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MODERN APPROACH TO THE TREATMENT AND PREVENTION OF ABDOMINAL CONNECTION DISEASE

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Abstract
The article examines the treatment of various clinical forms of peritoneal adhesive disease in 114 children. Based on this, a modern approach to surgical and conservative treatment methods, the clinical course, and the effectiveness of the conservative measures taken depending on the forms of the disease are determined. To achieve the set goal, treatment measures are aimed at significantly reducing the number of unjustified operations and complications, and decreasing mortality. In clinical practice, the prevention of peritoneal adhesive disease, the use of complex treatment methods, allows for a reduction in the recurrence of adhesive disease and a decrease in its complications.

Keywords: Adhesive disease of the peritoneum, treatment, prevention, children.

Introduction

Despite many years of scientific research on the current problems of peritoneal adhesive disease, this problem remains relevant in pediatric abdominal surgery [2, 3, 5, 6, 8].

Repeated studies of peritoneal adhesive disease, risk complications of adhesive intestinal obstruction after abdominal surgery, diagnosis of the disease, treatment tactics, prevention, and various discussions remain at the center of attention of scientific researchers and practicing physicians to this day [1, 2, 4, 5, 8].

Due to the frequency and predisposition to recurrence of peritoneal adhesive disease in children, the frequency of recurrence of the disease is 7-10%, complications of the disease are high, and the mortality rate is 31-40%.

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According to the medical literature, adhesion formation in intestinal obstruction in children occurs in 37% of cases after appendectomy, in 23% after obstructive intestinal obstruction, and in 10% after coloproctological operations.

After any surgical intervention in the abdominal cavity, adhesive disease of the peritoneum develops to varying degrees. Peritoneal adhesive disease is a polyetiological disease, and the process of adhesion formation is diverse. These are caused by mechanical irritation of the intestine, the aggressive action of exogenous chemical reagents on the intestinal walls, purulent diseases of the abdominal cavity, intestinal paralysis, and other factors. The above factors serve as the basis for a pathogenetic approach to the prevention and treatment of adhesive disease. Timely diagnosis and correctly chosen treatment tactics depend on the type of adhesive intestinal obstruction, its course is crucial, and a comprehensive approach to disease prevention and rehabilitation does not lead to positive outcomes or recurrence [1, 2, 4, 5, 7, 8].

The purpose of the study is to select rational surgical tactics for peritoneal adhesive disease, optimize its diagnosis, and develop a comprehensive approach to prevention and treatment.

Research methods:

During 2012-2024, 114 children with various forms of peritoneal adhesive disease were examined in the pediatric surgery department of the Center.

Of these, 24 patients were admitted with early adhesive intestinal obstruction, and 90 patients with late adhesive intestinal obstruction.

The age of the patients ranged from 4 to 17 years. Patients applied within 1.5 to 12 hours at different times of disease progression. Diagnosis was based on the clinical picture and radiological examination (general abdominal radiography with vertical and direct imaging), and in some cases, CT, MSCT, and ultrasound diagnostic methods were used.

Based on long-term practical experience in the early diagnosis of intestinal obstruction, CT, MSCT, and ultrasound methods play a key role in describing the known picture as it is. Conservative and surgical methods are used to eliminate intestinal obstruction. Conservative complex treatment methods include gastrointestinal decompression, gastric intubation, stopping feeding, correction of electrolyte imbalances and potassium levels, infusion therapy, drug stimulation of the intestine, and siphon enemas. Conservative measures were carried out in patients with subacute forms of early adhesive intestinal obstruction and late adhesive intestinal obstruction. The effectiveness of conservative measures in adhesive intestinal obstruction was determined based on the results of contrast studies of the gastrointestinal tract. The generally accepted forms of late adhesive intestinal obstruction in pediatric surgery, proposed by Yu.F. Isakov (1990), are distinguished as subacute, acute, and subacute.

If conservative treatment in children with adhesive intestinal obstruction is ineffective within 2-3 hours, despite intestinal stimulation, it is an indication for surgery.

Acute and subacute forms of adhesive intestinal obstruction serve as indications for emergency surgical intervention in hospitalized patients. Our center pays great attention to the early prevention of adhesive disease.

Early interoperative prevention of adhesive disease requires a very sensitive approach to the abdominal tissues. The main goal of disease prevention in the postoperative period is the rapid

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elimination of inflammatory processes in the abdominal cavity, leaving the drainage tube in the abdominal cavity for no more than 2-3 days. Abdominal lavage with the fibrinolytic mixture applied in the center should be carried out according to the scheme.

