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ARGUMENTAREA CLASIFICĂRII PANCREONECROZEI ÎN FAZA PRECOCE A BOLII

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Introducere. Problema clasificării pancreonecrozei în faza precoce a bolii, rămîne o problemă discutabilă.Scopul: Diferențierea formelor de pancreonecroză în funcție de semiologia laparoscopică.Material și metode: Au fost analizate rezultatele semiologiei laparoscopice a 133 de bolnavi cu pancreonecroză. Pancreonecroza lipidică a fost depistată în 40, pancreonecroza hemoragică - în 56 și pancreonecroza mixtă – în 37 cazuri.Rezultate: În pancreonecroza lipidică sunt caracteristice următoarele semne laparoscopice: exudatul seros cu nuanță gălbuie, cantitatea de exudat în limite moderate, exudatul este prezent în 77,5% din cazuri, nivelul de α-amilază moderat crescut în 74,2%, peritonita locală (27,5%), difuză (35%), generalizată (15%), steatonecrozele sunt depistate în toate cazurile, infiltrația seroasă „edemul de sticlos" al țesutului adipos parapancreatic, gradul de endotoxicoză: medie (85%), severă (15%). Semiologia pancreonecrozei hemoragice diferă în raport cu forma lipidică: exudatul hemoragic cu diferite nuanțe ale culorii roșii, cantitatea de exudat – de la 300-400 ml pînă la 3000- 4000 ml, prezența exudatului peritoneal în toate cazurile, nivelul înalt al α-amilazei în exudat, peritonita fermentativă prezentă în toate cazurile: difuză (51,8%), generalizată (48,2%), steatonecrozele lipsesc, peteșii și imbibiția hemoragică a țesutului parapancreatic, imbibiția hemoragică retroperitoneală (17,8%), gradul de endotoxicoză: medie (12,5%), severă (89,5%). În pancreonecroza mixtă sunt depistate semne caracteristice ambelor forme. Pancreonecroza lipidică în faza precoce evaluează cu un grad mediu de endotoxicoză fiind o necroză de coagulare, ce decurge mai lent și benign, și din contra, formele hemoragice și mixte sunt necroze colicvaționale și evoluează cu un grad sever de endotoxicoză, șoc pancreatogen și insuficiență poliorganică. Totodată, în fazele tardive ale bolii potențialul de complicații necro-purulente este echivalent în toate formele de pancreonecroză.

THE REASON OF THE PANCREONECROSIS CLASSIFICATION IN THE EARLY STAGE OF THE DISEASE

Introduction: The pancreonecrosis classification in the early stage of the disease remains a doubtful problem.Aim: Difference of pancreonecrosis forms due to laparoscopic semiology.Materials and methods: The results of laparoscopic semiology of 133 patients with pancreonecrosis were analyzed. Lipid pancreonecrosis was discovered in 40 cases out of 133, hemorrhagic pancreonecrosis–in 56 cases, combined–in 37cases out of 133. Results: For lipid pancreonecrosis the following signs are characteristic: yellow tint of exudat, the exudat amounts in temperate limits, in 77,5% the exudat is present, the level of α-amilazis moderately increased in 74,2%, local peritonitis (27,5%), diffuse peritonitis (35%), general (15%),in all cases steatonecroses were present, infiltration "glass edema" of the peripancreatic adipose tissue, the grade of endotoxicosis: average (85%), severe (15%). The semiology of the hemorrhagic pancreonecrosis differs relating to lipid form: hemorrhagic exudat with diverse tints of the red colour, the quantity of the exudat from 300-400ml to 3000-4000ml, the presence of the peritoneal exudat in all cases, high level of the α-amilazis, fermentative peritonitis present in all cases: diffuse (51,8%), general (48,2%), the lack of steatonecroses, petechiae and hemorrhagic imbibition of the peripancreatic tissue, retroperitoneal hemorrhage imbibition (17,8%), the endotoxication level: average (12,5%), severe (89,5%). Characteristic signs to both forms were traced out in joint pancreonecrosis. In lipid pancreonecrosis in the early stage estimates an average degree of endotoxication being a blood clotting necrosis which evaluates slowly and favorable, but hemorrhagic and joint forms are colicvational necroses and develop a severe grade of the endotoxication, pancreatogenic shock and multiorgan failure. On the other hand in the tardy stages of the disease the rate of the purulent necrosis complications is similar in every form of the pancreonecrosis.

