



**Health Ministry of
Azerbaijan Republic**

Riib Regional İnkişaf
İctimai Birliyi



**Euroasian Association
of Gastroenterology**



**Hepato Bilio
Pankreatoloji Derneği**



**“Azerbaijan Surgeons
and Gastroenterologists”
Public Union**



**Azerbaijan
Medical University**



**Scientific Center of Surgery
named after academician
M.A. Topchubashov**

**Milli
Onkologiya
Mərkəzi**



**National
Center of
Oncology**



**Turkish Association
For The Study of The Liver**



**Türk Gastroenteroloji
Derneği**

All patients with type 2 SM underwent laparoscopic subtotal cholecystectomy with preservation of the upper wall of the gallbladder neck adjacent to the fistula and the formation of a flap from it to close the existing vesicocholechocheal fistula with drainage of the common bile duct according to Kehr.

The completeness of lithoextraction was verified by intraoperative choledochoscopy in 18 (72%) patients before drainage of the common bile duct, and in 7 (28%) patients intraoperative cholangiography was performed through drainage of the common bile duct.

In the postoperative period, no nonspecific complications were observed in patients undergoing laparoscopic interventions. One patient had a specific complication in the form of residual choledocholithiasis, which was corrected on the 5th day after surgery by performing ERCP with EPST and removing the common bile duct stone. The average duration of stay of patients in a hospital bed was 8.6 days. Death was observed in 1 (4%) case, the cause of which was multiple cholangiogenic liver abscesses and sepsis.

Conclusions. The inclusion of ERCP, PTBD and MRI cholangiography in the diagnostic scheme improves the accuracy and quality of recognition of SM and allows one to evaluate the indications for the use of videolaparoscopy. The indication for laparoscopic treatment of type 2 SM is the presence of a single stone in the supraduodenal part of the common bile duct, which will reduce the number of conversions to laparotomy. In cases of type I SM, the operation of choice is laparoscopic cholecystectomy. The operation of choice in patients with type II SM is laparoscopic subtotal cholecystectomy, fistula repair with a gallbladder flap on a Kehr drainage.

ON THE ISSUE OF CLASSIFICATION OF MALLORY-WEISS SYNDROME

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Aim of the study was to improve the treatment outcomes of patients with Mallory-Weiss syndrome by systematizing the clinical signs of the disease and a differentiated approach to the choice of treatment method.

Materials and methods: The results of examination and treatment of 112 patients with Mallory-Weiss syndrome. All patients were divided into two clinical groups - control and main. The control group included 64 patients who underwent traditional treatment approaches. In the main group, 48 patients We have carried out an improved set of therapeutic measures.

Results. We have systematized the classification of Mallory-Weiss syndrome according to the localization of the lesion; by the length, number and length of ruptures; bleeding intensity.

I. By the location of the lesion: EF type (esophageal fissure) - Lower third of the esophagus; KEF type (kardioesophageal fissure) - Cardio-esophageal transition; KESF type (kardioesophageal-stomach fissure) is a cardio-esophageal transition that spreads to the gastric mucosa; HF type (hernial fissure) is a fissure inside a hiatal hernia.

II. By the Number of Gaps: Single; Plural.

III. By the length of the gap: Small - up to 1.0 cm; Medium - from 1.0 to 2.0 cm; Large - more than 2.0 cm.

IV. By the depth of the defect: Stage 1 - rupture of the mucous membrane; Stage 2 - rupture of the mucous membrane and submucosal layer; Stage 3 - rupture with involvement of the circular muscle layer; Stage 4 - rupture of all layers of the esophagus.

V. By the intensity of bleeding: Grade 1 - ongoing bleeding (1a - jet, profuse arterial bleeding, the source is not visible due to the inability to sanitize the esophagus from blood; 1b - jet, arterial bleeding, the possibility of debridement of the esophagus makes it possible to determine the source of bleeding; 1c - venous bleeding, no blood clots; 1d - the fissure is covered with fresh blood clots, there is a blood spurt under them).

Grade 2 - stopped bleeding (2 a - visible thrombosed vessel in the area of rupture; 2 b - fixed clot in the rupture area without bleeding; 2 c - the rupture is covered with fibrin).

Grade 3 - rupture without signs of bleeding, granulation of the fissure.

Conclusion. A differentiated approach to the choice of hemostasis method made it possible to increase the efficiency of primary hemostasis from 78,1% to 91,7%, reduce the frequency of repeated endoscopic interventions from 15,6% to 6,3%, and reduce the need for open surgical interventions from 6,3% to 2,1%.

NON-ALCOHOLIC FATTY LIVER DISEASE AND INTESTINAL DYSBIOSIS, WHAT COMMON?

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Purpose of the study: to evaluate the effectiveness of *Bacillus clausi* for the correction of intestinal microbiocenosis in the complex therapy of NAFLD.

Materials and methods. 58 patients with NAFLD were examined: 35 women, 23 men. The average age was 48.8 ± 5.1 years. Diagnostic measures included standard clinical, biochemical and instrumental examination of the liver profile. To assess the state of microbiocenosis of the large intestine, all patients underwent bacteriological dynamic study of stool. 48 made up the main group and 10 patients - the control group.

Research results. Analysis of the results showed that disturbances in intestinal microbiocenosis due to a decrease in the content of bifidobacteria, lactobacilli, and bacteroides occurred in all patients (100%). Manifestations of dyspeptic syndrome in those examined before treatment were distributed as follows: 62.4% of patients had a tendency to constipation; 13.1% had a tendency to diarrhea, 25.4% noted alternating diarrhea and constipation. All patients (100%) noted abdominal bloating. In 26.5% of cases, ultrasound data revealed manifestations of fatty hepatosis, 73.5% with steatohepatitis. 78.4% had manifestations of specific hepatological syndromes: cytolytic, cholestatic, asthenovegetative. Patients in the control group received UDCA at a standard dose. Patients of the main group additionally received *Bacillus clausi* 1 capsule 3 times a day for 1 month. Against the background of the therapy, in all patients of the main group, the manifestations of asthenovegetative and dyspeptic syndromes decreased and the intestinal microflora was restored due to an increase in the content of bifidobacteria, lactobacilli and a decrease in the level of opportunistic pathogens.

Flora to acceptable values. During a dynamic examination in the control group, positive dynamics regarding hepatological syndromes were also noted, however, compared with the indicators of the main group, colon dysbiosis was not subject to visible correction.

Conclusions. Research has found that the use of *Bacillus clausi* promotes normalization of intestinal microflora, improvement of clinical and laboratory manifestations of the underlying disease, which increases the effectiveness of treatment of patients with NAFLD with dysbiosis of the large intestine.

UDCA IN THE CORRECTION OF COMPONENTS OF METABOLIC SYNDROME (MS) IN PATIENTS WITH NON-ALCOHOLIC FATTY LIVER DISEASE (NAFLD)

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Purpose of the study: to study the effectiveness UDCA in NAFLD patients with MS components.

Materials and methods. 28 patients with NAFLD and MS were examined: 18 women, 10 men. The average age was 45.3 ± 7.1 years.

Diagnostic measures included instrumental, standard clinical and biochemical studies of the liver profile including lipoproteins and blood glucose. To assess the degree of obesity, we used BMI. The main group (MG) of patients receiving indap, metformin and ursosan consisted of 20 patients and the control group receiving indap, metformin and karsil (CG) - 8 patients.

