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SURGICAL TREATMENT OF INFECTED PANCREATIC PSEUDOCYSTS

*MD, professor Kryvoruchko I. A.,
PhD, Associate Professor Goncharova N. M.,
MD, Professor Teslenko S. M.,
PhD, Associate Professor Tonkoglas O. A.,
PhD, assistant Antonova M. S.,
resident Drozdova A. G.*

Ukraine, Kharkiv national medical university, department of surgery №2

Abstract. Results of operative treatment 101 patients with infected pseudocysts of pancreas, distributed on types according to classification D'Egidio A. et Schein M., 1991, were analyzed. The patient with infected pseudocysts the first type at development organs insufficiency, percutaneous drainage it was carried out for the purpose of "waiting" tactics, for simplification of the general condition of the patient and a sepsis current. The patient with infected pseudocysts the second and third types in 80 % of cases percutaneous punctures were a definitive stage in their treatment. Performance of radical operative interventions depended on weight of a condition of patients, prevalence pancreonecrosis or a chronic pancreatitis, localization of pseudocysts, conditions duct systems, and also presence of complications from adjacent bodies. Thus, at treatment infected pseudocysts miniinvasive and traditional "open" interventions it is necessary to regard as complementary, with a wide range of diagnostic and medical possibilities.

Keywords: pancreas, pancreatitis, infected pseudocyst, external drainage, internal drainage, miniinvasive methods.

Relevance. In the last two decades of growing interest for research is the problem of surgical treatment of pancreatic pseudocysts, which is directly associated with a significant increase in the number of patients with this disease [1, 2] and is the socio-economic aspect, since patients are mostly people of working age [3]. The incidence of pancreatic pseudocysts is 0,5-1 per 100 000 adults per year. In the overall structure of morbidity pseudocyst make 1,6-4,5% [4].

The capacity for spontaneous resolution of pseudocysts makes many surgeons resort to "delaying" tactics in their treatment. So earlier it was believed that the pseudocyst with a dense capsule, which lasted more than 6 weeks, are not capable of spontaneous resolution and due to the high risk of complications should be drained regardless of the clinical picture [5]. However, some authors point out that many chronic pseudocyst diameter of 4 cm or less, having a permanent fistula with ductal system pseudocyst spontaneously resolved within the period of 12 months from the date of its origin. [4]

It is in these terms, and there are life-threatening complications: festering pseudocysts, perforation, tears pseudocysts, bleeding from erosive vascular compression of the gastrointestinal tract, mechanical jaundice, the formation of pancreatic fistula, which often leads to death, making the structure of total mortality 14%, and in complications such as sepsis, hemorrhage, perforation into the abdominal cavity reaches 40-60% [6, 7]. Surgical treatment of pancreatic pseudocysts in most cases involves the implementation of the external or internal drainage, means of implementation which is largely dependent on the preferences and skills of surgeons, as well as the technical equipment of the clinic [8].

Currently advantage in the treatment of pancreatic pseudocyst is the widespread introduction and use of minimally invasive techniques (ultrasound and endoscopy), which allows you to defer the "open" surgery, and in most cases are the ultimate way of treating pseudocyst [9, 10, 11]. The use of "open" surgery techniques leads to a prolonged hospital stay, to the development of a number of post-operative complications, poor quality of life in the late postoperative period, long-term rehabilitation of these patients, which in the present conditions is economically disadvantageous. Therefore, laparotomy is an operation of "choice", the application of which must be due to a number of indications [13, 14]. Therefore, individualization and the development of a treatment program with the use of minimally invasive techniques to ensure that the patient sustained therapeutic effect with minimal surgical trauma is an actual problem of modern surgery.

Objective: optimization of methods of surgical treatment of patients with infected pancreatic pseudocysts with primary use of minimally invasive methods of treatment to ensure patient sustained therapeutic effect with minimal surgical trauma.

