

## MODERN SURGICAL APPROACHES OF TREATMENT FOR PANCREATICOBILIARY MALIGNANCY BY DAMAGING MECHANICAL JAUNDICE

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### Abstract

diagnosis of pancreaticobiliary malignancy is made the patient is usually in a terminal stage<sup>1,2</sup>. However, a palliative treatment of biliary obstruction is advisable to mitigate the effects of jaundice, independently of whether a surgical resection for attempting a cure is feasible or not. Alternative approaches to biliary stent placement have prompted a particular interest towards a comparative evaluation aimed at assessing optimal stent material and design, as well as stent placement strategies. A comprehensive comprehensive analysis of the use of laparoscopic operations in emergency abdominal surgery and their improvement is an urgent task of modern clinical surgery. The creation of qualitatively new laparoscopic equipment, the improvement of laparoscopic instruments required the revision of outdated provisions and the development of modern principles of laparoscopic surgery. The examined group consisted of 2,479 (26.2%) patients with urgent diseases of the abdominal cavity, among all the abdominal operations performed in the period from 2018 to 2020 using laparoscopic technologies.

**Keywords:** pancreaticobiliary malignancy, laparoscopic equipment, biliary obstruction, abdominal surgery, abdominal trauma, fibroesophagogastroduodenoscopy.

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**Relevance:** Laparoscopic surgical procedures can today be performed in almost all hospitals and the experiences of surgeons are increasing day by day. Cholecystectomy is especially one of the laparoscopic treatments that many surgical assistants firstly learn and apply. The validity of laparoscopic cholecystectomy (LC) is today indisputable in symptomatic gallbladder stones, other benign gallbladder diseases and early stage malignancy according to certain authors.[1–3] It is already the most common and widely applied laparoscopic intervention today. Despite the wide arsenal of non-invasive research methods, the diagnosis of acute surgical diseases of the abdominal cavity in some cases is very difficult. In this situation, the use of laparoscopy allows timely diagnosis and determination of surgical tactics.

Moreover, the 2016 WSES CC Guidelines included discussions on unclear areas such as diagnosis, surgical risk assessment, and appropriate management of associated common bile duct stones (CBDS). In 2017, WSES joined the Italian Society of Geriatric Surgery during a CC dedicated to the management of ACC in the elderly to study this subgroup of frail patients who are considered to be at "very high risk" for surgery. There was no consensus to support surgical treatment of CC in the elderly and consider advanced age as a contraindication for surgery per se. The authors found a significant lack of high-quality research on this topic. Biliary obstruction is a frequent presenting feature of pancreaticobiliary malignancy. Unfortunately, when a diagnosis of pancreaticobiliary malignancy is made the patient is usually in a terminal stage<sup>1,2</sup>. However, a palliative treatment of biliary obstruction is advisable to mitigate the effects of jaundice, independently of whether a surgical resection for attempting a cure is feasible or not. Endoscopic stent drainage has been proposed as an alternative to biliary-enteric bypass surgery to palliate malignant biliary obstruction. In addition, alternative approaches to biliary stent placement have prompted a particular interest towards a comparative

evaluation aimed at assessing optimal stent material and design, as well as stent placement strategies. A comprehensive analysis of the use of laparoscopic operations in emergency abdominal surgery and their improvement is an urgent task of modern clinical surgery. With the development of laparoscopic surgery and the accumulation of experience, the interest of many surgeons in the use of this method in emergency surgery is expanding. Within the framework of general scientific and technological progress, the constant introduction of new technologies makes them an integral part of a particular field of medicine. Today, emergency surgery is impossible to imagine without laparoscopy. In many complex cases, laparoscopy remains indispensable, as it allows you to give a direct visual assessment of the pathological process, identify its prevalence, perform a targeted biopsy and perform instrumental palpation. It is safe to say that the number of urgent operations performed by laparoscopic method is steadily increasing. This circumstance requires the development of clear recommendations on the use of laparoscopic technologies in emergency surgery. The method makes it possible to carry out diagnostics with a greater degree of informativeness, and when establishing pathology in the abdominal cavity, it provides an opportunity to transform diagnostic manipulation into therapeutic. In the Clinic of Surgical Diseases and Resuscitation of the Bukhara State Medical Institute, from 2018 to 2020, out of 9461 emergency abdominal operations performed, laparoscopic technique was used in 2479 (26.2%) observations.

