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Research Article

ANAMNESTIC AND ANTHROPOMETRIC FEATURES OF PATIENTS WITH BILIARY PANCREATITIS

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ABSTRACT

The article presents the results of a study of 154 patients with acute pancreatitis of biliary etiology treated in the clinic of And State Medical Institute and Central City Hospital Andijan for the period from 2015 to 2022 gg inclusive . All patients were divided into groups. The main group included 75 patients who were treated on the basis of these two centers for the period from 2019 to 2022 . These patients used the developed algorithm for choosing the tactics of treating acute biliary pancreatitis in conjunction with the proposed clinical and pathogenetic aspects of intensive care for pancreatogenic systemic complications. The comparison group included 79 patients treated from 2015 to 2018 .

Laboratory research methods were carried out for all patients with OP and included: complete blood count, urinalysis, biochemical blood test (total protein, albumin, total bilirubin and its fractions, urea, creatinine, glucose, amylase,

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lipase, AST, ALT, potassium , sodium , chlorides, total calcium, creatine phosphokinase , lactate dehydrogenase , C-reactive protein). Surgical activity in acute pancreatitis of biliary etiology was 25.6%, while in the alcoholic-alimentary form of the disease, only 7.9% of patients were operated on (p <0.001), the frequency of repeated interventions was 9.1% versus 1.6% (p< 0.001), respectively, in turn, postoperative mortality reached 25.9% and 20.5%, fatal outcomes of conservative treatment were noted in 2.1% and 0.7% of cases, and the overall mortality rate was 8.2% and 2.2 % .

KEYWORDS

Papilosphincterotomy, False abscess, pancreas, Interstitial pancreatitis, acute pancreatitis.

INTRODUCTION

In world practice, a number of targeted scientific studies are being carried out aimed at studying the pathogenesis of the development of AP depending on various factors, including the role of the etiological cause, molecular genetic aspects and the relationship of various specific substrates of inflammation on the pancreatic tissue with the formation of local and systemic pancreatitis-associated complications. among which the study of the role of damage to the lung tissue and the features of the progression of respiratory distress syndrome in conjunction with other manifestations of multiple organ failure is of particular relevance . Of particular interest is the issue of studying specific markers for identifying pancreatogenic complications, including a number of randomized clinical trials to evaluate the effectiveness of recommended scoring systems and improve systemic approaches to comprehensive verification of the severity of the pathological process .

The aim of the study is to improve the results of treatment of patients with OP by improving the tactical diagnostic monitoring of specific pancreatogenic complications and optimizing the complex of therapeutic and preventive measures .

MATERIALS AND METHODS

General characteristics of clinical material

The work is based on the results of a study of 154 patients with acute pancreatitis of biliary etiology treated in the clinic of the ASMI and Central City Hospital Andijan for the period from 2015 to 2022 yy inclusive.

All patients were divided into groups. The main group included 75 patients who were treated on the basis of these two centers for the period from 2019 to 2022 . These patients used the developed algorithm for choosing the tactics of treating acute biliary pancreatitis in conjunction with the proposed clinical

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and pathogenetic aspects of intensive care for pancreatogenic systemic complications. The comparison group included 79 patients treated from 2015 to 2018 yy.

RESULTS AND ITS DISCUSSION

The Ranson and APACHE II rating scales are used both to form the final diagnosis and to predict the risk of mortality in OP, which plays one of the main roles in determining the tactics of treating patients. So, a comprehensive assessment of the condition of patients according to the Ranson and APACHE II scales (Table 1.) showed a significant difference in the severity of the pathological process between biliary and alimentary OP (criterion $\chi 2=40.818$; Df =3; $p < 0.001$). At the same time, in 69.4% of cases, a biliary form of edematous OP or focal necrosis was noted, which corresponded to less than 3 points according to Ranson and <8 according to APACHE II, while in alimentary OP these criteria were defined in 86.1% (427 patients) cases. Acute destructive pancreatitis (>3 Ranson ; >8 APACHE II) was diagnosed in 20.3% (n=89) of cases of biliary etiology and in 10.9% of cases of alimentary etiology. In 10.3% and 3.0% of cases, destructive TOP was detected with complications (>6 Ranson ; >15 APACHE II) of biliary and alimentary etiology, respectively.

