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SURGICAL TACTICS IN ACUTE GASTRODUODENAL BLEEDING OF ULCERATIVE ETIOLOGY

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Abstract:

The choice of surgical tactics for gastroduodenal ulcer bleeding remains a highly relevant challenge. Although this topic has been widely discussed in the literature, disagreements persist between advocates of active intervention and those supporting a more conservative, expectant approach. Between 2015 and 2025, a total of 1,816 patients with gastric and duodenal ulcer bleeding underwent surgery at the Andijan State Medical Institute. Individually tailored active tactics enable accurate assessment of blood loss and patient condition, precise identification of the bleeding source, and optimal surgical timing, thereby improving outcomes in ulcerative gastroduodenal bleeding through the use of organ-preserving procedures.

Keywords:

RELEVANCE. Surgical tactics in gastroduodenal ulcerative bleeding still remain one of the most pressing problems. Despite the fairly frequent coverage of these issues in the literature, there are still differences between proponents of active and actively expectant tactics [2,6,9,12].

Based on the modern possibilities of diagnostic and therapeutic endoscopy, the availability of more reliable methods for determining the amount of blood loss, the possibilities of local and general hemostatic therapy, surgical tactics for ulcerative bleeding, from our point of view, it is impractical to build on the principles of a general increase in activity, which leads to an unjustified increase in the proportion of quite risky and often ineffective emergency surgical interventions[4,6,10,14]. At the same time, one should not stand in positions of prolonged dynamic observation, which creates an increased risk of recurrence of bleeding, leads to a delay in the timing of surgery, and increases the proportion of despair operations, the results of which remain unsatisfactory [3, 11].

A more serious individual approach is needed to choose the indications, timing and methods of surgical interventions, based on the following factors; 1) severity, volume and rate of blood loss; 2) localization, size and a formal assessment of the ulcerative substrate and the arrosized vessel; 3) duration of bleeding; 4) age, concomitant pathology and medical history; 5) the degree of operational risk.

A comprehensive assessment of these indicators makes it possible to formulate therapeutic and diagnostic tactics for ulcerative gastroduodenal bleeding as individually active, consisting of active diagnostic and individually active surgical tactics [1,8,9,14].

Active diagnostic tactics include emergency determination of the volume of blood loss and endoscopic examination to determine the location, size, and nature of the ulcer and the arrosied vessel, determine the rate of bleeding, and prognostically assess the possibility of its recurrence after achieving hemostasis [5,7,13,16]. At the same time, urgent laboratory diagnostic tests are performed: clinical blood and urine tests, basic biochemical analyzes, a coagulogram, an ECG, etc. The anamnesis of the disease and the nature of the concomitant pathology are being investigated. In severe and extremely serious condition, patients are hospitalized in intensive care and intensive care units or taken directly to the surgery room, where emergency endoscopy is performed under the protection of hemotransfusion and measures aimed at normalizing central hemodynamics [10,12,15]. In case of life-threatening bleeding, the complex of rehabilitation measures also includes emergency laparotomy with simultaneous endoscopy.

THE PURPOSE OF THE STUDY is improving the effectiveness of surgical treatment of gastroduodenal ulcerative bleeding by improving surgical tactics.

MATERIALS AND METHODS. In 2015-2025, 1,816 patients with bleeding ulcers of the stomach and duodenum were operated on at the Andijan State Medical Institute on the basis of the Andijan branch of the Republican Scientific Center for External Medical Care.

RESULTS AND DISCUSSION. Individually active surgical tactics include, based on the above factors, the establishment of indications and the implementation of surgical interventions, which,

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depending on the timing, are divided into the following 3 groups.

1. Emergency operations, or operations "at the height of bleeding", are performed at any time of the day for vital indications, which include: non-stopping profuse bleeding, recurrent bleeding in the hospital, a combination of bleeding and perforation.

2. Delayed operations are performed after stopping bleeding within 2-3 days in patients, most of whom have absolute indications for surgical treatment of peptic ulcer disease without bleeding; as a rule, there is a high risk of recurrence of profuse bleeding. Indications for delayed operations are: large-sized chronic colloidal ulcer with penetration into adjacent organs and tissues: chronic ulcer complicated by pyloric stenosis at the stage of sub-or decompensation: suspected malignancy of the ulcer; massive blood loss, unstable hemostasis with a long-term history of ulcerative diseases, especially in the elderly. Hemostasis in such situations is unreliable, recurrences of profuse bleeding are noted in 35-40% of patients, and excessively prolonged conservative measures in case of recurrent hemorrhage significantly worsen the condition of patients. This is especially dangerous in elderly and senile people with a history of ulcers for many years, who show the most severe morphological changes in the stomach and duodenum, as well as pronounced atherosclerosis of the arrosied vessels, which prevents stable bleeding.

3. Early elective operations are performed in patients with mostly relative indications for surgical treatment of the venous disease, provided stable hemostasis is achieved. Indications for them should be considered: a long-term ulcerative history; ineffectiveness of conservative treatment prior to bleeding; repeated bleeding; the presence of a chronic ulcerative ulcer, although first identified.

Operations are performed on the 10th-18th day after achieving stable hemostasis, complete replacement of blood loss and a long-term examination of the patient.

In the postoperative period, 112 patients died (mortality 6.1%), mostly elderly and senile with severe concomitant pathology, who underwent surgery for urgent indications. Emergency operations were performed in 345 patients (18.9%), 38 died (mortality 11.0%), delayed interventions -in 152 patients (8.3%), 6 died (mortality 3.9%), early elective operations -in 1319 patients (72.5%), 13 patients died (0.98%). The results of various types of operations are presented in table 1.

Table 1.
Results of various types of operations

№	Types of operations	All	Number	Deaths
1	Gastric resection: a.emergency b.delayed c.early planned	424 86 29 309	19 14 1 5	4,4 16,2 3,4 1,6
2	Vagotomy with antrumectomy: a.emergency b.delayed c.early planned	435 88 37 310	16 11 1 4	3,6 12,5 2,7 1,2
3	Vagotomy with excision of a bleeding ulcer: a.emergency b.delayed c.early planned	957 171 86 700	20 13 2 4	2,0 7,6 2,3 0,57
Total number		1816	110	6,1

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It follows from the table that the best results were obtained when performing organ-preserving interventions using techniques developed in the clinic, with radical removal of the ulcerative substrate and one type of vagotomy, most often anterior selective proximal, posterior stem. They are most preferable for emergency operations, which is manifested by a sharp reduction in the number of deaths (7.6% compared with 16.2% after gastric resection and 12.5% after antrumectomy with vagotomy).

Low injury rate and duration, good tolerability even in patients with increased surgical risk make these interventions the method of choice for ulcerative gastroduodenal bleeding.

Less significant differences in the results of delayed interventions (mortality 3.4% after resection,2.7% after antrumectomy with vagotomy and 2.3% after organ-preserving operations) are explained by a relatively homogeneous contingent of patients in a number of key characteristics (severity and duration of blood loss, age, concomitant diseases). The use of organ-preserving operations with excision of the underlying ulcer significantly reduced the number of deaths after early elective interventions (0.57% compared with 1.6% after gastric resection and 1.2 antrumectomy with vagotomy), which also indicates their advantage.

CONCLUSION. Thus, individually active tactics allow for a differentiated approach to assessing the severity of blood loss and the patient's condition, diagnosing the source of bleeding, and choosing the rational timing of surgery with extensive clinical implementation of organ-preserving interventions, which significantly improves the treatment outcomes of patients with gastroduodenal bleeding of ulcerative origin.

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