



Research Article

## OPTIMISING SURGICAL MANAGEMENT OF PATIENTS WITH ACUTE PARAPROCTITIS

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### ABSTRACT

303 patients with different clinical forms of acute paraproctitis were treated. All the observed patients were operated on radically. Treatment tactics and choice of surgical treatment method in patients with various clinical forms of acute paraproctitis depend upon the pus localization, the location of primary purulent passage in relation to anal sphincter fibers, the degree of cicatricial process development in pararectal tissue and rectal wall. The developed complex of tactical and therapeutic measures allows to reduce the period of patient's stay in the hospital, significantly reduce the percentage of recurrences of the disease, improve functional results of treatment.

### KEYWORDS

Acute paraproctitis, diagnosis, treatment tactics, surgical treatment, outcomes of the disease.

## INTRODUCTION

Acute pararectal suppuration of various etiologies remains one of the current problems of coloproctology. During many decades the questions connected with different aspects of diagnostics and treatment of patients with this pathology are subjects of animated discussions in Russian and foreign literature [1,6,14]. The urgency of the problem is proved by the fact that pararectal festering is one of the most common proctological diseases, comprising from 20 to 40% of all rectal diseases, and in patients of working age acute paraproctitis occurs in 6-22% of cases, which puts the problem of treatment of such patients in the category of social [2, 5, 13].

As a result, many patients have to undergo repeated surgeries, hospitalization period increases, sometimes disability is increased, and quality of life decreases due to chronic course of untreated purulent process or rough cicatricial deformity in perianal area with insufficiency of anal gland [16].

If to take into consideration that 70 % of cases of acute paraproctitis involve able-bodied population, most of them are men, this problem

on the national scale becomes not only medical, but also social and economic [3,18].

Thus, the diagnosis and treatment of patients with acute paraproctitis are still the subject of discussions. Despite the achieved success in the treatment of patients with acute purulent inflammatory diseases of pararectal tissue, the results cannot be considered satisfactory, and a final solution of many questions still haven't been found [4,7,10].

High frequency of postoperative complications, unsatisfactory long-term results of treatment, high lethality among the patients with complicated forms of acute paraproctitis testify once again to the multifacetedness, complexity and unsolved problems of diagnostics and treatment of this pathology. [11,12,17].

## OBJECTIVE OF THE STUDY

To improve the results and the choice of the radical method of surgical treatment in patients with acute paraproctitis.

## MATERIAL AND METHODS

We analyzed the results of treatment of acute paraproctitis in 303 patients who were treated in the proctology department of SamMI clinic during the period 2016-2022. Of these, 67 (22%) were women and 236 (78%) were men, ranging in age from 16 to 74 years. The time from the time of illness to hospital admission ranged from 3 to 12 days, with an average of 4 days. According to localization subcutaneous-subcutaneous paraproctitis forms were in 162 (53,4%), ischiorectal in 83 (27,5%), pelveorectal in 14 (4,6%), retrorectal in 25 (8,2%) and intermuscular in 19 (6,3%) patients.

Differentiated approaches in the choice of surgical tactics were developed.

Radical surgery at acute paraproctitis assumes a pararectal abscess opening taking into account its complexity degree, relation to sphincter fibers and liquidation of its internal rectal opening.

In general surgical hospitals, a simple opening and drainage of the abscess without elimination of the rectal opening is most often performed, which in a large percentage of cases results in a rectal fistula.

At subcutaneous, ischiorectal, intrasphincter paraproctitis with intrasphincter communication with the rectal lumen we perform an autopsy and drainage of the abscess with excision of purulent passage into the rectal lumen according to Rychy-Bobrov.

At ischiorectal paraproctitis with transsphincteric purulent passage passing through the superficial portion of the anal sphincter, i.e. occupying less than 1/3 of the anal bridge we perform an opening and drainage of the pus with excision of the purulent passage into the intestinal lumen.

In ischiorectal and retrorectal forms with abscesses as well as pelvio-rectal pustules with transsphincteric (more than 1/3 of anal gland) purulent passage, in all paraproctitis with extrasphincteric communication we perform an opening and drainage of the pustule, cryptectomy. With additional incisions (if the main access is not possible) we open the abscess, drain it and ligature through the internal opening and tighten it. Ligature tightening is performed after the inflammatory process in the wound has subsided, on average after 4-5 days. As a rule, 3 tightening of the ligature is enough, after which it falls off on its own, or we remove it on day 12-16.

In these forms, in rare cases, when the affected crypt cannot be clearly identified, we have to limit ourselves to a wide opening and drainage of the purulent cavity. Later on, if a fistula is formed, the operation is performed routinely after 2-3 months.

In recurrent paraproctitis, excise all scar tissue if possible, being extremely careful of sphincter fibres. Tightening the ligature in such patients is advisable after the wound bed has granulated. In all forms we perform intraoperative contrasting by puncturing the abscess and injecting dye with H<sub>2</sub>O<sub>2</sub> to identify the affected crypt. At the end of the operation we dress the wound with swabs of Vishnevsky's ointment or levomecol.

Dressing the next day. The wound is washed with antiseptic solutions, drained with ointment turunds. Antibiotics for purulent paraproctitis are prescribed for common processes with infiltration into the pararectal tissue.

## RESULTS

The results of treatment in 245 patients operated on in the proctology department at 1, 2 and 3 years after the operation were monitored. No fistula formation after radical operations for

paraproctitis with intrasphincter and esphincteric purulent passage (245 cases, 80,8%). After operations at paraproctitis with extrasphincteric purulent passage (58 cases, 19,2%) in two cases (3,4%) a fistula was developed, in one case (1,7%) relapse of acute paraproctitis in the postoperative scar was registered.

All patients with fistulas and acute paraproctitis were successfully operated on in our department. Postoperative failure in acute paraproctitis was more frequent in ligature application, in recurrent paraproctitis. According to our data there were 5 (1,6%) cases, with simultaneous provision of radical operative interventions. No surgical correction of jejunal insufficiency was required in any case.

Thus, the data show that despite the undoubted success, many questions concerning the management of patients with acute paraproctitis remain unsolved, which makes it advisable to continue research on the development of new highly effective and less traumatic methods of treatment of this pathology.

## CONCLUSIONS

1. surgeries for acute paraproctitis should be carried out taking into account the location of purulent passage to rectal sphincter fibres, with liquidation of internal orifice.
1. 2 Treatment in conditions of the specialized department of patients with acute paraproctitis leads to its radical cure without transformation into chronic paraproctitis.
2. If possible the operation for acute paraproctitis should be realized by surgeon with specialization in proctology.

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