DIAGNOSIS AND SURGICAL TREATMENT OF ACUTE DESTRUCTIVE CHOLECYSTITIS IN REGIONAL HOSPITALS

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Abstract. Cholecystectomy is a radical intervention leading to a complete recovery of the patient. Materials and methods. The study material was the medical records of 77 patients operated on in the Khankinsky district hospital in 2023 for acute cholecystitis within 72 hours of the onset of the disease. Results. A clinical examination revealed acute destructive cholecystitis in 35 out of 42 people, and acute cholecystitis in 26 out of 35 patients. Conclusion. Thus, in order to timely resolve the issue of urgent laparoscopic cholecystectomy in a regional hospital, the diagnosis of acute destructive cholecystitis with a high degree of reliability can be established by identifying a combination of clinical, ultrasound signs and changes in functional liver tests.
Keywords: acute destructive cholecystitis; in the conditions of regional hospitals; cholecystectomy; ultrasound signs.

Introduction. Cholecystectomy is a radical intervention leading to a complete recovery of the patient. Laparoscopic cholecystectomy is one of the minimally invasive and effective surgical interventions for acute destructive cholecystitis. Performing laparoscopic cholecystectomy at an early stage makes it a relatively safe and affordable intervention, which provides an additional advantage in the form of shorter hospital stays. To reduce the number of conversions, laparoscopic cholecystectomy is most appropriate within 72-96 hours of the onset of the attack. However, early diagnosis of acute destructive cholecystitis often causes difficulties, because the available clinical, laboratory and instrumental data do not always allow us to exclude or confirm the presence of destructive changes in the gallbladder wall [1, 3-10]. Accordingly, the purpose of our study was to study the effectiveness of the main methods used in the diagnosis of acute cholecystitis in regional hospitals.

Materials and methods. The study material was the medical records of 77 patients operated on in the Khankinsky district hospital in 2023 for acute cholecystitis within 72 hours of the onset of the disease. All patients were divided into two groups: the first group with acute cholecystitis without signs of destruction – 35 people; the second with acute destructive cholecystitis – in the presence of phlegmonous and gangrenous changes according to the results of morphological examination of preparations of removed gallbladders - 42 people.

Medical history data, clinical examination results, general and biochemical blood tests, and ultrasound examinations were used.

Patients with ASA III or IV surgical risk, over the age of 70, with a history of upper abdominal surgery, and pregnant women were not included in the study. For quantitative normally distributed features, statistical reliability was assessed using the Student's criterion (t). Nonparametric criteria were used for a different distribution of features from the normal one. The differences were considered significant with an error probability of $P<0.05$. One-factor analysis of variance was used to identify the significance of the established prognostic factors. To calculate the diagnostically significant levels, we used the definition of reference intervals using a central range covering 95% of the data values [2]. The obtained research results were processed using the "STATISTICA 6.0" application software package.

Results. A clinical examination revealed acute destructive cholecystitis in 35 out of 42 people, and acute cholecystitis in 26 out of 35 patients. Thus, the sensitivity of the clinical examination was 80.6%, and the specificity was 57.9%. Ultrasound of the abdominal organs revealed acute destructive cholecystitis in 15 patients, and acute cholecystitis in 34 patients. The sensitivity of this method was 38.7%, and the specificity was 84.2%. An increase in bilirubin levels was noted in 22 patients with acute destructive cholecystitis and remained within normal limits in 31 patients with acute cholecystitis.

Early detection of destructive forms of acute cholecystitis is often associated with significant difficulties. In the vast majority of cases, only such methods as medical history collection, clinical examination, general and biochemical blood tests, ultrasound of the abdominal organs are available in district hospitals. More expensive diagnostic tools and methods are usually unavailable. Currently, instrumental diagnostic methods are becoming increasingly important. The sensitivity of ultrasound in detecting cholelithiasis, according to the literature, exceeds 90-95%, at the same time, its sensitivity in detecting acute destructive cholecystitis is significantly lower. In this work, we have demonstrated that correct medical history collection and clinical examination are simple, affordable, cost-effective methods that surpass ultrasound in the diagnosis of acute destructive cholecystitis. On the other hand, the high specificity of ultrasound makes it an extremely valuable method of excluding acute destructive cholecystitis, although clinical examination is more sensitive than ultrasound in detecting acute destructive cholecystitis, in practice they complement each other, and sufficient accuracy in the diagnosis of acute destructive cholecystitis can be achieved if the results of clinical examination, ultrasound and the results of functional liver tests coincide. Ultrasound examination is used to confirm the diagnosis of acute destructive cholecystitis in cases where it is suspected clinically. On the other hand, the diagnosis of acute destructive cholecystitis can be ruled out with a sufficient degree of certainty if all these tests are negative. These data suggest a fairly simple assessment of the patient's status, which makes it possible to select those patients who need urgent surgery, as opposed to those who can be operated on as planned.

CONCLUSION.

Thus, in order to timely resolve the issue of urgent laparoscopic cholecystectomy in a regional hospital, the diagnosis of acute destructive cholecystitis with a high degree of reliability can be established by identifying a combination of clinical, ultrasound signs and changes in functional liver tests.

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