Materials and research methods: The results of surgical interventions in 101 patients with infected pancreatic pseudocysts who were treated at the surgical departments of Public health institution «Regional Hospital - Center for Emergency Medicine and Disaster Medicine", Kharkov, Ukraine, and the department of surgery of the pancreas and reconstructive surgery of the bile ducts of the National Institute of Surgery and Transplantation A.A. Shalimov Sciences of Ukraine, Kiev, for the period from 2000 to 2015. Of these men - 74 (73.3%) women - 27 (26.7%), aged 21 to 79 years, mean $43,3 \pm 1,2$ years.

All patients underwent general clinical methods of blood and urine tests, biochemical blood tests, also used instrumental methods: ultrasound, spiral computed tomography (SCT) (with / without contrast), endoscopic fibrogastroduodenoscopy (EFGDS), endoscopic retrograde cholangiopancreatography (ERCPG), magnetic resonance imaging (MRI), ultrasound endosonography (UESG), morphological studies (bacteriological, cytological, histological, histochemical and immunohistochemical).

All the patients were divided according to the etiopathogenetic classification proposed by D'Egidio A. and Schein M. [15]. For the first type include postnecrotic pseudocyst, which occurred after an episode of acute pancreatitis. For the second type include postnecrotic pseudocyst that developed after episodes of acute exacerbation of chronic pancreatitis. Pseudocysts of the third type are retention cysts caused by chronic pancreatitis as a result of pancreatic duct strictures.

When choosing a method of surgery called attention to gender, age of the patient, the time since the last attack of acute pancreatitis, the localization of the pseudocyst, complications of other organs and systems, as well as for patients with pseudocysts of the first type - assess the status of the patient on the APACHE II score and assess the degree of organ dysfunction SOFA (Sequential Organ Failure Assessment). Thus, for SOFA 3 organ dysfunction was observed. When SOFA 3 to 8 (the predicted mortality rate – 22,5%), organ dysfunction was considered moderate, while in terms of SOFA 8 or more organ dysfunction was considered severe.

Statistical analysis was performed using the statistical software package StatSoft Statistica 6.0. All comparisons were made at the selected confidence level of 95%, therefore, if the calculated level of significance $p < 0,05$ difference between groups was recognized meaningful.

Results and discussion

The diagnosis of acute pancreatitis was adjusted based on the clinical course (pain in the upper abdomen, left upper quadrant, which are periodically intensified after eating the food, the presence of dyspeptic symptoms - nausea, vomiting, changes in biochemical parameters - hyperamylasemia), on a scale of \geq Ranson 3 or on the scale of APACHE \geq II 8.

The diagnosis of pseudocyst of the first type installed on the basis of additional tests, including ultrasound and SCT, in the presence of fluid accumulation in the parenchyma of the pancreas is surrounded by a well-demarcated wall associated with pancreatic parenchymal necrosis; there is not less than 4 weeks of provoking an episode of acute pancreatitis. Pseudocysts of the first type were observed in 34 (33,7%) patients.

The diagnosis of chronic pancreatitis was set based on the following syndromes: the presence of pain in the upper or middle abdomen, recurrent or permanent nature, of referred in the back, sometimes taking surrounding the character; the presence of clinical manifestations of exocrine pancreatic insufficiency: weight loss, stool disorders, signs of steatorrhea, creators; the presence of clinical manifestations of endocrine disease - diabetes, at least - the hypoglycemic syndrome; the presence of biliary hypertension syndrome with its clinical manifestations (hepatic colic, itching, jaundice, acholia, symptom Courvoisier), as well as with a typical picture of the laboratory; violation of patency of the duodenum; segmental portal hypertension and its clinical manifestations (ascites, hepatomegaly, hypersplenism); symptoms of the central nervous system.

The diagnosis of pseudocyst of the second and third type established on the basis of additional tests, including ultrasound and SCT. With transabdominal ultrasound pseudocysts were hollow circular formations with a smooth wall and clear distal acoustic enhancement, the presence of echogenic seizures in the cavity at the postnecrotic pseudocysts. On SCT pseudocysts were a rounded hypodense fluid collection with a well defined thick wall, which is adjacent to the prostate or located in its parenchyma.