Table 1

Distribution of patients according to the severity of the condition (Ranson , APACHE II) in the formation of the final diagnosis

Index	Biliary		Alimentary		Total	
	abs .	%	abs .	%	abs .	%
<3 ranson ; <8 APACHE II (Edematous acute pancreatitis or focal necrosis)	107	69.4%	134	86.1%	241	78.3%
>3 ranson ; >8 APACHE II (acute destructive pancreatitis)	31	20.3%	17	10.9%	59	15.3%
>6 ranson ; >15 APACHE II (severe complicated destructive pancreatitis)	16	10.3%	1	3.0%	18	6.4%

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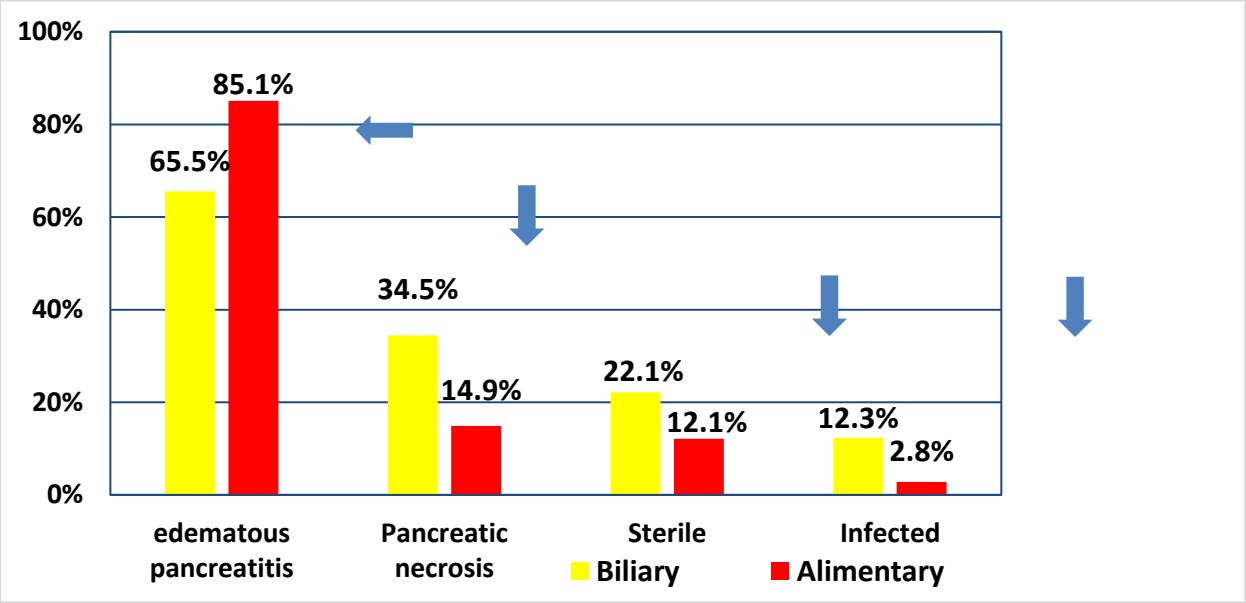
Total	154	100.0%	151	100.0%	318	100.0%
Criterion χ2	40.818; Df =3; p <0.001				-	-

Distribution of patients according to the international classification Atlanta-92 (2012) in fig. 1. Thus, 65.5% of cases of edematous form of pancreatitis were characteristic of biliary pathology, pancreatic necrosis was diagnosed in 34.5% of cases.



Rice. 1. Distribution of patients according to the international classification Atlanta (2012)

Among patients with AP of alimentary etiology, 85.1% of edematous pancreatitis was observed, which is more than in patients with biliary AP (χ2=48.642; Df =2; p <0.001), while the proportion of pancreatic necrosis was significantly lower, amounting to 14.9% (criterion χ2=6.680; Df =2; p=0.036). In turn, sterile pancreatic necrosis was diagnosed in 12.1% (n=60) cases with alimentary pancreatitis and 22.1% (n=97) with biliary etiology of pancreatitis, and infected in 2.8% (n=14) and 12, 3% of patients, respectively (criterion χ2=6.680; Df =2; p =0.036).

