



SIMULTANEOUS OPERATIONS FOR COMBINED SURGICAL AND GYNECOLOGICAL DISEASES

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Abstract

The presented work provides a review of domestic and foreign literature regarding the problems of performing simultaneous operations in gynecology - issues of terminology, classification, assessment of traumatism and clinical and economic effectiveness, features of performing combined operations in the combination of gynecological diseases with other surgical pathology (appendicitis, morbid obesity, hernias, cholelithiasis, varicose veins of the lower extremities, etc.).

Keywords

simultaneous operations, method, gynecology, surgery.

INTRODUCTION

In recent years, when providing gynecological care to patients, in addition to purely medical aspects, much attention has been paid to intensifying the work of gynecological hospitals, rational use of bed capacity, reducing economic costs, and expanding the scope of surgical interventions [1]. Thanks to the increase in life expectancy of women and the improvement of diagnostic technologies, there has been a tendency towards an increase in the number of patients with 2-3 concomitant surgical diseases.

MATERIALS AND METHODS

The presence of combined surgical and gynecological diseases in many patients, which, according to WHO, account for 20–30%, poses the task of simultaneous correction of such pathology for surgeons and gynecologists [2]. Increasing the effectiveness of treatment of gynecological patients requiring surgical intervention, if they have concomitant surgical pathology, is achieved by performing simultaneous operations. The use of combined surgical approaches (laparotomic/laparoscopic, hysteroscopic, vaginal) in the surgical treatment of patients with combined gynecological and surgical diseases makes it possible to eliminate all identified surgical pathology within one anesthetic procedure, eliminates repeated operations and associated operating rooms, after - operational surgical and anesthetic complications and emotional stress; eliminates the occurrence of exacerbation of uncorrected concomitant disease in the early postoperative period, improves the quality of life of patients (physical activity, mental state, role, social and sexual functioning) [3].

RESULTS AND DISCUSSION

Simultaneous operations are divided into emergency and planned, the main and accompanying stages are distinguished, according to indications, absolute, preventive, diagnostic and forced operations are distinguished, according to the timing of execution - simultaneous synchronous operations, which are performed simultaneously by several surgical teams at a significant distance from each other. From each other anatomical zones in need of surgical correction, and simultaneous-sequential, performed one after another by one or several teams in the same anatomical area. The order of performing simultaneous intervention is determined individually depending on the volume, technical features of the upcoming operations, topographical and anatomical features and the nature of pathomorphological changes in the

lesions [4].

Due to the widespread use of laparoscopic technologies in surgery, new opportunities are opening up for performing simultaneous operations. Low-invasiveness, quick rehabilitation period, good cosmetic effect with a larger volume of surgical intervention make minimally invasive methods preferable for simultaneous operations on the organs of the upper and lower floors of the abdominal cavity. In cases where a simultaneous operation includes a combination of technically complex and volumetric interventions, or one of the operations is performed in a complex anatomical area with limited possibility of inspection, it is advisable to use standard puncture points for each operation separately. The use of the “migrating port” principle in standard simultaneous interventions makes it possible to reduce the trauma of laparoscopic access by reducing the number of trocars used [5]. Today, single-port simultaneous operations (cholecystectomy + hysterectomy, cholecystectomy + ovarian cystectomy) are widely introduced into clinical practice.

The severity and nature of the postoperative period mainly depend on the volume of the main stage of the simultaneous operation, and the duration of inpatient treatment corresponds to the period of rehabilitation of the patient after one, larger intervention. The number of postoperative complications after simultaneous operations in women with diseases of the internal genital organs, according to national statistics, is 2–6.9%, mortality is 0–0.5%, the implementation of the simultaneous stage in most cases does not lead to an increase in the number of postoperative complications. complications compared to isolated interventions [4].

To determine the economic efficiency of simultaneous operations, most researchers recommend an economic analysis of the cost of the disease, on the basis of which it is possible to carry out a detailed calculation of the main cost components of the treatment process - from the initial visit to a specialist to discharge from the hospital [5].

CONCLUSION

The issue of performing a planned simultaneous surgical intervention must be agreed upon with the patient, and written informed consent must be obtained for its implementation. A comparative assessment of one-stage and simultaneous operations showed that with the correct individual selection of patients with combined pathology, adequate preoperative preparation of patients, taking into account the compensatory capabilities of the body and reducing the degree of operational risk, individualized choice of method and volume of surgery, an increase in the volume of surgery does not influence the frequency of postoperative complications and leads to significant financial savings both at the hospital and outpatient stages.

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