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SPATIUL RETROPANCREATIC-CHEIA RESTANTELOR SI A RECURENTELOR SEPTICE IN PANCREATITA ACUTA SEVERA

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Autorii prezinta un punct de vedere asupra spatiului retropancreatic, zona topografica raspunzatoare de evolutia supuratiilor din pancreatita acuta severa. In majoritatea cazurilor, chirurgia e restrictionata la abordul limitat prin bursa omentala, folosita ca unica zona de acces asupra pancreasului. De cele mai multe ori, insa, necrozele si supuratiile evolueaza in aria compartimentelor retropancreatice si retroperitoneale, aproape imposibil de abordat prin bursa omentala. De aici survin debridarile si drenajele insuficiente care lasa restante septice si permit recurente supurative ce reclama reinterventii succesive, mai mult sau mai putin programate. Exista insa posibilitatea unei strategii planificate de abord retropancreatic, de prima intentie, in scopul unei toalete cat mai complete a acestui spatiu. In cadrul acestei strategii un rol de maxima importanta revine CT cu contrast oral si I.V., dar mai ales imagisticii prin reconstructii in plan frontal si sagital. Acestea ar trebui sa constituie regula explorarii CT si sa fie solicitate de catre chirurg pentru a reusi sa aleaga calea de abord adecvata pentru accesul confortabil in spatiul retropancreatic. In sustinerea acestor afirmatii, autorii prezinta compartimentarea spatiului retropancreatic, zonele de comunicare ale acestuia cu celelalte arii retroperitoneale, la distanta de pancreas, cat si caile de difuziune ale proceselor supurative. De asemenea, sunt puse in evidenta reperele anatomice CT care asigura orientarea corecta in analiza imaginilor standard, cat si a reconstructiilor. Devine astfel posibil un acces cat mai direct in zonele care, aproape de regula, sunt neabordate chirurgical cu ocazia primei interventii.

RETROPANCREATIC SPACE- THE KEY TO REMNANTS AND SEPTIC RECURRENCES IN SEVERE ACUTE PANCREATITIS

The authors present a point of view on retropancreatic space, a topographic area responsible for the evolution of suppuration in severe acute pancreatitis. In the majority of cases, surgery is restricted to the limited approach through omental bursa, used as unique access zone to pancreas. However, in the majority of cases, necroses and suppurations progress in retropancreatic and retroperitoneal compartment area, which is almost impossible to approach through the omental pouch. This is the reason for debridations occurrences and for insufficient drainage that allow for septic remnants and suppurative reccurences requiring succesive reinterventions more or less scheduled. There is, however, the possibility for a planned strategy for retropancreatic approach, as primary intention, for the purpose of a thorough as possible cleaning. As a part in this strategy, a role of a maximum importance belongs to oral and intravenous contrast CT and especially to imagistics by frontal and sagital reconstructions. These should constitute the rule for CT exploration and should be requested by the surgeon to succeed in choosing the retropancreatic approach for confortable access to this area. In sustaining these affirmations, in this paper, the authors present the compartmentation of retropancreatic space, its commnunicating zones to other retroperitoneal areas, futher away from pancreas, but also diffusion routes for suppurative processes. Also, CT anatomic landmarks that assure wright orientation in the analysis of standard, but also reconstructed images, are highlighted here. Therefore, an as direct as possible access in the areas, that as a rule are not surgically approached during the first intervention, becomes feasible.

