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SURGICAL TACTICS AND SCOPE OF SURGICAL INTERVENTION FOR GASTROESOPHAGEAL BLEEDING IN PATIENTS WITH LIVER CIRRHOSIS

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Abstract: The most dangerous and frequent complication of PG syndrome in patients with cirrhosis is bleeding from the urinary tract and gastrointestinal tract, which kills from 14.5% to 90% of hospitalized patients (Patsiora M.D., 1984; V.V. Vakhidov et al., 1988; Karimov Sh.I. et al., 1992, 1996; Johnson Wetal., 1988; Franco D. et al., 2000; , 2000). The mortality rate for this complication depends mainly on the functional reserve of the liver and the duration of bleeding (Sherzinger A.G. et al., 1986; Eramishantsev A.K. et al., 1996, 1998, Nazyrov F.G. et al., 1997;1999; Khashimov Sh.H., 1998, Callow A.D. 1984; According to M.D. Patsiora (1974, 1984), bleeding from the intrauterine veins is observed in 72% of patients with cirrhosis with PG, and in 80% it recurs and 60% of them die within one year. I. Littmann (1982) provides data that 35% of patients with cirrhosis experience the first bleeding, and within 1 year after bleeding, 70% of patients die. According to V.S. Savelyeva et al. (1983), with bleeding from intrauterine veins, mortality, regardless of the method of treatment, is 17-45%. According to W. Johnson et all. (1982) mortality after the first bleeding from varicose veins and gastrointestinal tract ranges from 50 to 80%; A.K.Eramishantsev, 1997; A.G. Scherzenger et al., 1997; S.J. Knechtle et al., 1999; V.A. Luketic et al., 2000 report that the first episode of such bleeding kills 30-40% of patients. M.A. Ballesteros Amozurrutia (1998) provides data according to which bleeding from the esophagus is observed in 80% of patients with varicose veins of the venous zone. Moreover, such bleeding accounts for 1/5 of all gastrointestinal bleeding, and the mortality rate in the first week reaches 27%, after a week - up to 41%, and after a year reaches 75%. In this regard, Vlachogiannakos J. et al., 2000 believe that such high mortality rates and the difficulty of predicting bleeding in PG can justify the treatment strategy for all patients with varicose veins of the esophagus and stomach in order to prevent the first bleeding.

Key words: gastrointestinal bleeding, diseases, fibrosis, nodular, etiological, vascular system.

Introduction. It is erroneous to assert that the cause of any bleeding from the urinary tract is pre-existing liver failure (Morgunov G.A. et al., 1993). According to A.Ya. Lipsky et al. (1980), who analyzed the causes of death of 248 patients with cirrhosis, PN was preceded by bleeding from the urinary tract and liver only in 8.9%, in 12.5% it developed as a result of liver hypoxia due to bleeding. And 37% of patients died from banal anemia as a result of blood loss without any signs of PN due to bleeding that was either uncompensated or not stopped in a timely manner by surgical intervention. G.A. Morgunov et al., 1993 draw attention to the fact that there are two categories of patients with bleeding from intrauterine urinary tract and gastrointestinal tract. The first are patients with advanced cirrhosis, who, against the background of exacerbation of the activity of cirrhosis and PN, develop bleeding from the urinary tract and its temporary stop in most cases ends in death. The second is patients with cirrhosis with good liver potential, in whom

stopping bleeding should include the use of the entire arsenal of temporary stoppage, followed by clarification of the optimal option for surgical correction of hemorrhage.

Thus, from the data presented, it is obvious that the problem of treating bleeding from intrauterine veins in patients with cirrhosis has not lost its importance at present.

The use of such modern technologies as computed tomography, nuclear magnetic resonance, Doppler ultrasound, endoscopic echography, digital angiography, complex radionuclide studies in the diagnosis of complications of CP and PG will in the near future contribute to the solution of not only controversial issues of PG formation in patients with cirrhosis, but also optimization indications for selecting patients with cirrhosis for surgical treatment.

Thus, V. Kraus et al., 1995 conducted a comparative assessment of the effectiveness of diagnostic methods of echography, computed tomography, and nuclear magnetic resonance. According to their data, all methods are equally effective in assessing the condition of the portal vein. Ultrasound methods and nuclear magnetic resonance are more sensitive than computed tomography in the qualitative and quantitative characteristics of portal blood flow; nuclear magnetic resonance is more sensitive in determining blood flow through the splenic vein and its direction. Computed tomography and nuclear magnetic resonance are noticeably more effective than ultrasound methods in diagnosing the spread of varicose veins and spontaneous RCA. According to G. Galetti et al., 1995, endoscopic echography is one of the most promising methods for examining patients with cirrhosis. It allows you to simultaneously have an image of most of the portal vein system and, especially, its collaterals adjacent to the gastroesophageal zone, to effectively assess the condition of the venous vessels of the liver itself during (ZwiebelW., 1995; Michielsen P. etal., 1995).

Y. Patel et al., 1995 believe that computed tomography as a method of studying the portal system is unlikely to be inferior to endoscopic echography. This method makes it possible to see collateral vessels in all details. It can be seen that varicose veins have a tubular or tortuous structure, they are smooth, have a homogeneous liquefaction and are effectively contrasted. Moreover, the same authors found that in 80% of patients with cirrhosis and varicose veins, the most pronounced natural collateral vessels were the coronary veins of the stomach.

