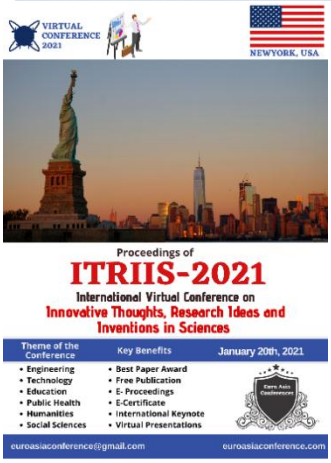

OUR EXPERIENCE IN TREATMENT OF STRESS ULTRASONS IN SEVERE BURNED

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Relevance.

Among the serious complications in severely burned patients are lesions of the gastrointestinal mucosa, including erosion and ulcers. Erosive and ulcerative bleeding from the upper digestive tract is one of the most severe complications in severe thermal burns. It is noted that in victims of severe thermal burns, the frequency and extent of erosive and ulcerative lesions of the upper gastrointestinal tract and bleeding from them is directly proportional to the area and depth of the burn and the degree of burn shock. Although gastrointestinal bleeding is the immediate cause of death in 1-3% of burn victims, mortality in patients with complicated acute ulcers remains at a high level for many years, reaching 50-100%. In 56-75% of cases, severe burns entail asymptomatic erosive and ulcerative lesions of the gastrointestinal tract, which are diagnosed only at autopsy.

Keywords

Burn Disease, Gastroduodenal Bleeding, Treatment.

Material and methods.

In the control group of patients from 2014 to 2019. in the Samarkand branch of the RSCEMP, from the moment of hospitalization, stress ulcers were diagnosed in 41 (40.59%) of 101 severely burned patients. There were 65 (64.36%) men and 36 (35.64%) women. The patients' age ranged from 17 to 72 years (41.5 ± 3.5 years). At the same time, in 20 (48.78%) patients, stress ulcers developed in a severe and extremely serious condition, and in 21 (out of 41) people (51.21%) of whom there was an unfavorable life prognosis. All patients were divided into two groups. Patients of the first group (n = 73) received histamine H2-receptor blockers from the moment of admission in shock 20 mg x 1-2 times a day - 7-10 days, sometimes up to 20 days - intravenously. At the stage of septicotoxemia: 20 mg at night and in the morning peros for 24-30 days. The comparison group consisted of burned (n = 28), who had comparable thermal lesions and, for various reasons, did not receive histamine H2 receptor blockers. Some of them received antacids (sodium bicarbonate, calcium carbonate), gastroprotective agents (sucralfate or aluminum sucrose sulfate).

Results and its discussion.

When analyzing the nature of the sources of bleeding, the following data were obtained. According to the results of diagnostic EGDFS in patients of the control group, erosive changes in the mucous membrane of the upper gastrointestinal tract were detected in 9 (8.91%), and ulcerative defects - in 12 (26.73%) patients. In addition, 5 out of 41 (4.95%) severely burned patients showed a simultaneous combination of mucosal erosion and acute ulcers.

In patients of the first group (n = 73), after 2-3 days of treatment with histamine H2-receptor blockers (ranitidine, histodil, quamatel), pain in the epigastric region significantly decreased, the feeling of discomfort in the stomach area, heartburn, belching almost disappeared,

pronounced paresis of the gastrointestinal tract. At pH-metry, an increase in pH by 52% from the initial one was noted. Healing of erosions up to 1 mm in diameter was observed on average in 8-10 days. Bleeding from acute ulcers was detected in 8 (out of 73) patients (10.95%), which stopped after endoscopic therapy. One patient had a relapse on the second day.

In patients of the comparison group (n = 28), pain syndrome, discomfort in the stomach, belching persisted for 7-10 days, some had vomiting of eaten food. With pH-metry, an increase in pH was noted only by 25% from the initial one by the end of the burn shock stage. In 21 (out of 28) patients, GCC were identified, which were stopped endoscopically, but relapse occurred in three cases.

Endoscopic hemostasis (injection, clipping, coagulation) was performed urgently in 10 patients with ongoing bleeding. In three cases, due to the impossibility or instability of the achieved hemostasis, it was necessary to expand the volume of intervention to an emergency gastroduodenotomy and surgical stopping of bleeding. In the remaining 7 cases, it was possible to stop bleeding by the endoscopic method.

Thus, the need to expand the volume of surgical intervention to an emergency gastroduodenotomy with suturing of the bleeding source arose in 2 victims. Until recently, bleeding in acute ulcers in burned patients was considered a surgical problem, while our data indicate that the problem of bleeding in burns should be solved by combustiologists together with endoscopists and surgeons, while the role of surgical interventions should be minimized when using preventive and therapeutic measures ...

Conclusions.

The pathogenetically substantiated method of choice in the development of massive bleeding in burned patients is endoscopic arrest against the background of complex hemostatic, replacement and angioprotective therapy. If it is impossible or ineffective to stop bleeding, laparotomy with gastro- or duodenotomy and suturing of the bleeding vessel in the ulcer should be performed, and if an acute ulcer is perforated, it should be sutured, since ulcers in burned patients are acute and do not lead to the development of peptic ulcer disease, and hyperchlorhydria is of a temporary stimulated nature and at the end of the acute period of the burn disease, gastric secretion returns to its original state. It should be noted that endoscopic stopping of bleeding has now taken the leading place in the provision of assistance to other categories of patients with gastroduodenal bleeding.

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