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SURGICAL MANAGEMENT FOR BLEEDING FROM ESOPHAGUS VARICOSE VEINS

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Abstract
Portal hypertension and bleeding from varicose veins of the esophagus and stomach due to portal hypertension are the most dangerous and threatening complications of liver cirrhosis (6,7). The mortality rate from ongoing bleeding is about 4-8% (6,8,11). 20% of patients with acute bleeding die within 6 weeks compared with other complications (6,8,11). Mortality from rebleeding in patients with decompensated stages of liver cirrhosis reaches up to 78% (7). Currently, there are a number of different methods for the treatment of portal hypertension complicated by bleeding from varices of the esophagus and stomach (VES), including both endovascular interventions and endoscopic treatment. Many surgical methods have been developed to reduce pressure in the portal vein and prevent re-bleeding. But these operations have their limitations. Minimally invasive methods for bleeding from VES include endoscopic sclerotherapy, endoscopic ligation, endovascular transjugular intrahepatic portosystemic shunt, endovascular percutaneous transhepatic embolization of gastroesophageal varices and other combined methods.
Surgical practice has proven that treatment results and patient survival are much better with delayed and especially with planned surgical interventions. At the same time, in the last decade, preference has been given to indirect portocaval anastomoses, and recently many adherents of the Sugiura operation have appeared (3,10,13).
Thanks to the joint efforts of gastroenterologists, radiologists and surgeons in the treatment of bleeding from the esophagus with portal hypertension, gastrointestinal endoscopy and invasive diagnostic and therapeutic radiographic methods have acquired significant importance. Transendoscopic sclerotherapy of VRV has become particularly widespread. Recurrence of hemorrhages is possible in approximately 10% of cases, which is not much higher than the best results of surgical treatment (1,6,11), and complications (mediastenitis, pyothorax, bleeding, stenosis) develop in only 2% of patients (3).

Keywords Surgical management, esophagus, varicose veins.

INTRODUCTION

Purpose of the study. Improving the results of surgical treatment in patients with bleeding of esophageal varices due to portal hypertension and cirrhosis of the liver.

MATERIAL AND METHODS

Patients treated at the Department of General Surgery, Anesthesiology and resuscitation of the Andes State Medical Institute and surgery department of Republican Research Center Emergency Medicine of the Andijan branch during 2013-2024. 164 patients with portal hypertension were operated on. 38(127) other patients received only conservative treatment, including active resuscitation, hemostatic drugs, blood transfusions, vitamins, cimetidine, etc. We used

fibrinolysis inhibitors (e-aminocaproic acid, trasylol), as well as medications that reduce pressure in the portal system (vasopressin , somatostatin, proprenolone, etc.).

Results and discussion. The Blakemore probe was used in the treatment of 28 (59) patients, a positive result was noted in 16 (32) of them. After conservative treatment, 38(59) patients, 9(28) died. Observing patients in this group allows us to draw some conclusions. In most patients, the use of 20-21 units of pitugormone intravenously, followed by a maintenance dose of 8 units, gives a fairly good result. The effect in patients with subhepatic block is much better and longer lasting, while in patients with decompensated cirrhosis all measures often fail. The results of local compensation are unreliable and success is temporary. This time should be used to prepare the patient for surgery or sclerotherapy.

Surgical treatment was performed in 164 patients. Urgent surgical intervention was performed in 27 of them due to massive bleeding from the cervical vein and unsuccessful conservative treatment, the other 11 people were operated on urgently within 24-72 hours. Of these 38 patients, 22 died (mortality rate 57%). The operations used are varied, some of them are of only historical significance. The remaining 126 patients were operated on as planned. The main indication for surgery was bleeding from esophageal varices. 111 patients had a history of one or more bleeding events. 80% of these patients had intrahepatic block.

The main surgical interventions were splenectomy - alone or in combination with another technique (73), direct portacaval anastomosis (10), splenorenal anastomosis (19), etc. After the operation, 15 patients died (mortality rate 12.4%), which is significantly less than compared to with the previous group. Early recurrent postoperative bleeding developed in 14 (8.5) of 164 patients. Bleeding was caused by repeated rupture of the cervical vein in 9 of them (5.4%), acute (2) or chronic (2) gastric ulcer and was a consequence of anticoagulant therapy (1). These bleedings occurred after 7 urgent and 7 planned surgical interventions.

These data indicate unfavorable results of urgent operations. Significantly better results with a longer lasting effect were obtained after conservative treatment of hemorrhagic shock and planned surgical intervention. Quite satisfactory results were also obtained with the Sugiura operation, performed in 2 patients. We used a modified version in which splenectomy, devascularization of the upper 2/3 of the stomach and 1/3 of the esophagus, instrumental transsection and reanastomosis of the esophagus were performed through the abdominal approach. Postoperative observations indicate rapid stabilization of the patients' condition and the absence of recurrent bleeding.

The rapid development of endoscopy in the last 15 years has led to its use in esophageal varices. Endoscopic sclerotherapy is currently used in various ways for bleeding from the esophageal varices. The goal of this method is to achieve complete obliteration of the esophagus in the distal third of the esophagus. This stops the hemorrhage or reliably extends the period (up to 1-2 years or more) before a new relapse occurs. The great advantage of this method is the possibility of simultaneous diagnosis and treatment of the disease.

Sclerotherapy. It is performed under the same conditions as routine endoscopy. A 1-3% solution of Aethoxysclerol is injected into the esophagus of the distal third of the esophagus 10 times per course of treatment with an interval of 3-7 days. At least 4 courses of treatment are carried out. We used this method in 48 patients, less than 4 courses – in 5 patients. Immediately after the manipulation, complete obliteration of the varicose veins was observed in 33%, and their reduction was observed in 64% of patients. Over the next 2 years, no complications were observed. 4 patients died: 1 after the second course of sclerotherapy without recurrent bleeding due to the development of primary liver cancer, the remaining 3 with the clinical picture of hepatic coma, 2 of them without recurrent bleeding and 1 with bleeding from the hepatic vein.

CONCLUSION. The method is accessible, poses no risk to patients, and produces few complications. The effectiveness of obliteration is achieved with the help of varying amounts of sclerosing drugs, depending on the severity of varicose veins, the condition of the surrounding mucosa and other factors.

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