As noted above, acute destructive pancreatitis was diagnosed in 34.5% of cases of biliary etiology and 14.9% – alimentary. At the same time, complicated forms, in particular, purulent-septic complications of destructive TOP, were observed in 12.3% and 2.8% of cases of biliary and alimentary pancreatitis, respectively. Infected postnecrotic pancreatic cysts were detected in 5.7% (25

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patients with biliary pancreatitis) and 1.6% (8 patients with alimentary pancreatitis) cases. Retroperitoneal phlegmon was diagnosed in 4.6% (n=20) of patients with biliary pancreatitis and 1.0% with alimentary pancreatitis.

The proportion of patients with purulent peritonitis, omental bursa abscesses and pancreatogenic abscess was also higher in biliary pathology, amounting to 3.2%, 3.4% and 1.4% versus 0.4%, 0.6% and 0.4%, respectively. . At the same time , it should be noted that one patient accounted for from 1 to 3 complications.

Thus, a comprehensive assessment of the condition of patients according to the Ranson and APACHE II prognostic scales showed a significant difference in the severity of the course of the pathological process (criterion $\chi2=40.818$; Df =3; p <0.001), while the edematous form of the disease of alimentary etiology was determined in 85.1% (422 patients) of patients, destructive in 14.9% (74) cases, while in biliary pancreatitis these figures were 65.5% (287 patients) and 34.5% (151), respectively (criterion $\chi2=48.642$; Df =2 ; p <0.001), in turn, sterile pancreatic necrosis was diagnosed in 12.1% (60 patients with alimentary pancreatitis) and 22.1% (97 patients with biliary pancreatitis), and infected in 2.8% (14) and 12, 3% (54) patients ($\chi2=6.680$; Df =2; p=0.036).

Among patients with OP of biliary etiology, the number of operated patients was 112 out of 438 (25.6%), while in the alimentary form of the disease, surgical activity was 7.9% (39 out of 496 patients) (criterion $\chi2 = 53.814$; Df = 2 ; p < 0.001). According to the nature of the operations, the patients were distributed as follows (Table 3): drainage of the omental sac under ultrasound control was performed in 2.7% (n=12) cases of biliary etiology OP and 0.8% (n=4) cases - alimentary; laparatomy ,HEC, drainage of the choledochus , opening, sanitation and drainage of the omental sac were performed in 5.9% and 0.8% cases; CHEC, choledocholithotomy, drainage of the choledochus, opening, sanitation and drainage of the omental bag - 4.6% and 1.0% ; laparoscopy, drainage of the choledoch according to Pikovsky, drainage of the omental bag in 5.0% and 1.6%; laparotomy, necrosequestrectomy, drainage of the abdominal cavity and retroperitoneal space in 4.8% and 1.0% cases with biliary and alimentary OP, respectively.

Table 2

Distribution of patients by type of operation performed

Operation	Biliary		Alimentary		Total	
	abs .	%	abs .	%	abs .	%

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Drainage of the stuffing bag under ultrasound control	12	2.7%	4	0.8%	16	1.7%
Laparotomy, CHEC, drainage of the choledochus, opening, sanitation and drainage of the omental sac	26	5.9%	4	0.8%	thirty	3.2%
Laparoscopy, laparotomy, drainage of the omental sac and abdominal cavity	3	0.7%	5	1.0%	8	0.9%
CEC, choledocholithotomy , drainage of the choledochus , opening, sanitation and drainage of the omental bag	20	4.6%	5	1.0%	25	2.7%
Laparoscopy, drainage of the choledoch according to Pikovsky , drainage of the omental bag	22	5.0%	5	1.0%	27	2.9%
Laparotomy, opening, sanitation and drainage of the abscess of the omental bag	8	1.8%	8	1.6%	16	1.7%
Laparotomy, necrosequestrectomy , drainage of the abdominal cavity and retroperitoneal space	21	4.8%	8	1.6%	29	3.1%
Total operated	112	25.6%	39	7.9%	151	16.2%
Conservative therapy	326	74.4%	457	92.1%	783	83.8%
Reliability of differences in treatment tactics	$\chi 2=53.814$; Df=2; p <0.001				-	-

The proportion of minimally invasive interventions was 30.4% for biliary pathology versus 23.1% for alimentary pancreatitis (Fig. 2).