The following laparoscopic operations were performed: laparoscopic cholecystectomy (LCE) for acute calculous cholecystitis was performed in 1984 (80%) patients, diagnostic and therapeutic laparoscopy - 49 (1.9%), diagnostic and therapeutic thoracoscopy in 32 (1.3%) patients, laparoscopic appendectomy - 18 (0.7%), suturing of perforative ulcers of the stomach and duodenum (duodenum) -15(0.6%)patients, laparoscopic cystectomy (gynecology)- 112(4.5%), laparoscopic tubectomy -181(7.3%), laparoscopic dissection of adhesions - 24 (0.9%) and laparoscopic ureterolithotomy - 64(2.6%) patients. Biliary obstruction results in a variety of biochemical and physiologic disturbances, such as elevated serum bilirubin, altered liver function tests, as well as impaired hepatic and renal functions with associated coagulation problems. In view of the fact that most patients with pancreatic cancer are diagnosed at an advanced and inoperable stage of the disease, the intent of treatment is palliation. Among these patients, some will survive only a few weeks, many of them will die within six months, but some others may survive in a fairly good health condition for longer time. Until recently, two kinds of therapeutic options were offered to such patients: (a) surgical bypass and (b) endoprosthesis. The percutaneous insertion of an endoprosthesis has been shown to provoke an excess morbidity<sup>19</sup> due to a 12 French gauge access through the liver, and it should not be considered as the primary option for common bile duct obstruction, although it can be recommended for the palliative treatment of porta hepatis strictures.

**The purpose of the study:** Improving the results of surgical treatment of patients with acute surgical diseases of the abdominal cavity, by improving diagnostic and therapeutic laparoscopy.

**Materials and methods of research:** The work was carried out in the Bukhara branch of the Emergency Hospital on the basis of surgical departments. In 2018 – 2020, 20493 operations were performed in the Bukhara branch, of which 9461 (12.1%) were cavity operations. The examined group consisted of 2,479 (26.2%) patients with urgent diseases of the abdominal cavity, among all the abdominal operations performed in the period from 2018 to 2020 using laparoscopic technologies.

The paper analyzes the results of a parallel comparative study of laparoscopic and open methods of surgical treatment. All the admitted patients were subjected to a comprehensive clinical study according to the generally accepted scheme using traditional laboratory and radiological methods, general clinical and biochemical studies were conducted; in-depth study of the coagulation system; overview radiography of the abdominal cavity, radiopaque studies of the gastrointestinal tract (gastrointestinal tract); computed tomography (CT), including with contrast, ultrasound examination (ultrasound) of the abdominal cavity and pelvis, magnetic resonance imaging in rare cases - to clarify the diagnosis; endoscopic studies fibroesophagogastroduodenoscopy [1-20].According to the indications, patients with cholelithiasis underwent endoscopic retrograde pancreato-cholangiography, supplemented, if necessary, by endoscopic papillosphincterotomy. The patients subjected to laparoscopic examination and surgical treatment were aged from 23 to 77 years, while there were 961 patients older than 60 years (38.7%). The

following laparoscopic operations were performed: laparoscopic cholecystectomy (LCE) for acute calculous cholecystitis was performed in 1984 (80%) patients, diagnostic and therapeutic laparoscopy - 49 (1.9%), diagnostic and therapeutic thoracoscopy in 32 (1.3%) patients, laparoscopic appendectomy - 18 (0.7%), suturing of perforative ulcers of the stomach and duodenum (DPC) - 15 (0.6%) patients, laparoscopic cystectomy (gynecology) - 112 (4.5%), laparoscopic tubectomy -181 (7.3%), laparoscopic dissection of adhesions - 24 (0.9%) and laparoscopic ureterolithotomy - 64 (2.6%) patients. Table No. 1

Types of laparoscopic operations in the Bukhara branch of the Emergency Hospital 2018-2020yy

| Operation by years                      | 2018 | 2019 | 2020 | 2018-2020 |
|---|------|------|------|-----------|
| Diagnostic and treatment of laparoscopy | 12   | 21   | 16   | 49(1,9%)  |
| Appendectomy via the Laparoscopy        | 5    | 6    | 7    | 18(0,7%)  |
| Cholisisectomy via the Laparoscopy      | 603  | 708  | 673  | 1984(80%) |
| Laparoscopy in the Perforative ulcer    | 4    | 5    | 6    | 15(0,6%)  |
| Laparoscopic dissection of adhesions    | 4    | 8    | 12   | 24(0,9%)  |
| Laparoscopic cystectomy (gynecology)    | 35   | 30   | 47   | 112(4,5%) |
| Laparoscopic tubectomy                  | 72   | 74   | 35   | 181(7,3%) |
| Diagnostic and therapeutic thoracoscopy | 2    | 8    | 22   | 32(1,3%)  |
| Ureterolithotomy                        |      |      | 64   | 64(2,6%)  |
| Total laparoscopic operations           | 737  | 860  | 882  | 2479      |

To assess the effectiveness of the technique of surgical intervention, the following indicators were evaluated: the duration of surgery, normalization of body temperature, the need for drug stimulation of the intestine, the recovery time of intestinal peristalsis, the time of activation of the patient, the volume of intraoperative blood loss, the duration of hospitalization, the need and duration of stay in the intensive care unit (ICU), the need and duration of the use of analgesics, the number and the severity of the intra- and postoperative complications, cosmetic defect after surgery, the need for repeated surgical interventions, the number of conversions [21-40].

