Methods of treatment of acute intestinal obstruction

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Annotation: this article is dedicated to the treatment of acute intestinal obstruction

Key words: postoperative period, anticoagulant therapy, lumbarization, drainage of the small intestine according to Dederer, Jitnyuk, nasogastrointestinal intubation.

Treatment of acute intestinal obstruction is a difficult task and it must be pathogenetic and complex. That is why all patients with acute intestinal obstruction or even with suspicion should be immediately hospitalized in the surgical department, where the diagnosis is clarified or confirmed by differential diagnosis with a possible other acute pathology of the abdominal cavity and, first of all, the nature of the existing obstruction is clarified. Treatment of patients with acute intestinal obstruction in the preoperative, operational and postoperative periods includes: 1) decompression of the gastrointestinal tract; 2) elimination of obstruction; 3) removal of toxic contents from the intestinal tube; 4) fight against peritonitis; 5) correction of metabolic and hemodynamic disorders Pain control is also carried out (administration of analgesics, antispasmodics), stimulation of intestinal activity, anticoagulant therapy.

In some cases, conservative therapy can be an independent method of treatment, for example, with dynamic - paretic and spastic intestinal obstruction, and even with some types of mechanical - coprostasis, for example. With strangulation obstruction, volvulus or intussusception, conservative treatment is possible only for the purpose of preoperative preparation because of the risk of wasting time and the threat of viability of the intestine. Conservative therapy is also carried out until the final diagnosis is established. At the same time, it is inappropriate to use novocaine blockades, analgesics, especially narcotic ones. An absolute contraindication to conservative treatment are signs of increasing intoxication and peritonitis. The main method of treatment of mechanical forms of acute intestinal obstruction is surgical. All patients with acute intestinal obstruction subject to surgical treatment undergo preoperative preparation, the volume of which is determined by the duration of hospitalization, the degree of intoxication and the severity of the patient's condition. It includes the

following activities: 1. Constant aspiration of gastric contents; 2. Cleansing or siphon enema until the determined effect; 3. Bladder catheterization followed by diuresis control; 4. Intensive corrective infusion therapy; 5. Preventive antibiotic therapy (broad-spectrum antibiotics); 6. The use of antispasmodics; 7. Anticoagulant therapy. The terms of preoperative preparation coincide with the terms of permissible conservative therapy and should not exceed 1.5–2 hours. In the absence of the effect of the ongoing treatment, surgery is indicated. General anesthesia is applied. In this case, it is necessary to obturate the lumen of the trachea well in order to avoid getting gastric contents there and developing severe bronchospasm (Mendelssohn's syndrome). Access should be free enough. The operation for acute intestinal obstruction is always performed under anesthesia by a three-medical team. When performing the operation, the following tasks should be solved: 1. Elimination of the cause of intestinal obstruction (dissection of adhesions, removal of a foreign body, resection of the intestine, etc.); 2. Fight against peritonitis (sanation and drainage of the abdominal cavity, drainage (intubation) of the small intestine); 3. Carrying out detoxification (removal of the contents of the small intestine) - drainage of the thoracic lymphatic duct, enterosorption, lymphosorption, plasmapheresis, hemosorption, peritoneal dialysis, blockade of the mesentery of the small intestine; 4. Prevention of cardiovascular, thromboembolic and pulmonary disorders; 5. Fight against hepatic and renal insufficiency. Particular importance is attached to drainage and decompression of the small intestine, while the method of nasogastrointestinal intubation is especially effective, but some surgeons use drainage of the small intestine according to Dederer, Zhitnyuk, and cecoenterostomy. Indications for bowel decompression are: 1. Diffuse peritonitis. 2. The presence of microcirculatory changes in the intestinal wall, but with its viability preserved. Z. After resection of a section of the intestine in conditions of paresis and peritonitis. 4. With persistent postoperative intestinal paresis, not amenable to corrective therapy. 147 Taking into account severe metabolic disorders, pronounced changes in the internal organs and a violation of their function, often combined with peritonitis, treatment should be comprehensive. It is necessary to carry out adequate corrective infusion therapy (intravenous administration of polyionic and plasma-substituting solutions, administration of 5% glucose solution, vitamins) in order to replenish the volume of circulating blood, water-electrolyte, colloid-osmotic and acid-base disorders, correction of protein losses by introducing protein hydrolysates, amino acid solutions. Tissue hypoxia is eliminated by normalizing external respiration, correcting hemodynamics by introducing cardiac and respiratory agents and respiratory analeptics. Sorption methods of detoxification can be used - hemo- and

lymphosorption, enterosorption. Of great importance in the postoperative period is the restoration of motor function of the intestine. For this, in addition to draining and washing the intestines, epidural anesthesia, the introduction of drugs stimulating intestinal motility (prozerin, ubretide), and electrical stimulation of the intestines are used. Antibacterial therapy is started before surgery and continued in the postoperative period by intramuscular, intravenous and intraperitoneal administration of antibiotics. The intubated intestine is regularly washed out, and the contents of the stomach are constantly aspirated. Correction of microcirculatory disorders, immunocorrection is carried out. Mandatory control of diuresis. Activation of the patient in bed, breathing exercises, massage, physiotherapy exercises, oral care, general hygiene measures also greatly contribute to the rehabilitation of patients. Prevention of thromboembolic disorders is carried out by the appointment of antiplatelet agents, anticoagulants, active management of patients after surgery. Mortality after surgery for acute intestinal obstruction remains high (13–18%). Early hospitalization and early surgical intervention greatly influence the outcome of the disease. Thus, according to many surgeons, mortality among patients with acute intestinal obstruction operated on in the first 6 hours is 3.5%, and among those operated after 24 hours - 24.5% or more.

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