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MODERN ASPECTS OF SURGICAL TREATMENT OF PANCREATIC PSEUDOCYSTS USING MINI INVASIVE TECHNOLOGIES

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Introduction. The pseudocyst of pancreas is the most common variant of local complication of pancreatitis and occurs in 71-83% of patients with destructive and 5% of patients with interstitial pancreatitis [1]. More than 20% of pseudocysts become infected, and 9–15% of patients experience bleeding. The death rate in patients with pseudocyst is 17%, and, in the presence of infection, it increases to 42% [2]. The bleeding into cavity of the pancreatic cyst or into the lumen of the gastrointestinal tract is a possible complication of the disease. The cause of bleeding is dissolution of the arterial vessel wall as a result of the action of enzymes in pancreatic juice. The bleeding in case of chronic cystic pancreatitis can appear in the cavity of the cyst, stomach, duodenum, omental bursa, ducts of pancreas. The most common sources of bleeding are the splenic, gastroduodenal and pancreatoduodenal arteries and their branches, less often - the hepatic and left gastric arteries, as well as aorta [3, 4]. The treatment tactics for the patient with pseudocyst hemorrhagic complications depends on various factors: arterial or venous bleeding, massive bleeding and the degree of blood loss. If previously the availability of pseudocysts of pancreas, complicated by bleeding, was an absolute indication for open laparotomy and was often lethal, today, thanks to the success of modern diagnostics and its implementation in everyday practice, it is possible to achieve encouraging results in treatment [5].

Objective of the work - development of diagnostic and therapeutic algorithm for pancreatogenic pseudocysts with bleeding into their cavity.

Materials and methods. To achieve this objective, there was conducted a prospective and retrospective analysis of the results of surgical treatment of 61 patients with acute and chronic pancreatitis complicated by pseudocysts characteristic of erosive bleeding into the cavity. All patients underwent the necessary diagnostic tests: electrocardiography, clinical and biochemical blood tests, fibrogastroduodenoscopy, echosonography and computed tomography of the abdominal cavity.

Results of studies and their discussion. 7 patients (11.5%) had symptoms of bleeding into the lumen of the gastrointestinal tract, 4 patients (6.6%) - intra-abdominal bleeding. In order to stop the bleeding into the pseudocyst cavity, 24 patients (39.3%) underwent X-ray endovascular occlusion of the vessel, which caused the bleeding. The main contraindications to occlusion of X-rayed vessels were bleeding from venous vessels, vessels inaccessible to embolization, the presence of strong collateral blood flow in the bleeding area, bleeding from the main vessel, embolization of which was life-threatening, and the technical impossibility of occlusion of all sources. The bleeding from the common hepatic artery was detected in 1 patient during the study, and a stent-graft was installed to provide hemostasis as a method of alternative X-ray endovascular intervention, which allowed maintaining the blood flow through the vessel and closed the vascular defect.

If it was impossible to apply to the patient the X-ray occlusion of the vessel that caused the bleeding, laparotomy was performed to achieve hemostasis, which allowed not only to eliminate the bleeding, but also to remove the pancreatogenic pseudocyst. Thus, 6 patients (9.8%) underwent marsupialization of pseudocysts, and hemostasis was performed during open operation that was followed by external drainage of pseudocysts.

In 3 patients (4.9%) with pseudocysts complicated by bleeding from the splenic artery, the cyst was opened in an open way with its subsequent external drainage, hemostasis was achieved by a. lienalis suturing. The laparotomy, distal resection of

the pancreas with aneurysm and splenectomy were performed in 2 patients (3.2%) with bleeding from splenic artery aneurysms. The external puncture drainage of pseudocysts was performed in 10 patients (16.4%) after stopping the bleeding and conservative treatment, including in 5 patients (8.2%) after stabilization with subsequent laparotomy and cystoenteroanastomosis. The pancreaticoduodenal resection was performed in 2 patients as a "despair" operation.

In one observation of combined bleeding into the pseudocyst cavity and its rupture, there was first performed the endovascular embolization of the vessel as a method of stopping the bleeding, and later, after stabilization of the patient's condition, the external drainage of the pseudocyst. 3 patients were subjected to laparotomy with external pseudocyst drainage, including 1 patient in the early postoperative period with recurrent bleeding that was stopped by endovascular embolization. In 1 patient with chronic pancreatitis, with pseudocyst, bleeding into its cavity and rupture, the operation was completed by distal resection.

In case of chronic pancreatitis, which run was complicated by pseudocysts with arosive bleeding, 2 patients underwent laparotomy, followed by external drainage for 1 patient, and longitudinal cystojejunostomy for the other patient. In 1 observation, for the patient infected with disseminated severe pancreatic necrosis, and with pseudocyst having suppuration and bleeding into the cyst cavity, disseminated serous-fibrinous peritonitis, there was performed laparotomy, necresequarectomy, tamponade of the cavity.

In 1 observation, during perforation of the pseudocyst and bleeding into the free abdominal cavity, the puncture drainage of the pseudocyst was performed under ultrasonography control and after stabilization, with subsequent laparotomy, suturing of the vessel that caused the bleeding, rehabilitation and drainage of the abdominal cavity.

Among 3 patients with chronic pancreatitis complicated by mechanical jaundice and bleeding into the pseudocyst cavity, for 1 patient, bleeding was stopped by endovascular embolization, 2 patients underwent pancreaticoduodenal resection.

In case of recurrent bleedings, they were stopped with the use of endovascular

occlusion. The reasons for the said relapses were nonobservance of the diet and enzyme replacement therapy. Of all patients studied, 5 were hospitalized. 3 patients (4.9%) died, the cause of death of whom was the development of septic shock and multiorgan failure syndrome, as well as recurrence of bleeding from erosive vessels.

Conclusions. The endovascular hemostasis allows to avoid emergency surgery in the summit of bleeding and to create favorable conditions for further surgical treatment of the underlying disease.