SCT provides detailed information about the anatomic relationships of cystic formation with surrounding organs and vessels, as well as the related pathological changes: extension and calcification of the main pancreatic duct, the common bile duct expansion, the presence of arterial pseudoaneurysms adjacent to the wall of the pseudocyst. By the second type of pseudocysts treated post necrotic cysts that developed after episodes of acute exacerbation of chronic pancreatitis, since the outbreak of which has been more than six weeks, which marked the formation of a dense wall of the cyst. Pseudocysts of the second type were observed in 32 (31,7%) patients. Pseudocysts of the third type are retention cysts caused by chronic pancreatitis as a result of pancreatic duct strictures (35 (34,6%) patients).

Ultrasound structure of pseudocyst becomes more integrated with festering its contents, as well as bleeding in the cyst cavity. The presence of infection of pancreatic pseudocysts also confirmed bacteriological research culture, which was taken during surgery or percutaneous drainage of cyst puncture under ultrasound.

Current infected pancreatic pseudocysts first type was complicated at the 2 - patients by bleeding into the cavity pseudocysts, 1 patient - perforation pseudocyst into the stomach to form fistulous, 1 patient - rupture of the pseudocyst with the development of general peritonitis, 4 patients - an acute purulent peritonitis. Current infected pseudocysts second type was complicated in 5 patients virsungolitiiasis, from 2 - patients - bleeding into the cavity of the pseudocyst, from 3 - patients - compression of the gastrointestinal tract (stomach and / or duodenal ulcer) from 2 - patients - mechanical jaundice, 1 patient - rupture of the pseudocyst with the development of general peritonitis. Current infected pseudocysts complicated by the third type at 4 - patients - obstructive jaundice, from 3 - patients - compression of the stomach and / or duodenal ulcers.

For the treatment of patients with pseudocysts of the first type we have proposed the following algorithm. Patients with organ dysfunction (SOFA $>$ 8) to expectant management was performed by percutaneous or endoscopic drainage of pancreatic pseudocysts. This campaign was designed to "control" sepsis or to improve the overall condition of the patient, necessary for future use "open" surgery on the pancreas.

Patients with pseudocysts without organ failure or mild organ dysfunction (SOFA 3 to 8), as well as patients who could move the surgical risks, laparotomy was performed with the surgical treatment of oral cysts, and later, when the constitution of the walls - forming cystoenteroanastomosis. Patients with pseudocysts with thin walls performed external drainage of cavities with an additional tamponade large gland. Thus, 16 patients with infected pseudocysts do them puncture under ultrasound guidance, including 3 patients after failure of puncture, external drainage was performed under ultrasound guidance with installation of drainage in their cavity-type «pig tail».

In 7 patients s limited presence of infected pancreatic necrosis and pseudocyst operations include its external drainage followed by closure of the abdominal cavity, including 2 patients was accompanied by tamponade drainage cavity pseudocysts greater omentum as described clinic (Ukraine patent for utility model № 95264 from 10.12.2014. "The method of surgical treatment of pancreatic pseudocysts complicated by suppuration"). The technique was performed when infected pseudocysts with thin walls, with the probability of insolveny cystodigestive anastomosis.

If you have a patient pseudocyst pancreatic infection is suspected it previously performed a puncture under ultrasound. At the same time determined the nature of the liquid, the level of amylase and type of pathogen. It monitors the overall health of the patient, and after its stabilization was performed upper-median laparotomy. After revision of the abdominal cavity, mobilized duodenum by Kocher opened the packing bag.

Pseudocyst cavity was punctured, ripped along the needle, carried out its reorganization and rapid biopsy site cysts. If no signs of malignancy, a strand of omentum wound up in the cavity of the pseudocyst with its tamponade.

Additionally, the cavity summed pseudocyst drainage in the form of a U-tube drainage, and above it - the seal rubber and dissected pseudocyst wall sutured to the parietal peritoneum.

The tube is withdrawn through the seal and separate counter opening and fixed to the skin, the abdominal cavity sutured tightly. The glove was removed on 4 - th day, and up - to the termination of its proceeds to discharge. At the same time improving the efficiency of the surgical treatment of pseudocysts of the first type was achieved by biological obliteration pseudocyst cavity strand of omentum, which in turn reduces the likelihood of arrosive bleeding, pancreatic fistula or abscess formation.