Methodology. A radioisotope method for assessing portal hypertension is presented in the study of J. Wang et al., 1995. The heart-liver ratio (H/L) was chosen as a parameter describing the condition of patients. In three groups of patients: control (15 people), histologically confirmed viral hepatitis (13 patients), cirrhosis (57 patients). The H/L ratio was respectively equal to: 0.27+ 0.14; 0.43+0.14; 1.00 +0.28 ($p<0.001$). A large H/L value was associated with a high probability of encephalopathy (1.25 + 0.17) and ARVIP - (1.27 + 0.20). An association was also noted between H/L and bilirubinemia, albuminemia, and prothrombin levels. A clear relationship was found between H/L and portal vein pressure. The regression equation made it possible to calculate the pressure in the PS. The prognostic value of the test was confirmed by the fact that a good correlation was observed between H/L and the well-known prognostic classification (Child-Pugh). This gives reason to hope that this new method can be adopted for non-invasive assessment of the degree of pSS, to predict and monitor the effects of drug interventions to reduce cirrhosis in patients with cirrhosis.

Improving the methods of radionuclide diagnostics of portal circulation disorders, S. Shiomi et al., 1995 discovered an effective assessment criterion for the condition of the liver - the liver shunt index. These authors found that the liver shunt index was highest in patients with cirrhosis compared to patients with chronic hepatitis and the control group of subjects. The value of the shunt index increases if there are complications of PG - varicose veins, ascites or encephalopathy. The correlation between the bypass index and the classical indicator of liver functional reserve was significant. The shunt index was empirically associated with the survival of patients with cirrhosis, on the basis of which the authors identified 3 groups of patients with cirrhosis: A (< 30%), B (10 < index < 70%), C (- 70%). Survival was lower in groups B, C

compared to A, but lower in C than in B. The authors believe that the method can be effective in predicting the outcome of PSS surgery.

Studying the influence of structural changes in hepatocytes and sinusoids liver for the state of portal hypertension using the method of morphometric analysis, implemented in the form of a computer system with a color image analyzer, was adopted by N. Imamura et al., 1994. For this purpose, the pressure gradient coefficient in the sinusoidal space of the liver was used, which was calculated theoretically based on the Poiselle equation. Significant differences were found when comparing this indicator with the pressure gradient in the hepatic vein. The absolute values of the former were much lower than those of the latter. Therefore, in cirrhosis, compression of the liver sinusoidal space by proliferating hepatocytes may increase vascular resistance to portal blood flow. Similar hemodynamic coefficients of blood flow in the portal system were studied using phase-contrast magnetic resonance imaging D. Burkart et al., 1993. The effectiveness of the method was assessed in comparison with echo Dopplerography. The authors claim that the proposed method is accurate, and given its non-invasiveness, it is promising for measuring volumetric blood flow in the portal vein system, which is fundamentally important when addressing issues of surgical intervention.

Conclusions The vast majority of methods of direct operations on ARVIZh are of only historical interest. Gone and practically not used are such traumatic interventions as methods of transthoracic access to the esophagus and suturing of large venous trunks of the submucosal layer of the esophagus J. Boerema (1949), I. Crile (1950), K.N. Tsatsanidi (1987); complete transverse transection of the esophagus (Walker R.M., 1952), circular dissection of the muscular lining of the esophagus (Nissen N., 1954), transverse transection of the stomach (Tanner N., 1961) in various modifications (Petrov B.A., 1959; Napalkov N.N. ,1971; Nilson et aI., 1970, etc.), gastrectomy (Wangensteen O.H., 1947), resection of the lower third of the esophagus and cardia (Phemister et Humphreys, T947), isoperistaltic esophagostomy according to Roux (Barnes, Redo, 1957), interposition of an isolated segment small intestine (Merendino et Dillard, 1955), interposition of an isolated segment of the large intestine (Cohr et Rodely, 1958), extirpation and replacement of the esophagus (Cohn et Mathewson, 1957) and many others. Of this type of disconnecting operations, the operation of M.D. Patsiora (1971) continues to be widely used - gastrotomy with suturing of the veins of the cardia and esophagus from the stomacous membrane of the stomach. There are quite a lot of publications about the use of the operation M. Sugiura, S. Futagara (1973), performed from thoracic and abdominal approaches, one- and two-stage. It consisted of a combination of ligation of the veins of the esophagus by crossing it and suturing it in the lower third with extensive devascularization of the esophagus (up to 18 cm) and stomach (7 cm along the lesser curvature), splenectomy, vagotomy and pyloroplasty.

To this day, there are isolated messages about the performance of other operations of this type. So, K. Sanjoetal. (1992) reported transsection and devascularization of the esophagus in 60 patients with PG with good results. M.P. Wilansky et al. (1988) provide data on transsection of the esophagus using a stapler and a mortality rate of 24.1%. And in 1992. J. Manzano-Irovamala et al. reported on laparoscopic esophagogastric devascularization and transsection of the esophagus in a patient with cirrhosis.

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