

**THE CLINICAL CASE IS PNEUMATOUS, A CHANGE IN THE SIGMOID COLON
WALL AND ITS COMPLICATION**

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Annotation: This article is an analysis of a clinical case devoted to the clinical manifestations, course and tactics of treatment of pneumatous stent change of the sigmoid colon and its complications. Intestinal pneumatosis occurs in people of different ages, in men it occurs 2 times more often than in women (1,3). There is still no consensus on the origin of intestinal pneumatosis.

Keywords: Pneumatosis, intestinal emphysema, flatulence.

Annotation: This article is an analysis of a clinical case devoted to the clinical manifestations, course and treatment tactics of pneumatous changes in the wall of the sigmoid colon and its complications. Pneumatosis intestinalis occurs in people of all ages; in men it occurs 2 times more often than in women (1,3). There is still no consensus on the origin of pneumatosis intestinalis.

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Pneumatous changes in the intestinal wall, i.e. intestinal emphysema is a very rare disease, characterized by the accumulation of gas mainly under the serous membrane, as well as in the muscular and submucosal layers and in the mucous membrane with the formation of many rounded, oval bubbles ranging in size from a pinhead to a large cherry and more. There is still no consensus on the origin of intestinal pneumatosis. So, according to the infectious theory of A.I. Abrikosov. bubbles arise as a result of vital activity in the intestinal wall of various microorganisms (B.Pneumatosis, cocci, yeast fungi, etc.) forming gas. The most significant objection to this theory is the absence of pronounced inflammatory changes characteristic of any infectious process. Proponents of the mechanical theory consider (Kolli V.A.) the possibility of gas penetration into the intestinal wall through the damaged mucosa in people suffering from diseases of the gastrointestinal tract, accompanied by constipation, flatulence, vomiting (with pyloroduodenal stenosis), etc. (1,3. 1,2,3.).

In most cases, pneumatosis of the small intestine is detected, much less often – the vermiform process, colon, sometimes the pathological process (pneumatosis) spreads to the mesentery and parietal peritoneum. The surface of the intestine, opposite to the mesentery attachment site, is more often affected. The intestine can be affected for a considerable length – from 1 to 3.5 meters (1.).

In some cases, conglomerates of blisters turn into tumor-like formations. There is swelling and hemorrhage around the bubbles. There are no signs of acute inflammation. Nitrogen and air make up up to 81% of the gas collected from the bubbles, carbon dioxide 4%, oxygen up to 15%. Accumulations of serous fluid in the vesicles are very rare. The gas spreads mainly in the interstitial spaces of the intestinal wall (1,3,4).

In the clinical course of pathognomonic symptoms, there is no indication of the presence of intestinal pneumatosis. With large submucosally located cysts, intestinal obstruction may develop, and with damage to the peritoneum, signs of peritonitis may occur. As a rule, intestinal pneumatosis is a godsend during operations for another disease. If doctors are unaware, intestinal

pneumatosis may remain unrecognized on the operating table. X-ray examination of these patients in an upright position determines the free gas between the liver and the diaphragm, which disappears in a horizontal position (1.).

Intestinal pneumatosis often goes away on their own, therefore, if it is accidentally detected, most cases should be limited to either diagnostic laparotomy or surgery on the organ in connection with which the operation was performed. It is not necessary to pierce the subserosally located vesicles because of the danger of developing peritonitis. Intestinal resection is indicated for its obstruction caused by pneumatosis. In some cases, indications for intestinal resection may arise in the presence of large conglomerates of blisters, when there are doubts about the possibility of their spontaneous elimination (3.).

Due to the rarity of intestinal pneumatosis, the difficulty of diagnosis due to the lack of characteristic symptoms and the ambiguity of surgical tactics and treatment, we present the following clinical observation:

Patient T..., born in 1961, Case history No. 5705/663, was taken to the hospital surgery clinic of the Andijan State Medical Institute on the basis of the surgical department on 06/27/2023 at 2 p.m. from the Andijan region with a directional diagnosis: "Acute intestinal obstruction", 3 days after the onset of the disease. Upon admission, he complains of severe bloating and cramping abdominal pain, subsequent acquisition of a permanent character, nausea, 3-4 times vomiting, lack of stool and non-discharge of gases during the last 3 days.