The reoperation rate was 9.1% (40 out of 438 patients with biliary OP) versus 1.6% (8 out of 496 patients with alimentary OP) ($\chi 2=24.430$; Df =2; p <0.001). According to the nature of repeated operations, patients were distributed as follows (Table 4): repeated necro- and sequestrectomy were performed in 4.6% (n=20) and 1.0% (n= 5) cases; laparotomy,

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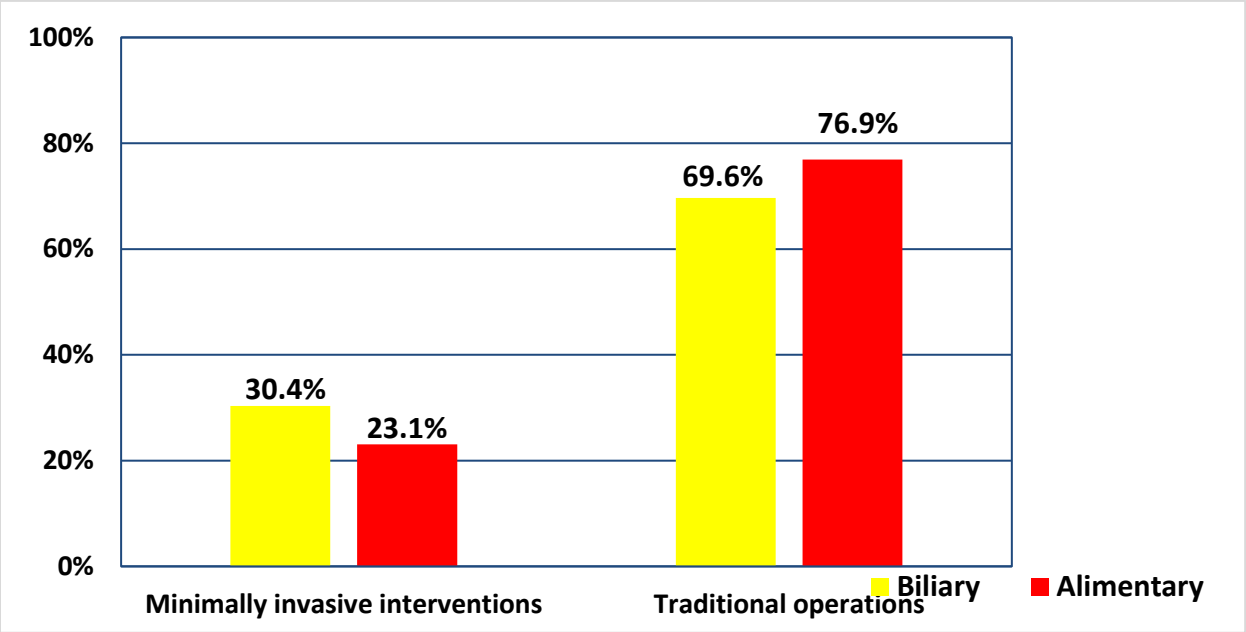
sanitation of the abdominal cavity, necro- and sequestrectomy after minimally invasive interventions in 3.2% and 0.4%; stop arrosive bleeding in 1.4% (6 patients) and 0.2% (1 patient) of cases of biliary and alimentary pancreatitis, respectively.



Rice. 2. Share of minimally invasive and traditional interventions

The overall postoperative mortality was 25.9% in biliary AP and 20.5% in alimentary AP (Fig. 3.). After minimally invasive surgical interventions in AP of biliary etiology, mortality was 17.6% (6 patients), while in alimentary etiology it was 11.1% (1 patient) ($\chi 2=0.280$; Df =2; p =0.597); after traditional operations, mortality was 29.5% (n=23) and 23.3% (n=7) in pancreatitis of biliary and alimentary etiology, respectively.

