ISSN: 2775-5118 VOL.3 NO.11 (2024) I.F. 9.1

ORGANIZING EMERGENCY CARE FOR PATIENTS WITH ESOPHAGEAL BLEEDING AT THE REGIONAL LEVEL AND DEVELOPING OPTIMAL LONG-TERM

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Annotation. In solving the block of urgent problems before the created emergency medical care service, the most pressing issues are organizing emergency care for patients with esophageal-gastric bleeding. The results of treating such bleeding, especially in patients with liver cirrhosis, remain extremely unsatisfactory. And this is stated against the background of the increase in the number of patients with chronic hepatitis in a number of regions of Uzbekistan revealed by the analysis of the previous chapter. According to the latest, updated data, within 2 years after the detection of liver cirrhosis, bleeding from the esophageal varices and gastrointestinal tract occurs in 35%, and 55% of patients die during its first episode.

Despite modern, original methods of hemostasis using surgical, pharmacological, angiographic and endoscopic equipment, the issues of treatment tactics for bleeding from the esophageal varices and gastrointestinal tract in modern surgical hepatology remain in the category of urgent, controversial and completely unresolved problems.

Key words: diseases, fibrosis, nodular, etiological, vascular system

Introduction. Some authors treat these patients with conservative methods. Others believe that surgical treatment at the height of bleeding gives the best results. Although it should be noted that in recent decades there have been certain changes in the treatment tactics for this group of patients. This is due, on the one hand, to new achievements in pharmacology, improvement of angiographic, endoscopic and surgical equipment, clarification of indications and contraindications for its use. On the other hand, the approach to patients with LC with bleeding from the esophageal varices and liver has become selective and more differentiated. Depending

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on the functional state of the liver, patients are divided into three groups: ChildA - minimal, B - moderate, and C - severe changes in liver function. The results of treatment of group A are assessed as good with a mortality rate of 5%, and the mortality rate in group C reaches 68%. The triad of unfavorable signs - jaundice, ascites, and encephalopathy - increases mortality to 80-90% (Sh. Sherlock, 1999).

Methodology. The standardized tactics for bleeding from the varicose veins and the gastrointestinal tract developed in developed countries include high-tech expensive hemostasis methods, such as transjugular portosystemic shunting, transhepatic endoportal embolization of the varicose veins and the gastrointestinal tract, endoscopic ligation, clipping, sclerotherapy options for veins, the use of vasoactive drugs, and even liver transplantation. Unfortunately, the use of the vast majority of the listed methods guarantees the achievement of stable hemostasis in bleeding from the varicose veins and is available only to certain specialized centers. Taking into account these features in modern PG surgery, the following two conceptual options for the tactics of managing patients with cirrhosis with bleeding from the varicose veins and the gastrointestinal tract should be recognized as the most adapted to practical use in the conditions of the emergency medical care service created in Uzbekistan. The concept of diagnostic and treatment tactics formulated by A. Keramishantsev et al., 2000, based on the experience of 30 years of treatment of more than 1000 patients with acute bleeding from the varicose veins of the esophagus and stomach. An important point in determining the treatment tactics, according to these authors, is an emergency endoscopic examination. The source of bleeding in patients with varicose veins of the esophagus and stomach is most often located in the area of the cardia of the stomach and the lower third of the esophagus. The use of a Blackmore-type obturator probe provides primary hemostasis in 94% of patients. After stabilization of hemodynamics, a constant infusion of nitroglycerin solution is performed, which reduces portal pressure by an average of 28%. The effectiveness of other drugs (vasopressin, glypressin, somatostatin, sandostatin) is low. In the future, during 24 hours, measures are used to detoxify the body by cleansing the intestines with siphon enemas or transintestinal irrigation with solutions of osmotically active substances.

Conclusions Observations have shown the possibility of recurrent bleeding during the first three days from the moment of admission in 25% of patients. In this regard, within 24 hours, a decision should be made on further tactics, namely: surgical intervention, endoscopic sclerotherapy of veins, endovascular embolization of extraorgan veins of the stomach or continuation of conservative therapy. Patients with liver cirrhosis in the compensation and

subcompensation stage and extrahepatic portal hypertension in case of recurrent bleeding or the threat of its occurrence should be urgently operated on. The operation of choice is suturing of the veins of the esophagus and stomach, which was performed in 236 patients with a postoperative mortality of 30.9%. For patients with decompensated liver cirrhosis, surgery is poorly tolerated, which is what causes the high mortality rate - 70%.

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