

POSTGASTRORESECTION SYNDROMES

Davirova Gulbakhor Mamasaliyeva

Siyob Public Health College After Named Abu Ali ibn Sina

Abstract

In the development of dumping syndrome, psychoneurological changes and disorders of the autonomic nervous system play a significant role. Clinically, dumping syndrome manifests itself with weakness, hot flashes, cold sweats, dizziness, palpitations, tachycardia, chest pain and tightness, and even fainting. The clinical manifestations of the disease and the severity of symptoms depend on the severity of dumping syndrome and the intake of food, especially sweet and dairy foods. Diagnosis of the process is anamnestic, clinically uncomplicated. X-ray examination shows accelerated contrast evacuation.

Introduction

Treatment of dumping syndrome consists of following a diet, excluding foods that cause dumping from the diet, eating frequent meals and eating as much coarse food as possible: meat, fish, vegetables, sauerkraut, etc. When conservative treatment does not help and in severe cases of dumping syndrome, surgery is performed. These are mainly reconstructive operations aimed at restoring the duodenal passage (Bilroth II and Billroth I). The resulting gallbladder syndrome is a consequence of a defect in the surgical technique, the development of adhesions or duodenal permeability disorders.

The pathology most often appears in the first year after surgery. Clinically, the disease is characterized by heaviness and pain in the right hypochondrium, occasionally vomiting with bile or bile mixed with food, after which the patient feels significant relief. Regurgitation, belching, heartburn, and pain behind the sternum are possible. The pathogenesis of diverticulum syndrome is complex and multifaceted:

- 1) compression of the diverticulum behind the gastroenteroanastomosis;
- 2) rotation or torsion of the diverticulum;
- 3) invagination of the diverticulum at the junction between the intestines;
- 4) infiltration of the diverticulum mucosa into the gastrointestinal anastomosis;
- 5) compression by adhesions;
- 6) compression by a tumor, narrowing by scarring;
- 7) technical errors, etc.

Diagnosis is made on the basis of the clinical picture. X-ray examination shows the ingress of contrast material into the esophageal sphincter, but this can also occur in patients without symptoms of esophageal sphincter syndrome.

Treatment is conservative, as in dumping syndrome, with vitamin therapy - protein preparations, amino acids are administered, and treatment is carried out in a sanatorium-resort. In severe cases of esophageal sphincter syndrome, when mechanical obstructions occur, it is recommended to use a surgical method that gives good results. Peptic ulcers of the anastomosis are formed mainly in the retained gastric secretion. If the acidity is very high, they are frequent, if it is low, they are rare, and they are completely absent in the axilla. This is the most severe complication after resection and



occurs in 0.5-2.5% of patients who have undergone surgery, usually within the first 3 years and mainly in men. However, it can also occur in women, older people and the elderly. The location of the peptic ulcer is different - both in the ascending colon and in the anastomosis area, often penetrating into the mesentery, transverse colon, pancreas, intestines.

The main symptom of a peptic ulcer is severe and excruciating pain. It is stronger than the pain before the operation. Painless periods are gradually reduced, the pain is constant, radiates to the back, chest (irradiation), heartburn, vomiting are characteristic. The patient loses weight, pigmentation appears in the epigastric region due to constant use of a heating pad. A peptic ulcer after surgery can cause a number of complications - bleeding, perforation, penetration, in severe cases, even a fistula can develop (external or intragastric fistula).

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