



Prevention Of Thromboembolic Complications In Postoperative Bemoans

X.A.Abdullayev

Master of Anesthesiology and resuscitation specialist stage 3

Muratov TM.N.

PhD. Department of Anesthesiology and resuscitation
Tashkent Medical Academy
Tashkent, Uzbekistan

ABSTRACT

Pulmonary artery thromboembolism is one of the most common emergencies in the postoperative period. Pulmonary artery thromboembolism is a pathological condition caused by thromboembolism of the trunk or small branches of arteries in the small circulatory circle, initially, the right ventricle later leading to the development of biventricular heart failure.

Pulmonary embolism is the third most common in mortality from cardiovascular disease after myocardial infarction and stroke. In economically developed countries, 0.1% of the population dies from this pathology every year. It is impossible to accurately assess the frequency of oate after surgery, since this condition is often asymptomatic.

Keywords:

alanine-amino-transferase, aspartate-amino-transferase, arterial blood pressure, erythrocyte deposition rate, chronic venous vascular insufficiency, C-reactive protein, body mass index

Relevance. According to modern literature, the frequency of recording venous thromboembolic complications in the population is 1-1.92 episodes (average per 110.05 people). According to recent literature, 2/3 corresponds to thrombosis and 1/3 corresponds to pulmonary embolism [55]. In addition, 10 to 25% of all cases of thromboembolism are fatal [1, 12, 14,]. Even if the patient is discharged from the hospital with a positive result, the risk of death in the first month increases by 10 times, and in the case of cancer - by 25 times. The main cause of death in 4 months after the first episode of thromboembolism is a recurrence of thromboembolism [52]. In second place, chronic pulmonary hypertension developed after the first episode. Even with timely anticoagulant therapy, irreversible changes in the pulmonary artery persist in 80% of patients, leading to chronic pulmonary hypertension

[56]. This pathology leads to a significant deterioration in the quality of life, a complete or partial loss of working capacity, and in a five-year life cycle, from 30 to 10% of individuals come [25]. In deep venous thrombosis, immediate death occurs in 4.6% of cases and mortality is 6% in the first month after the initial episode of thrombosis [56]. Previously suffering from deep venous thrombosis, it later leads to the development of post-thrombophlebitis syndrome and the development of 19-42% venous insufficiency. The recurrence of thromboembolic complication is 13-25% in the first 11 years and 24-30% in 10 years from the moment of the manifestation of thrombosis [52]. These conditions lead to the development of a post-thrombosis disease and a partial or complete loss of working capacity. In the hospital, thromboembolic complications are often growing. Currently, deep venous

thrombosis is 1.3% and pulmonary artery thromboembolism is 0.4%. [10, 44, 61, 302], this is 10 times higher than the likelihood of thrombotic complications compared to the population. The hospital mortality rate from pulmonary embolism is 0.3-0.5%, while non-fatal pulmonary embolism is 1.52% [28]. The most common cause of death after surgical interventions in 6-25% of surgical patients is pulmonary embolism [3]. The intensity of prevention of venous thromboembolic complications from the hospital should be appropriate to assess the likelihood of their development. Standard preventive approaches can significantly reduce the risk of thromboembolic complications in moderate to low-risk groups, while the proportion of complications in the high-risk group remains much higher [4,5,] and in this the number of patients. it reaches 41% in surgical hospitals [4]. Venous stagnation is one of the most important mechanisms of thrombus formation in the postoperative period, and can be corrected using 12 mechanical methods to prevent the formation of venous thrombosis. LA Smith and others were the first to conduct a clinical study showing a link between slowing blood flow and the appearance of thrombosis [9]. Venous stagnation, in turn, consists of the following components: slowing blood flow, overflowing of the vessels and widening of the venous segments. There are studies that show a decrease in venous outflow on the first day after surgery and when the patient is on the operating table. When recording venous blood flow after 4 hours in the horizontal position of patients, it was found that the volumetric rate of blood flow decreased by 47%, and the highest rate by 22% [3]. The situation is aggravated by the fact that many patients after surgery have gastroesophageal reflux and pulmonary ventilation-related pneumonia [3] which must be kept with the tip of the head raised to prevent [8]. A.D. According to a study by maclaquin et al [24], it has been found that the muscle veins of the lower leg have the ability to accumulate contrast substance more than other veins of the lower leg, and its evacuation occurs 3 times slower.