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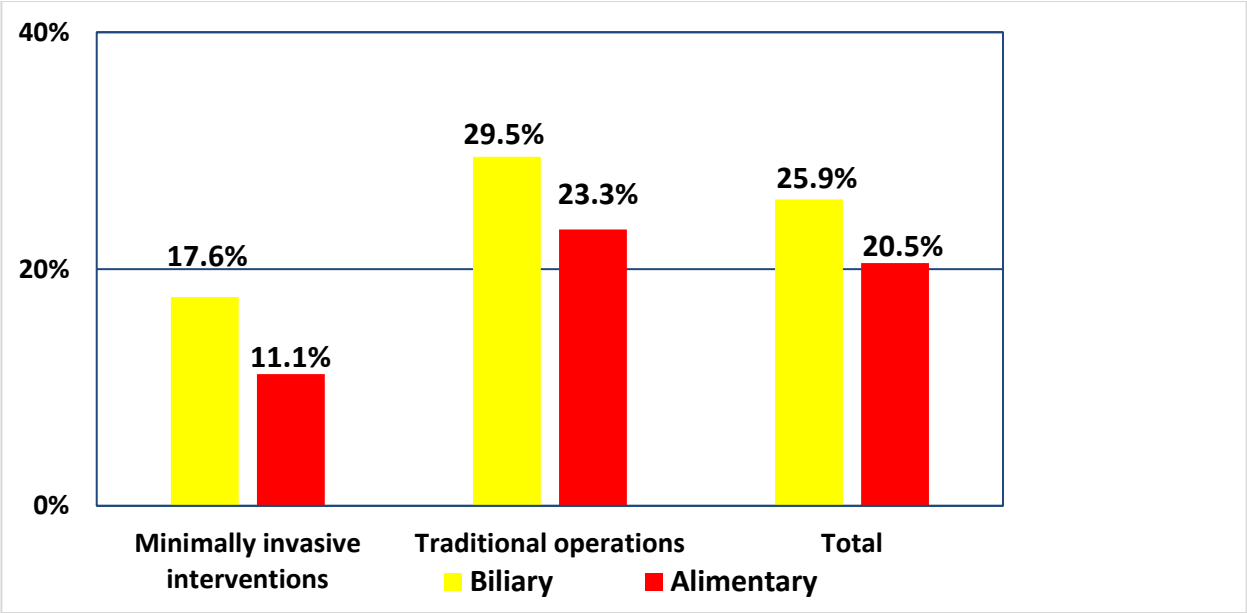

Rice. 3 . Postoperative mortality in pancreatitis of biliary and alimentary etiology

The general structure of mortality in OP is shown in Fig. 1. 4. Thus, the overall mortality rate was 8.2% (36 cases) and 2.2% (11 cases) in biliary and alimentary AP, respectively ($\chi 2=30.358$; Df =3; p <0.001).

Lethal outcomes after conservative treatment were observed in only 2.1% (7 cases) and 0.7% (3 patients) cases.

From Table. Table 5 shows that the highest percentage of deaths in both biliary and alimentary AP was characteristic of patients with severe complicated destructive pancreatitis and baseline scores of more than 6 on the Ranson scale and more than 15 on the APACHE II scale. However, a higher mortality rate was observed in biliary AP (44.4% vs. 33.3%; 15.807; Df =1; p <0.001). For acute destructive pancreatitis with more than 3 points according to Ranson and more than 8 points APACHE II, the mortality rate was 18.0% (16 cases) in biliary and 11.1% (22 cases) in alimentary etiology of the disease.