From anamnesis: Suffers from chronic constipation for a long time. The stool happens after 3-4 days. The disease began gradually with cramping abdominal pain, which increased sharply and became permanent on the 10th day of the disease, accompanied by severe bloating, nausea and 3-4 times vomiting. The patient associates the onset of the disease with the intake of fatty, flour-based foods. There was no chair, the gases did not go away.

The general condition at admission is severe. The patient is malnourished, sluggish, and dynamic. There is vesicular respiration in the lungs. The pulse is 120 beats per 1 minute, weak filling and tension. A/D 100/70 mmHg. The tongue is dry, overlaid with a white coating. The abdomen is rounded – evenly, sharply swollen, does not participate in the act of breathing, the patient reacts to palpation of the abdomen in all departments. With percussion, hepatic dullness is not detected, pronounced tympanitis of percussion sound. The Shchetkin-Blumberg symptom is positive. The temperature is 36,20C. The protective tension of the muscles of the anterior abdominal wall is not pronounced.

Laboratory and instrumental data: Blood test: Hb-88 g/l, erit- $3.71 \cdot 10^{12}$ g/l, leukocyte- $8.4 \cdot 10^9$ g/l, p-21%, c-52%. Biochemical blood test: urea-5.1 mmol.l, residual nitrogen-2.4 mmol.l., Bilirubin-10.44 mmol/l, (direct-3.4, indirect-6.96), creatinine-96 mmol/L. Ultrasound examination of the abdominal cavity: stone-free cholecystitis, signs of intestinal obstruction. An overview R-scan of the abdominal cavity revealed a high standing of the diaphragm dome on both sides, a large amount of free gas and a single "Cloiber frequency". ECG: Myocardial ischemia.

The diagnosis was made: "Perforation of the hollow organ, widespread peritonitis." The patient was examined by an anesthesiologist, a therapist and, after intensive preoperative preparation, operated under endotracheal anesthesia on 06/27/2023, 3 hours after admission. Operation: Mid-median laparotomy bypassing the navel from the left with an extension of the incision downwards. Gas whistled out of the abdominal cavity. In the abdominal cavity, in the

lateral canals and in the pelvis, about 300 ml of cloudy effusion with fibrin deposits. There are loops of the sigmoid colon on the long mesentery, quite mobile in the form of a huge conglomerate measuring 35.0 x 19.0 cm with numerous subserous air bubbles on the surface of the mesentery, ranging in size from a cherry stone (0.5 x 0.6 cm) to a matchbox (3.0x5.0 cm), which almost completely covers the intestinal lumen. the sigma wall is thickened. After the separation of the conglomerate, two perforations were found on the cystically altered anterior wall of the sigmoid colon. Above the affected part of the sigma, the colon is swollen. Taking into account the nature of morphological changes and the functional unsuitability of the loop, a resection of the cystically altered sigma area was performed within the healthy area of the eye. The continuity of the gastrointestinal tract was restored by creating an invagination end of the lateral sigmoctal anastomosis, between the proximal loop and the anterior wall tightly closed by the abdominal rectum according to Hartmann. The abdominal cavity is drained and drained by two polypropylene drains through separate punctures in the side walls of the abdomen. The surgical wound is sutured in layers. Stitches on the skin. Aseptic dressing. Histological examination: The wall of the colon with vascular hyperemia, edematous with focal hemorrhages and mucosal necrosis in places.

Conclusion: The postoperative period was smooth. The healing of the surgical wound is primary. The patient was discharged on the 11th day for outpatient observation by a surgeon. Examined at 3.6 months, in satisfactory condition, engaged in household chores.

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