The complex treatment regimen for adhesive disease developed in the clinic includes: adherence to diets, physiotherapy courses against adhesive disease, and dispensary observation of patients. The main tasks of restorative therapy and prevention of adhesive processes in the abdominal cavity are to ensure adequate functioning of intestinal motility, prevent long-term coprostasis, ensure the absorption of abdominal adhesions and strength of the muscles of the anterior abdominal wall. Prevention of intestinal paralysis is one of the main goals of providing food products in small portions 4-5 times a day to prevent patients from starving for a long time. It is necessary to limit products that are poorly digested and produce gases in the intestinal lumen. Regular enzyme intake (festal, pancreatin, panzinorm), control of free bowel movements, physiotherapeutic treatment against adhesive disease with 1-2 month intervals, 4 courses per year. Physiotherapeutic treatment, starting from the stages of inpatient treatment, includes UHF No. 5-7, electrophoresis with potassium iodine No. 15, phonophoresis with hydrocortisone No. 15, ozokerite application to the anterior abdominal wall No. 10. Depending on the situation, balneotherapy is recommended once or twice a year. It is always necessary to conduct therapeutic exercises to increase the strength of the anterior abdominal wall muscles. In recent years, we have recommended the drug "Serrata" as part of a comprehensive program for the prevention and rehabilitation of adhesive disease. This drug has enzymatic, proteolytic, anti-inflammatory, immunomodulatory, detoxifying, and antioxidant properties.

The results of the study:

A comparative approach to timely early diagnosis and tactics, improvement of treatment methods for adhesive intestinal obstruction can lead to very good results in the treatment of patients of this contingent. A total of 43 patients underwent surgery (11 of them laparoscopically), 5 children underwent surgery for the early form of adhesive intestinal obstruction, and 38 children underwent surgery for the late form of adhesive intestinal obstruction. Relaparotomy was performed in 2 patients, i.e., due to necrosis of the intestines, intestinal resection and butt anastomosis were performed.

Among the observed children, relapse with adhesive intestinal obstruction was observed in 3 patients, in whom intestinal obstruction was eliminated laparoscopically. After discharge from the hospital, all patients were recommended to undergo complex treatment against adhesive disease according to the scheme introduced in the center and were placed under dispensary observation at their place of residence for 3 years. Among the operated patients, no fatal outcomes were observed.

Conclusion:

The results of the treatment of children with adhesive intestinal obstruction and the subsequent prognosis are determined by the timely diagnosis of the disease, the correct choice of treatment method in compliance with the basic principles of the organization and implementation of medical care. The possibilities of laparoscopic surgery expand the prospects for a minimally invasive approach to the treatment of this pathology. A comprehensive approach to the rehabilitation and

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prevention of adhesive disease is of great importance for long-term results, which significantly reduces the frequency of disease relapses and ensures stable restoration of the digestive tract in children.

REFERENCES:

1. Алиев С. А. Особенности диагностики и хирургической тактики при спаечной кишечной непроходимости // Хирургия. - 1994. - № 2. - С. 13-17.
2. Гринев М. В., Курыгин А. А., Ханевич М. Д. Острая кишечная непроходимость как проблема неотложной хирургии // Вестн. хирургии. - 1992. - № 5. - С. 130-138.
3. Женчевский Р. А. Спаечная болезнь: Учеб. для студентов мед. вузов. - М., 1989. - 30 с.
4. Иванова М. Н., Коновалов А. К., Сергеев А. В. Профилактика, диагностика и лечение спаечного процесса брюшной полости у детей // Хирургия. - 1996. - № 4. - С. 67-69.
5. Нейков Г. Н. О послеоператsионной спаечной непроходимости у детей // Детская хирургия. - 1999. - № 1. - С. 12-14.
6. Симонян К. С. Спаечная болезнь: Учеб. для студентов мед. вузов. - М., 1966. - 274 с.
7. Томашук И. П., Беломар И. Д., Отурин Е. П. Ранняя спаечная непроходимость кишечника. - Киев, 1991. - 19 с.
8. Menzies D. Postoperative adhesions: their treatment and relevance in clinical practice // An. R col. surg. engl. - 1993. - № 75. - P. 17-153.
9. Бондаревский, И. Я. Современное состояние проблемы прогнозирования и профилактики послеоперационного адгезиогенеза брюшины (обзор литературы) [Текст] / И. Я. Бондаревский, М. С. Шалмагамбетов, В. Н. Бордуновский // Уральский медицинский журнал. - 2018. - № 1 (156). - С. 69-78.
10. Видеолапароскопические вмешательства в проблеме релапаротомии [Текст] / В. Е. Соболев, И. П. Дуданов, А. В. Дербенев, Ю. В. Андреев // Эндоскопическая хирургия. - 2007. - Т.13, №1. - С. 88-89.
11. Возможности функциональной МРТ в оценке спаечной болезни после пластики передней брюшной стенки [Текст] / Е. А. Мершина, Е. С. Васильева, В. Е. Синицын [и др.] // Кубанский научный медицинский вестник. - 2010. - № 6 (120). - С. 95-100.
12. Вопросы патогенеза спаечной болезни брюшины и современные подходы к ее предупреждению. Обзор литературы [Текст] / О. Э. Луцевич, В. П. Акимов, В. Г. Ширинский, А. А. Бичев // Московский хирургический журнал. -2017. - № 3 (55). - С. 11-26.

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