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ENDOSCOPIC AND ENDOSURGICAL TREATMENT OF CHOLEDOCHOLITHIASIS

Yangibaev Otabek Zaribboevich
Tashkent Medical Center National Academy of Sciences

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Abstract:

Our first experience with the use of our developed papillotomes in patients with calculous cholecystitis, choledocholithiasis, and DSFS shows the prospects of this technique.

Keywords: Cholelithiasis (GI), Laparoscopic cholecystectomy (LCEC), endoscopic papillosphincterotomy (EPST), choledocholithotomy (CLT), choledochoduodenoanastomosis (CDA), papillosphincterotomy (PST), transduodenal papillosphincteroplasty (TDPSP), precancerous stenosis of the Vater nipple (DSFS), the terminal part of the choledochus (PCH), and the vater parts of the nipple (FS).

INTRODUCTION. Today, worldwide cholelithiasis is mainly treated by laparoscopic cholecystectomy (LCEC), and endoscopic papillosphincterotomy (EPST) with the removal of stones from the hepaticocholedocha. But, the results of these methods of treatment sometimes do not satisfy a number of experienced surgeons, which requires the search and development of new methods of treating this pathology.

PURPOSE OF THE STUDY To improve the results of endosurgical treatment of patients with GI.

RESEARCH OBJECTIVES. Find ways to improve the treatment of patients suffering from GI.

MATERIALS AND METHODS OF RESEARCH. During the last almost For 50 years, we have been studying the results (our own and other experiments) of the treatment of GI by open and LCEC, choledocholithotomy (CLT), endoscopic papillosphinterotomy (EPST), choledohoduodenoanastomosis (CDA) and papillosphincterotomy (PST), transduodenal papillosphincteroplasty (TDPSP), etc., using the most modern research methods (Clinical and laboratory, Ultrasound, CT scan, RPHG, MRI cholangiography, etc.). However, it turned out that all of them were not saved from a number of complications

DISCUSSION OF THE STUDY RESULTS. Our observations have shown that recently cholelithiasis is mainly treated by LCEC and EPST, and other operations (CDA, PSP, etc.) are less often used. Some patients after the above-mentioned operations on the biliary tract, often need repeated treatment due to various complications (mainly for "postcholecystectomy syndrome", as well as for "postcholecystectomy syndrome"). as well as residual or recurrent choledocholithiasis and DSFS .Among them, the most common type of treatment turned out to be LCEC and EPST, and it turns out that they were not covered by a number of shortcomings.

These include applies to-nevocability of DSFS cannulation in up to 26.6% or more cases, non-radicality in extended DSFS, T perforationTschX or duodenum up to 0,3 - 3 %, postoperative pancreatitis up to 2 - 10%., postoperative pancreonecrosis up to 2%, mortality reaching up to 0.2-3%.and sometimes even more (especially in emergency surgery) Finally, EPST can sometimes be non-radical and not always safe, and also not always possible. Especially in advanced cases of pathology, when there is an expansion of the diameter of the hepaticocholedocha more than 20 – 30 mm. In addition, these operations are more often performed two times, first LHEC, then EPST, or noorot.

Therefore, we have developed new methods of PST that allow performing operations during LCEC and choledocholithotomy, by using the new "papillotomes" created by us, which allow us to expand the narrowed part of the FS quickly, bloodlessly and standardly (only the narrowed part of the FS expands strictly to the required diameter). This method, after being tested in an experiment (on a cadaver and on animals), was used in clinical practice in 18 patients operated on for CDL and DSFS (1-2 degrees) when the extent of stenosis did not exceed 10 -12 mm. In all operated patients, the postoperative course was smooth (without complication).

CONCLUSIONS. Our first experience with the use of our developed papillotomes in patients with calculous cholecystitis, choledocholithiasis, and DSFS shows the prospects of this technique.

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