stagnation and varicose vein expansion in the esophagus and stomach exacerbates the development or worsening of hepatogenic ulcers in the presence of portal hypertension. Bleeding from one location can potentially induce bleeding from another source, further complicating the situation. Surgical interventions focus on removing the current source of bleeding.

Different viewpoints and methods exist regarding the extent of surgical care for bleeding from duodenal or stomach ulcers in patients with portal hypertension and cirrhosis. Some procedures that have been performed include devascularization of the stomach's proximal half along its lesser curvature, ligation of the arteries leading to the bottom of the stomach along its greater curve, and skeletonization of the abdominal esophagus. Excision of the ulcer with pyloroduodenoplasty has been performed for duodenal ulcers. In cases of bleeding from gastric and duodenal ulcers in cirrhosis patients, more radical methods such as gastric resection or trunk vagotomy with suturing or excision of the ulcer have been recommended. Proximal selective vagotomy or economical resection of the stomach combined with other surgical procedures has been considered the method of choice by some experts. Temporary endoscopic hemostasis is often used to stabilize patients before surgical treatment to decrease the high mortality rate associated with treating bleeding at the height of the hemorrhage.

Purpose: improving the results of surgical tactics in patients with ulcer bleeding combined with liver cirrhosis by choosing the most optimal methods of diagnostic and treatment tactics

Material and methods. Considering cirrhosis in combination with duodenal and gastrointestinal ulcers, we examined the results of treatment of 83 patients with bleeding from pg. The age of the patients ranged from 25 to 79 years. The majority of patients (71.1%) with this pathology are of working age (40-60 years). Men made up 67.5% of the population and women 32.5%. The source of bleeding was arrosion of varicose veins (bpb) of the esophagus and gastric cardia in 41 patients (49.4%); gastric and duodenal ulcers in 31 patients (37.3%); in eight of these patients, the source of bleeding was giant gastric and duodenal ulcers; in 11 patients (13.3%) both bpb and gastric and duodenal ulcers were observed simultaneously.

The diagnosis was based on the patient's medical history, clinical manifestations of the disease, esophagogastroduodenoscopy (EGDS), abdominal ultrasound, presence of hepatitis markers, liver biopsy obtained during surgery, and the surface of the stomach and esophagus after the procedure. The severity of liver failure was assessed according to the Child-Pugh classification. There were three groups: Group A had 51 patients (61.5%), Group B had 23 patients (27.7%), and Group C had 9 patients (10.8%).

With the development of a scar-inflammatory process with compression of the splenic-portal trunk, 37 (44.6%) patients with peptic ulcer developed mixed forms of portal hypertension due to cirrhosis of the liver and secondary extraepatic hypertension due to penetration of the ulcer into the hepatoduodenal ligament and pancreas. Eight of 46 (55.4%) patients with giant ulcers had intraepatic portal hypertension and liver cirrhosis at the time of ulcer formation. Of the 83 patients, in 7 (8.4%) the ulcer was discovered for the first time during hospitalization, and in 4 (4.8%) symptoms of portal hypertension were not detected before surgery due to liver cirrhosis.

Results and discussion. Of the 83 patients who underwent surgical treatment, 71 (85.5%) had bleeding from gastric and duodenal ulcers, 24 from arrozed BPB of the esophagus and stomach, and 11 patients had bleeding from both sources at the same time, which led to the need for suturing the BPB of the esophagus, stomach, and duodenum ulcers. 39 (54.9%) unwell patients underwent urgent and urgent surgery (table). B 24 (33.8%) patients had emergency surgery between two hours and one day, during the peak of their bleeding (between two and six hours — 18 ill Eleven patients had bleeding ulcers and eleven had two sources of bleeding (from BPBP and F) at 4–20 hours. Of them, 15 patients (up to 2-3 days) or 21.1% had recurrence bleeding at 4 sick, indicating the need for emergency operational measures. In 32 (45.1%) patients with stable hemostasis.

To those who are sick the group underwent thorough preoperative preparation, What favorablereflected on immediate results of treatment.

Of the 39 patients who underwent emergency or urgently, at 37 eliminated both source bleeding , both active and potential.