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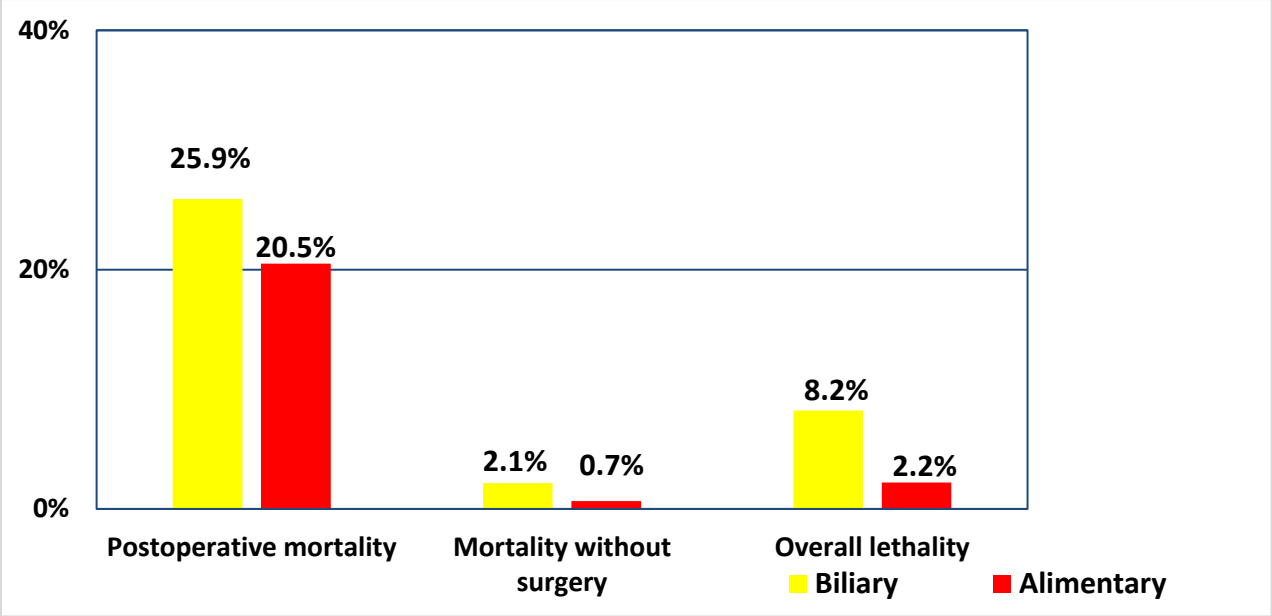

Rice. 4. The structure of mortality in patients with pancreatitis of biliary and alimentary etiology

Table 5

Fatality rate according to the severity of the condition (Ranson , APACHE II)

Index	Biliary		Alimentary		Total	
	abs.	%	abs .	%	abs.	%
<3 ranson ; <8 APACHE II (Edematous acute pancreatitis or focal necrosis)	0	0.0%	0	0.0%	0	0.0%
>3 ranson ; >8 APACHE II (acute destructive pancreatitis)	3	18.0%	1	11.1%	3	15.4%
>6 ranson ; >15 APACHE II (severe complicated destructive pancreatitis)	4	44.4%	1	33.3%	5	41.7%
Total	7	8.2%	2	2.2%	9	5.0%

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Criterion χ2	15.807; Df =1; p <0.001	-	-

A high frequency of deaths was characteristic of infected forms of OP, so with biliary etiology this figure was 48.1% (3 cases), with alimentary etiology - 42.9% (2 cases) (2.693; Df = 2; p = 0.261) . In pancreatic necrosis, a relatively high mortality rate was also observed, amounting to 22.5% and 12.2% in biliary and alimentary pancreatitis, respectively (17.046; Df = 2; p < 0.001) (Table 6).

Thus, the surgical activity in acute pancreatitis of biliary etiology was 25.6%, while in the alimentary form of the disease, only 7.9% of patients were operated on (criterion χ2=53.814; Df =2; p <0.001), the frequency of reoperations was 9, 1% versus 1.6% (criterion χ2=24.430; Df =2; p <0.001), in turn, postoperative mortality reached 25.9% and 20.5%, fatal outcomes of conservative treatment were noted in 2.1% and 0 .7% of cases, and the overall mortality rate was 8.2% and 2.2% (criterion χ2=30.358; Df =3; p<0.001).

CONCLUSIONS

Surgical activity in acute pancreatitis of biliary etiology was 25.6%, while in the alcoholic-alimentary form of the disease, only 7.9% of patients were operated on (p <0.001), the frequency of repeated interventions was 9.1% versus 1.6% (p< 0.001), respectively, in turn, postoperative mortality reached 25.9% and 20.5%, fatal outcomes of conservative treatment were noted in 2.1% and 0.7% of cases, and the overall mortality rate was 8.2% and 2.2 % (p<0.001).

The dynamics of the severity of acute biliary pancreatitis during treatment is characterized by the possibility of progression of the pathological process with a significant increase in the proportion of destructive forms of the disease from 16.5% upon admission to 33.8% (p <0.001), including the increase in sterile (from 13.9% to 21 .9%) and infected (from 2.5% to 11.8%) pancreatic necrosis (p=0.027) with various purulent-septic complications.

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