Laparoscopic intervention was performed in a limited hermetic space (in the abdominal, thoracic cavity), which was created by the introduction of gas. A certain level of intra-abdominal pressure (12-15 mmHg) was created by introducing carbon dioxide into the abdominal cavity and was stably maintained throughout the operation, which provided favorable conditions for performing the necessary manipulations under the control of a laparoscope. The gas was injected through a Veresh needle by puncture of the anterior abdominal wall. The air cushion obtained in the abdominal cavity prevented damage to its organs during the introduction of trocars. A Veresh needle was inserted into the abdominal cavity through a small incision (up to 1 cm) in the umbilical region along the white line of the abdomen. To prevent damage to internal organs or vessels with a Veresh needle, the anterior abdominal wall was gripped with a brush into a longitudinal fold or a clamp and lifted up. After the creation of the pneumoperitoneum, trocars were inserted into the abdominal cavity, starting with the paraumbilical, through which a laparoscope was inserted into the abdominal cavity. Other trocars were administered under visual laparoscopic control. Laparoscopic instruments were introduced through trocars, with the help of which laparoscopic intervention was performed.

**Results and discussions:** This study was programmed in order to provide a basis for advising patients on the possibility of having their jaundice relieved either by an endoscopic stenting procedure or by a surgical bypass procedure. The prerequisites for a successful endoscopic stenting are (a) accuracy of diagnosis and (b) exclusion of patients presenting with tumors potentially treatable by a curative resection. This evaluation is simple whenever metastases are evident or whenever serious medical disorders are coincidental, thus precluding resection, but it may be difficult when a solitary primary lesion is detected.

As a result of 1984 laparoscopic cholecystectomies (LCE), complications of LCE for acute cholecystitis were observed in 14 (0.8%) patients. Parenchymal bleeding from the gallbladder bed was observed in 11 (0.6%) patients; in all, bleeding was stopped by laparoscopic coagulation. Damage to the extrahepatic

bile ducts occurred in 3 (0.2%) patients and required laparotomy. In 2 observations, a lateral lesion of the choledochus was sutured. Completely crossed hepaticocholedoch 1 patients were restored on the drainage of the Kerus.

Damage to the bile ducts is facilitated by various anatomical variants of the structure and mutual disposition of the tubular structures of the hepatoduodenal ligament. An extremely dangerous situation is when the common hepatic duct is attached directly to the neck of the gallbladder, and the latter has a short duct. We have repeatedly encountered similar cases, but in one of them we could not avoid a complete intersection of the common bile duct.

Damage to the hepaticocholedocha can also occur in the absence of anatomical prerequisites, if the technique of performing the operation is violated. These are the so-called "classic" cases of duct injury. They occur when excessive traction of the gallbladder is created. In order to prevent complications in the isolation of the cystic duct and artery, we use the following technique: using an electric hook, we dissect the peritoneum from the lateral side of the gallbladder to the level of the confluence of the cystic duct into the common hepatic duct, then we isolate the medial wall of the gallbladder with mandatory tissue preparation behind the cystic duct. Thus, the shape of the neck is created according to the type of "elephant trunk", which makes it easy to differentiate the cystic duct to the confluence with the common hepatic duct. If damage to the hepaticocholedochus is detected during surgery, it is advisable to apply its primary suture with a duct width of at least 5 mm with a sufficient wall thickness. Reconstructive surgery requires an experienced surgeon, the necessary tools and suture material.

In the postoperative period, complications occurred in 22 (1.1%) patients: bile drainage from the abdominal cavity - in 8 (0.4%), subhepatic abscess in the bed of the gallbladder — in 2 (0.1%), suppuration of epigastric puncture was observed — in 12 (0.6%) patients. (Table 2.)

**Table 2. Complications after laparoscopic cholecystectomy**

| Types of complications                           | Number of abs patients (%) |
|--|----------------------------|
| Bile drainage from the abdominal cavity          | 8 (0,4%)                   |
| Subhepatic abscess in the bed of the gallbladder | 2 (0,1%)                   |
| Suppuration of the epigastric puncture           | 12 (0,6%)                  |
| Total complications                              | 22 (1,1%)8                 |

Laparoscopic interventions made it possible to reduce the length of stay of patients in the hospital (by 22.2 - 37.5%), reduce the percentage of unnecessary laparotomies (by 15-25%), shorten the time of diagnosis, eliminate the occurrence of postoperative hernias, reduce the appointment of narcotic analgesics, transfer patients to enteral nutrition at an earlier date.

**Conclusion:** Within the framework of general scientific and technological progress, the constant introduction of new technologies makes them an integral part of a particular field of medicine. The current trend in the development of surgery is to reduce the invasiveness and traumaticity of surgical interventions. Due to the development of surgical technologies, one of the main tasks in surgery is to minimize surgical trauma and the subsequent reduction in the number of postoperative complications and mortality, as well as the duration of inpatient treatment of patients while maintaining the quality of surgical care. Today, urgent surgery can no longer be imagined without laparoscopy. The decision is more difficult in patients with unresectable disease who may be poor operative risk. The results show that surgical and endoscopic approaches have both advantages and disadvantages. We did not address quality of life issues directly and did not attempt to assess the relative cost-effectiveness of the procedures under study. These items, as well as the level of specialistic expertise available, will influence the therapeutic decision, that should be taken by the attending physician in strict cooperation with the fully informed patient.

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