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СПОСОБЫ НАЛОЖЕНИЯ ПАНКРЕАТОЕЮНАЛЬНЫХ АНАСТОМОЗОВ В ПРОФИЛАКТИКЕ ПОСЛЕОПЕРАЦИОННЫХ ОСЛОЖНЕНИЙ ПОСЛЕ ПАНКРЕАТОДУОДЕНАЛЬНОЙ РЕЗЕКЦИИ

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Целью настоящей работы явилось изучение осложнений, клинических показателей реабилитации больных в раннем послеоперационном периоде, которым были применены различные хирургические технологии панкреатодуоденальной резекции (ПДР).Материал и методы. В клинике хирургии №2 ОНМУ с 2003 по 2011 год ПДР выполнена у 141 больного, из них — 40 женщины, 101 — мужчины. По поводу рака головки поджелудочной железы оперированы 83 больных, 40 - по поводу рака периамплуярной зоны и у 18 больных показанием к операции служил хронический псевдотуморозный панкреатит.Все больные разделены на 4 группы: 1 группу составили 47 больных, которым выполнена ПДР по Уипплу; 2группа 31 больной с анастомозом по Шалимову - Копчаку; 3 группа - 41 больной - терминолатеральный панкреатоеюноанастомоз по нашей методике (патент Украины №27530); в 4 группу вошли 22 больных, которым наложен панкреатогастроанастомоз (патент Украины № 53181).Результаты и обсуждение. Проведенный анализ показал, что относительно высоким общее число осложнений было у больных, которым реконструктивную часть ПДР осуществляли формируя анастомоз по Уипплу (39,4%). Несостоятельность панкреатоеюноанастомоза выявлена у 10 больных и свищ ПЖ — у 9. В группе больных с применением терминотерминальной техники по Шалимову- Копчаку общее число осложнений составило 38,3%. При этом несостоятельность панкреатоеюноанастомоза выявлена у 8 больных.При применении разработанной нами методики выполнения панкреатоеюноанастомоза общее число осложнений в группе составило 10,8%, из них у 4 больных выявлена несостоятельность панкреатоеюноанастомоза.Общее число осложнений у больных с панкреатогастральным анастомозом выявлено у 4,3%. При этом несостоятельности панкреатогастроанастомозов не наблюдали. Общая летальность после ПДР составила 8,5% (12 больных).Выводы: Разработанные нами методики формирования панкреатоеюно- и панкреатогастроанастомоза при выполнении ПДР обеспечивают снижение несостоятельности швов и общего числа осложнений.

METHODS OF PANCREATICOJEJUNOANASTOMOSIS IMPLEMENTATION IN PREVENTIVE MAINTENANCE OF POSTOPERATIVE COMPLICATIONS AFTER PANCREATICOJEJUNAL

The purpose of the present work was studying of complications, clinical indicators of rehabilitation of patients in the early postoperative period with various methods of pancreaticojejunal resection (PJR).Material and methods. In clinic of surgery №2 ONMedU from 2003 till 2011 PJR was performed in 141 patients, from them - 40 females, 101 - males. 83 patients were operated on because of the cancer of the head of pancreas, 40 - concerning a cancer of periampullar zones and in 18 of patients the indication to operation was chronic pseudotumoral pancreatitis.All patients were divided into 4 groups: 1 group consist of 47 patients with PJA according to Wipple' s modification; 2group - 31 patients with Shalimov – Kopchak' s anastomosis; 3rd group - 41 patients - terminolateral pancreaticojejunoanastomosis according to our modification (the patent of Ukraine №27530); 4th group included 22 patients with pancreaticogastroanastomosis (the patent of Ukraine № 53181).Results and discussion. The carried out analysis has shown that rather high total number of complications was in patients with Wipple' s modification of PJR (39,4 %). The incompetency of pancreaticojejunoanastomosis is revealed in 10 patients and pancreatic fistula - in 9 of patients. In group of patients with Shalimov – Kopchak' s terminoterminal anastomosis total number of complications was 38,3 %. Thus the incompetency of pancreaticojejunoanastomosis was revealed in 8 of patients.In case of pancreaticojejunoanastomosis implementation according to our methodic total number of complications was 10,8 %, from them in 4 patients the incompetency of pancreaticojejunoanastomosis was revealed.Total number of complications in patients with pancreaticogastroanastomosis was revealed in 4,3 % of cases. Thus incompetency of pancreaticogastroanastomosis did not observe. The general lethality after PJR was 8,5 % (12 patients).Conclusions: Our techniques of pancreaticojejuno - and pancreaticogastroanastomosis during PJR performance provide decreasing of stitches incompetency and total number of complications.