

**EFFECTIVENESS OF MINIMALLY INVASIVE INTERVENTIONS
IN THE TREATMENT OF ACUTE DESTRUCTIVE PANCREATITIS**

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Annotation: In the presence of a formed focus of pancreatic necrosis, therapeutic measures are aimed at ensuring the aseptic course of the process and preventing its infection.

Keywords: Acute destructive pancreatitis, minimally invasive intervention, puncture-drainage treatment.

Relevance: The rapid increase in the incidence of acute pancreatitis in Uzbekistan has been outlined since the middle of the XX century, and until that time, no more than a thousand observations of this disease were described in the domestic literature. Currently, according to various authors, acute pancreatitis accounts for 10 to 25% of the total number of surgical patients and ranks third in the structure of acute surgical diseases after acute appendicitis and acute cholecystitis [1,2,3]. Such a rapid increase in the incidence of acute pancreatitis can probably be explained by the peculiarities of the diet, the increasing abuse of alcohol and its surrogates, the prevalence of cholelithiasis, and on the other hand, a significant improvement in clinical laboratory and instrumental diagnosis of the disease [4]. The number of destructive forms of the disease is also increasing, which account for 20-44% among patients with acute pancreatitis [5]. At the same time, infection of necrotic foci occurs in 40-70% of patients [1,2]. Mortality in destructive forms of acute pancreatitis varies from 7 to 50% (20-30% on average) depending on the severity of the process [1,2,6,7]. With infected pancreatic necrosis, mortality reaches 85%, with a fulminant course of the disease – 100% [1,8]. Early toxic and late septic complications of destructive pancreatitis are still the main cause of death in patients [2, 3]. High mortality in infected pancreatic necrosis is directly related to multiple organ failure, which follows hemodynamic disorders.

Objective: To perform a comparative analysis of the effectiveness of minimally invasive technology (MIT) at various stages of the development of acute destructive pancreatitis.

Materials and methods: MIT was performed in 132 patients, depending on the prevalence of destructive changes in the pancreas and parapancreatic tissue. Group 1 included patients who underwent only therapeutic and diagnostic laparoscopy (LDL). Group 2 consisted of patients who, along with LDP, performed various (MIT). Group 3 included patients operated on for purulent complications of EDP.

Results and discussion. Laparoscopic sanitation and drainage of the abdominal cavity were performed in 36 patients as the final treatment method. Microbiological examination revealed no growth of microflora. Drains were removed as the discharge disappeared from the abdominal cavity. The Glasgow – Imrie index at admission was 12. During the first two days of the postoperative period, a significant ($p < 0.05$) depression of this indicator to 0.94 ± 0.09 was obtained. The second group consisted of 44 patients with acute destructive pancreatitis (EDP), who had various minimally invasive interventions (MIV). At the same time, the number of patients who were initially admitted was 12 (27.3%), 71 others were transferred from the district CRH, due to the complicated course of the disease. A comparison of the severity of

endotoxycosis according to the Glasgow - Imrie index showed that the severity of the patients' condition at admission was objectively different from the patients of group 1, which probably indicated a larger scale of pancreatic lesion. The simultaneous volume of the removed effusion ranged from 130 to 1600 ml with a high level of amylase (from 850 to 11800 units). Drains were extracted after the disappearance of the separated and resorption of the liquid component under dynamic sonographic control. The third group included patients with purulent-necrotic complications of ODP. Upon admission, the Glasgow - Imrie severity score significantly exceeded that of patients in groups 1 and 2. During the surgical intervention in patients who had previously undergone minimally invasive interventions, the localization of drainage structures was necessarily clarified. The drainage function was effective against only the liquid component of parapancreatitis. Puncture-drainage treatment was inconclusive in patients with multicameral fluid formations that had many internal partitions that made it impossible to adequately sanitize and drain them through percutaneously installed thin-light drains.

Conclusion. Thus, clinical observations, dynamic ultrasound data compared with intraoperative verification allow us to state that during the formation of large-scale destruction in retroperitoneal tissue in the first week of the disease, the liquid component is manifested by diffuse impregnation of devitalized tissues with exudate. In the presence of high enzymatic activity of effusion in combination with an incomplete sequestration and demarcation process, the formation of liquid parapancreatic accumulations available for intervention under ultrasound control seems unlikely. In connection with these identified changes, it seems unlikely to us that minimally invasive interventions at this stage of the disease will be used as the final treatment method, due to their limited effectiveness in relation to the tissue component of widespread parapancreatitis. The mortality rate in group 3 was 23.1%.

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