In 10 patients with acute necrotizing pancreatitis and infected a total of pancreatic pseudocysts made laparotomy followed pancreatonecrsecvestrectomy and external drainage of pseudocysts and abdomen. In 5 of them the operation is completed omentobursostomy formation.

In 1 patient with acute infected (prevalence) pancreatic necrosis, infected pancreatic pseudocysts complicated by bleeding into the cyst cavity, common seroplastic peritonitis abdominal sepsis made necrosectomy the formation omentobursostomy with VAC - methodology using a set of bandages NPWT Dressing Kit, England.

In the treatment of pseudocysts of the second and third types guided by the following principles. Thus, for large pancreatic pseudocysts choice of treatment was determined overlooking the cyst, its location and size. As the first stage of treatment to patients to reduce the voltage of the walls do those cysts percutaneous puncture and drainage under ultrasound guidance with mandatory biochemical, bacteriological and cytological puncture material. When infected pseudocysts complicated by peritonitis, sepsis, patients underwent external drainage of cysts. When infected pseudocyst located head-body of the pancreas, patients were shown to the imposition cystojejunum or cystopancreatojejunum anastomosis.

The indications for surgery Ch. F. Frey were deep location of ducts and pseudocysts in the enlarged head of the pancreas without the involvement of adjacent organs, and the presence of duct strictures during corpocaudalis department in which the operation is completed the imposition of longitudinal pancreatojejunum anastomosis. Radical surgery - resection of the lesion of the pancreas or the extirpation of a cyst - was possible only at small pseudocysts, localized mainly in the distal pancreas with thick walls.

Thus, patients with pseudocysts of the second type were made following the intervention. Percutaneous puncture under ultrasound as a first step were performed in 12 patients, of whom 4 patients after failure of puncture, performed external drainage under ultrasound guidance with installation of drainage in their cavity-type «pig tail», 1 patient with chronic fibro-degenerative pancreatitis , virsungolitiasis infected pseudocysts pancreatic head performed surgery Ch. F. Frey, 1 patient with an infected pseudocyst, which caused compression of the stomach performed imposition cystojejunum anastomosis by Roux.

In one case, a patient with an infected pseudocyst laparotomy with external drainage of the cyst, which was due to the severity of his condition. In one case, external drainage of pseudocysts under ultrasound guidance with installation of drainage for the type of «pig tail» was ineffective; patients underwent laparotomy, resection of the distal tail of the pancreas with splenectomy. Endoscopic ultrasound puncture performed in 2 patients with infected pancreatic pseudocysts. A prerequisite for their conduct was the presence of thick walls and pseudocysts proximity pseudocyst to the stomach or duodenum.

Outside drainage of pancreatic pseudocysts was performed in 7 patients, including a 2 - are infected pseudocyst was complicated by bleeding into its cavity. In 1 patient with rupture of an

infected pseudocyst, peritonitis development of general surgery finished debridement and drainage of the abdominal cavity.

When infected pseudocysts arranged head-body of the pancreas, eight patients were applied cystojejunostomy or pancreatojejunostomy hyperreflexia or cystitis, including 1 - laparoscopically. The distal resection performed at the 2 - patients with localization of pseudocysts in the tail of the pancreas.

Patients infected with pseudocysts third type the following procedure. Percutaneous puncture under ultrasound as a first step were performed in 18 patients, including 3 patients after failure of puncture, external drainage was performed under ultrasound guidance with installation of drainage in their cavity-type «pig tail». In 7 patients underwent internal drainage of pseudocysts by applying longitudinal pancreatojejunostomy (3), cystojejunostomy by Roux (3), cystojejunostomy by Brown (1). Operation Ch. F. Frey made 4 patients who have chronic degenerative fibrosis pancreatitis was complicated virsungolitiatis, virsungoectasy, obstructive jaundice (2). External drainage of infected pancreatic pseudocysts was performed in 6 patients.

Duration puncture pseudocysts treatment ranged from 5 to 12 days, on average $7,6 \pm 3,3$ hours. The duration of treatment in patients with type drainage «pig tail» ranged from 10 to 25 days, on average, $17,8 \text{ days} \pm 5,3$. The mortality rate was 1.9%. It brought heavy death during sepsis and the development of multiple organ dysfunction syndrome, and recurrent bleeding from vessels arrosive pancreas.

