On the issue of classification of Mallory-Weiss syndrome

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ABSTRACT

The aim of the study was to improve the treatment outcomes of patients with Mallory-Weiss syndrome by systematizing the clinical signs of the disease and a differentiated approach to the choice of treatment method

Keywords: Mallory-Weiss syndrome, hemostatic therapy, infusion program, antiulcer drugs,

Materials and methods: The results of examination and treatment of 112 patients with Mallory-Weiss syndrome, who were hospitalized in the emergency surgery department of the multidisciplinary clinic of the Tashkent Medical Academy for the period from 2012 to 2024, were analyzed. All patients were divided into two clinical groups - control and main. The control group included 64 patients who underwent traditional treatment approaches. In the main group, 48 patients We have carried out an improved set of therapeutic measures.

Results. In the control group, when patients were admitted to the hospital after endoscopic examination, conservative measures were taken (general and local hemostatic therapy, infusion program, antiulcer drugs, endoscopic methods of hemostasis - electrocoagulation, pricking, installation of a Blackmore probe). In case of ineffectiveness of conservative therapy and active bleeding, surgical treatment was performed: gastrotomy and suturing of a fissure in the mucosa of the cardioesophageal junction. Primary hemostasis was achieved in 50 (78.1%) patients, repeated endoscopic interventions had to be resorted to in 10 (15.6%) cases, and in 4 (6.3%) cases, hemostasis was achieved by open surgery.

The analysis of the reasons for the unsatisfactory results of treatment of patients in the control group showed that the main reason was the low efficiency of the primary hemostasis methods used, in particular endoscopic methods, and the lack of a differentiated approach depending on the intensity of bleeding. It should be noted that another of the negative aspects was the phenomenon of discomfort when using the Blackmore probe as a result of inflating the esophageal balloon.

With this in mind, we modified the Blackmore probe, which consisted of reducing the size of the esophageal balloon and giving it a

spherical shape, which made it possible to reduce the discomfort phenomena in patients.

We have systematized the classification of Mallory-Weiss syndrome according to the localization of the lesion; by the length, number and length of ruptures; bleeding intensity.

I. By the location of the lesion

EF type (esophageal fissure) - Lower third of the esophagus

KEF type (kardioesophageal fissure) - Cardio-esophageal transition

KESF type (kardioesophageal-stomach fissure) is a cardio-esophageal transition that spreads to the gastric mucosa

HF type (hernial fissure) is a fissure inside a hiatal hernia.

II. By the Number of Gaps

Single

Plural

III. By the length of the gap

Small - up to 1.0 cm

Medium - from 1.0 to 2.0 cm

Large - more than 2.0 cm

IV. By the depth of the defect

Stage 1 - rupture of the mucous membrane.

Stage 2 - rupture of the mucous membrane and submucosal layer.

Stage 3 - rupture with involvement of the circular muscle layer.

Stage 4 - rupture of all layers of the esophagus.

V. By the intensity of bleeding

Grade 1 - ongoing bleeding

1a - jet, profuse arterial bleeding, the source is not visible due to the inability to sanitize the esophagus from blood

1b - jet, arterial bleeding, the possibility of debridement of the esophagus makes it possible to determine the source of bleeding

1b - venous bleeding, no blood clots

1d - the fissure is covered with fresh blood clots, there is a blood spurt under them

Grade 2 - stopped bleeding

2 A - visible thrombosed vessel in the area of rupture

2 b - fixed clot in the rupture area without bleeding

2 V - the rupture is covered with fibrin

3 - rupture without signs of bleeding, granulation of the fissure.

The intensity of bleeding and the types of fissure location play a major role in the choice of hemostasis method.

In case of bleeding of 1a, 1b degree, regardless of the type of location (EF, KEF, KESF and HF types), clipping or electrocoagulation of the bleeding area is performed. If endohemostasis is not possible, temporary hemostasis is performed by inserting a modified Blackmore probe for 24-48 hours, followed by an attempt to clip the bleeding area. If endoscopic hemostasis is ineffective, open surgery is performed. However, if the source is located inside the HPOD (with a hernia size of 5.0 cm or more in length and 3.0 cm or more in width), it is necessary to insert a nasogastric tube for gastric lavage followed by endoscopic clipping of the fissure, since in such cases the placement of the Blackmore probe does not give a hemostatic effect due to the slippage of the gastric balloon from the HPOD. In the KESF type, retrograde clipping of the gastric fissure is performed after the bleeding has stopped with a Blackmore probe.

In grade 1b, due to the high risk of bleeding recurrence, the edges of the fissure are injected with electrocoagulation.

In case of bleeding of the 1st degree, the edges of the fissure are pricked with a 33% ethanol solution (up to 20 ml) in order to prevent the recurrence of bleeding.

In grade 2a, due to the high risk of recurrence, clipping or electrocoagulation of the thrombosed vessel is performed using an endoscopic mosquito clip.

In case of bleeding of 2b, 2c and 3 degrees, conservative treatment is carried out.

Conclusion. A differentiated approach to the choice of hemostasis method made it possible to increase the efficiency of primary hemostasis from 78.1% to 91.7%, reduce the frequency of repeated endoscopic interventions from 15.6% to 6.3%, and reduce the need for open surgical interventions from 6.3% to 2.1%.

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