The main type of surgery were varioustechniques vagotomy With devascularization of the esophagus according to V.T. Zaitsev , gastrotomy with vein ligation in combination with excision of ulcers and pyloroplasty , resection of the stomach with suturing of the BPB through the resected stump stomach resection was performed in 11 patients with gastric ulcer and duodenum. Of these, 8 had giant ulcers (more than 3 cm) of the stomach and duodenum with a complicated

course diseases.Bo everyone cases had place _ combination more two complications simultaneously (bleeding and perforation, bleeding of cicatricial ulcerative stenosis and penetration), which was indication For resections stomachAnd stitching _ BPB esophagus And stomach throughstump. Patient bleeding occurred on the 5th day from arrozed BPB stomach,at second Bleeding from the BPB of the lower third of the esophagus and gastric cardia occurred one year after surgery, which required repeated surgery interventions subcardial gastrotomy With ligationveins Sick died from progressive acute hepaticinsufficiency. In the remaining 9 patients who were producedstitching BPB esophagusand stomach through the stump of the resected stomach, there were no relapses of bleeding or mortality. In 10 sick, which was produced gast rotomia With stitching bleeding BPB And excision _ ulcers DPK With pyloroplasty V 2 (20%) case - h ayah marked relapsebleeding from BPB food water, which was stopped using an obturator probe. 1 patient died from posthemorrhagic anemia and acute hepatic-renal failure. Mri suturing bleeding ulcers WPC (2) marked relapse bleedingV both cases: in 1 - from a sutured ulcer and in 1 - from the BPB of the esophagus and stomach, which led to death against the background of increasing liver failure.

Thus, out of the number of urgently and urgently operated patients (39), 6 (15.4%) patients had a relapse bleeding. Died this oh _ group 4 sick, postoperative mortality composed _ 10.3%. Complications And lethal outcomes more often marked at those sick,which were you are full palliative operational interventions _ in view of heavy states, V two cases limited _ only resection stomach, eliminating only the active source of bleeding.

Bleeding was stopped by conservative measures at 44 sick. Lethal Exodus in this group marked at 2 patients (both from group C), or V 4.5% cases. Mrichinaof death acute hepatic-renal failure occurred.

From 44 patients 32 operated on through 3–4 weeks after the bleeding stopped , 14 of them underwent gastric resection (5 according to Gorbashko) with suturing of veins through the stump of the stomach. For duodenal ulcers, various methods of vagotomy were used , of which 13 MCB with proximal gastrotomy with ligation of the BPB of the lower segment of the esophagus and stomach according to M.D. Maciora , 7 were supplemented with laser irradiation with extraperitonealization according to Beresnev , 9 Electrocoagulation for the deceased in this group there was no common mortalityamounted to 7.2%.

So way, choice surgicaltactics for cirrhosis with PG in combination with peptic ulcer complicated bleeding, is certain difficulties. Heaviness state patients are often unable to perform a more adequate amount of surgical intervention. At the same time, on background available violations hemostasis caused by pathologyliver, hypoxia mixed genesis achieve stable hemostasis not always succeeds What leads To relapsesbleeding . That's why in everyone cases necessary correct both causative factors, such as active,So And potential, What promotes reduction numbersrelapses bleeding and improves the immediate results of treatment of patients with this pathology.

Acute gastrointestinal bleeding is still a frequent reason for hospital admission and is a potentially fatal emergency. Variceal hemorrhage is the most frequent cause of acute upper gastrointestinal bleeding in individuals with liver cirrhosis. It is also a major cause of morbidity and mortality in these patients and a dangerous complication of portal hypertension. It's also conceivable for lesions seen in the general population, such as portal hypertensive gastropathy, to cause bleeding. Patients who survive an acute variceal hemorrhage should get therapy to avoid recurrence before they are released from the hospital due to the high likelihood of recurrence.

Conclusion. It has been reported that in patients with cirrhosis, mortality can reach 50% after the index hemorrhage. These patients typically require extensive treatment, which calls for a collaborative approach and clear, step-by-step supervision. Endoscopic therapy is a key aspect, but pharmacological treatment with vasopressors and antibiotic treatment are also important components of successful patient care.

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