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OUR EXPERIENCE IN THE SURGICAL TREATMENT OF PATIENTS WITH TYPHOID PERITONITIS

Собиров С. О.
врач Областная больница» г. Уиже Республика Ангола
Научный руководитель

Азизов Гафур Абдурахимович
Андижанский государственный медицинский институт
к.м.н. ассистент кафедры 1факультетской и госпитальной хирургии

ABSTRACT

In connection with the increasing resistance of S. typhi to antibiotics, it is important to improve etiotropic therapy and optimize antibacterial therapy approaches in the complex treatment of typhoid peritonitis. 185 patients with acute typhoid peritonitis were studied in 2023–2025 in the surgical department of the regional hospital in the city of Uige in the Republic of Angola. The article describes the main variants of surgical tactics in typhoid peritonitis. The results are presented surgical interventions.

Keywords: Typhoid peritonitis, results of surgical interventions.

INTRODUCTION

Typhoid fever (BT) is an anthroponosis of bacterial nature caused by salmonella (Salmonella typhi) and transmitted by the fecal-oral route. The multi-organ lesions inherent in typhoid fever are fully manifested in the severe course of the disease, leading to the development of functional insufficiency of vital organs and systems. BT is determined by a large number of patients, the severity of the course and the persisting high mortality, which is about 25-30%. The disease is more common in regions with a warm climate, low sanitary culture of the population, as well as imperfection of the water supply and sewerage system. The highest prevalence is in India (incidence of 1000 per 100 thousand population), Central and Southeast Asia, South America, Africa. The closest territories to Uzbekistan are Tajikistan, Kyrgyzstan and Russia (Dagestan, Chechnya). [2] Depending on the characteristics of the course, typhoid fever can be divided into complicated and uncomplicated, as well as with exacerbations and relapses. According to a number of authors [3, 4, 5, 6, 7, 8, 9], the most formidable specific complications of typhoid fever are perforations of typhoid ulcers followed by peritonitis, intestinal bleeding, infectious and toxic shock, and meningoencephalitis. [10] The cause of death of patients with typhoid fever - perforative peritonitis is (26.2%).The simultaneous presence of various structural changes in the lymphatic formations of the intestine (cerebral swelling, necrosis of Peyer's plaques, the stage of ulcer purification, etc.) was established in the majority of the deceased (95.2%). [1] The most important element in the successful treatment of BTP is the choice of surgical tactics [1, 3, 7, 8]. The main tasks of surgical treatment in BTP are: elimination of the cause of peritonitis, sanitation of the abdominal cavity, its adequate drainage, decompression of the gastrointestinal tract [6].

MATERIALS AND METHODS

We monitored 185 patients with acute typhoid peritonitisfor the period 2023–2025 in the surgical department of the regional hospital in the city of Uige in the Republic of Angola. Of these, 67 (36.2%) were women and 118 (63.8%) were men. 88 patients (47.6%) were of working age.

During the day from the moment of perforation of the typhoid ulcer, 30 (16.3%) patients were diagnosed, 68 (36.7%) patients were diagnosed up to 3 days, 45 (24.3%) patients were diagnosed after 3 days, and 24 (12.9%) patients were diagnosed after a week, and 18 (9.8%) patients were very neglected. The terms of circulation are presented in Table No1.

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№	*Time of circulation*	*Total*	*%*
1.	*Within a day.*	*30*	*16.3*
2.	*Within 2-3 days.*	*68*	*36.7*
3.	*In 3 or more days.*	*45*	*24.3*
4.	*After 1 week.*	*24*	*12.9*
5.	*Very neglected.*	*18*	*9.8*
	Total	***185***	***100***

We observed intestinal perforation in typhoid fever, severe and moderate forms of the disease. There are cases of an obliterated course of the disease with perforation of a typhoid ulcer, sometimes, on the contrary, the most severe general intoxication is noted with a slight lesion of the intestine (sometimes swelling of several lymph nodes in the mesentery without perforation of ulcers, that is, there are ulcers but not perforated).

All patients, depending on the methods of surgical treatment used, are divided into 3 groups. The following types of surgery were performed: closure of intestinal perforation, ileostomy, intestinal resection and Anastomosis. The distribution of patients by sex and the operation performed is presented in Table No2.

Distribution of patients by sex and surgery Table No2.

№	Group Name	Man	Woman	Total
1,	Ileostomy	48	34	82
2.	Anastomoses	30	17	47
3.	Pinhole Clamping	40	16	56
	Total	**118**	**67**	**185**

The results were evaluated according to the following indicators: general and biochemical blood tests in dynamics, bacteriological, serological tests (Vidal reaction, ELISA, RPGA), X-ray examination, ultrasound. Study of objective and subjective data of the patient - changes in body temperature, A/D, pulse, volume of fluid excreted from the abdominal cavity and nasogastric tube. postoperative complications

Results of their discussion

After operations and complex treatment, 133 (72%) patients were discharged in satisfactory condition. 52 (28%) had complications. Complications by type of operation are presented in Table No3

Complications by type of operation Table No3

№	Group Name	Complications	%
1,	Ileostomy	16	19.5
2	Anastomoses	20	42.5
3.	Pinhole Clamping	16	28.6
	Total	**52**	**28.1**

The following complications were revealed during the application of ileostomy: suppuration of wounds of the anterior abdominal wall-4, suppuration and divergence of sutures around ilestomy-3, subphrenic abscess-2, adhesive intestinal obstruction-2, eventration-4. And tertiary peritonitis accounted for -2 cases. the following complications: suppuration of wounds of the anterior abdominal wall-3, divergence of sutures-5, eventration-3, subphrenic abscess-2, reperforation-3. Tertiary peritonitis accounted for 10 cases.

Conclusion:

The best results with fewer complications were observed with the application of an ileostomy. Complications were observed in 42.5% with the application of an anastomosis. The main reason for the negative results is considered to be the late time of treatment. The severity of peritonitis also played an important role.

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