Conclusions

When treating patients with infected pancreatic pseudocysts is necessary to apply individualized treatment policy, which is based on modern minimally invasive therapies. Patients with infected pancreatic pseudocysts of the first type in the development of multiple organ failure, percutaneous drainage was carried out with the purpose of "delaying" tactics, to facilitate the patient's general condition and course of sepsis.

Patients infected pancreatic pseudocysts second and third types in 80% of cases were percutaneous puncture in the final stage of the treatment. Radical surgical interventions depended on the severity of the patients, the prevalence of chronic pancreatitis or pancreatic necrosis, pseudocyst localization, the state of the duct system as well as the presence of complications related bodies. Thus, the treatment of infected pancreatic pseudocysts minimally invasive and traditional, "open" intervention should be regarded as complementary with a wide range of diagnostic and therapeutic opportunities.

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CLINICAL EXPERIENCE OF USING IMPROVED METHODS OF MAKING REMOVABLE PROSTHESES USING SELF-CURING ELASTIC MATERIAL

MD Yanishen I. V.

PhD, Associate Professor Maslovskii O. S.

Assistant Kulish S. A.

Assistant Bilobrov R. V.

Assistant Horiushko V. S.

Ukraine, Kharkiv, Kharkiv national medical university, Department orthopedic dentistry

Abstract. Offered advanced technology of fabrication of two-layer removable prosthetic devices with using the rubber-band base material to cool vulcanizes.

Offered strategy of fabrication of clasplless removable prosthetic devices with use of selfhardening rubber-band material at presence of single teeth on the mandible and is given its evaluation on results of clinical observations.

Keywords: wax-abrasive occlusion platens, individual occlusion surface, two-layer prosthetic devices, soft lining, clasplless prosthetic devices, selfhardening rubber-band material, single teeth.

In prosthetic dentistry one of the hardest sections is the restoration the function of the masticatory apparatus with removable dentures. The quality of the prosthesis is largely dependent on the choice of the most rational design of dentures, depending on the individual patient's prosthetic field, namely the state of alveolar processes, their ratio in the mouth; state of the oral mucosa; periodontal status [1].

There are numerous messages where the author, speaking of improving the quality of dentures, pay attention to articulation, occlusion, constructing artificial dentition that affect the fixation and stabilization of dentures [2, 3, 4 etc.].

Known methods of constructing artificial dentition on an individual occlusal surface, which is obtained grinding wax-abrasive rollers in the oral cavity of the patient [2]. The authors believe that the use of this technique is best suited for displayed features of chewing muscles and movements of the lower jaw of the patient. Prostheses in which artificial teeth set in individual occlusal surface are more resistant require fewer adjustments, more evenly transmit chewing pressure on the underlying tissues and thus prevent atrophy of the alveolar processes. This prompted us to use method of obtaining an individual occlusal surface in the manufacture of two-layer removable lamellar dentures use self-curing flexible base materials.

Some authors suggest that individual teeth that prevent the creation of a continuous circular valve should be removed [6]. But this position recently reviewed by many authors for numerous reasons. First, when an isolated tooth has an antagonist, it should be left to save intraalveolar height. But if the tooth is isolated and has no antagonist, it is desirable to save for people who dentures will be manufactured for the first time. Especially should keep isolated teeth on the lower jaw, even if they have the II and III degree of mobility [1]. Indications for removal or preservation of individual teeth should be considered in connection with future prosthetics, to provide best conditions for fixing dentures [1, 5 etc.].

M.I.Kyrylyuk [6] proposes to use a isolated teeth when his designed elastic root attachments for cover prosthesis. But this method requires a special therapeutic and prosthetic tooth preparation. In addition, his proposed structure is quite complicated to manufacture. N.V.Kalinina [1] indicates that at presence of single tooth advantages the telescopic bonding system of prosthesis as when using mechanical fasteners for prosthesis combined with the effect of continuous circular valve executed using functional tests, providing more reliable fixation of the prosthesis.