The purpose of the work. In postoperative patients, pulmonary artery thromboembolism is a deep approach to preventive measures and reduction of mortality by early detection of possible complications as a result of the study of forecasting criteria and the introduction of new methods of treatment into practice.

Materials and methods. 60 patients who have applied to the multidisciplinary clinic of the Tashkent Medical Academy are examined in laboratory and instrumental. We divided the patients into 2 groups control group - 20 patients, the main group - 40 patients. Prevention of thromboembolic complications in patients of the Nazarite group was carried out on a protocol basis with treatment and elastic compression, bandage fixation. In our main group of patients, treatment measures were carried out in the preoperative period, taking into account the time of blood clotting, laboratory and instrumental examinations and possible complications on the surface. Also, in the main group, elastic bandages, knitted bandages were applied to prevent thromboembolic complications. In the main group, the number of patients was 40, of which 27 men and 13 women. The number of patients in our control group is 20, 14 men and 6 women.

Research results. It became known that the risk of developing thromboembolic complications according to the age indicator of patients is observed in patients over 40 years of age, and the incidence is further increased as age opens.

Vascular disease ranked first with Group II at 35% and Group I at 28%. The next major group was obesity II-III at 30%, urinary tract infection at 15%, respiratory diseases at 12.5%. If in our control group obesity Grade II and III 15%, and respiratory system diseases were observed in 5% no changes were noticed in other reviews. The high risk factor for the development of thromboembolic complications was 35% for vascular diseases, 30% for obesity II and III, and 15% for urinary tract infection.

When we pass an analysis on surgical amality in patients, we can see that group I consists mainly of patients with little development of small-

scale operations and thromboembolic complications. In our Group II were mainly patients with large-scale operations (requiring 40 minutes of open time) and medium to high risk of thrombo embolic complications.

In patients, no clinical - laboratory changes were observed based on the standard treatment measures taken in the postoperative period.

In patients, the observation was carried out mainly in 4 outposts: 1 etap - in the preoperative period, 2 etap - in the postoperative period, i.e. until the introduction of preventive measures, 3-etap - in the postoperative period, i.e. the period during which thrombo embolic preventive measures began, 4 - etap-in the postoperative period 5-7 days is the period in which the patient's home is answered.

All patients are subject to the level of risk of VTEO during the preoperative period and during the operation, the attachment of the lower leg with an elastic bandage was applied. In the postoperative period, compression strain was applied until Yes was answered.

Early activation of patients began at 1 day after surgery. In patients of the main group, low molecular heparin - nadroparin calcium "fraciparin" was administered under the skin for 5 days at a prophylactic dose of 0.3 ml 1 time per day. For obese patients, 0.6 ml was administered 1 time per day for 5 days, and 0.9 ml was administered one time per day for a patient with high thromboembolism development for 5 days.

In early activation of patients, along with elastic compression and preventive treatment, adequate anesthetic, infusion treatment, antibiotic treatment for antibacterial prophylaxis, as well as symptomatic and anti-inflammatory treatment were used.

Treatment of patients in addition to Bunnan was observed in blood clotting time, fibrinogen content, hemocritus, and thrombotest, using coagulogram.

Conclusion. Clinical – laboratory tests in the early detection of thromboembolic complications (coagulogram, blood clotting time, thrombotest, hemotocritus, platelet content), MSKT angiography from instrumental examinations, dopplerography, ExoKG helped

to accurately compare with other methods. Anticoagulant treatment with prophylactic doses to prevent thromboembolic complications has greatly reduced the risk of developing thrombo embolic complications

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