

SIMULTANEOUS LAPAROSCOPIC SURGERY IN GYNECOLOGY AND SURGERY

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ABSTRACT

The presence of many patients with combined pathology, which according to the WHO is 30-40%, confronts surgeons and gynecologists the problem of possibility of simultaneous correction of this pathology. Relevant is the question of the necessity and safety of invasive techniques, both classic and minimally invasive, using the endosurgical techniques.

UDC CODE & KEYWORDS

■ UDC: 618.1-08-089 ■ Simultaneous laparoscopic surgery ■ Calculous cholecystitis

INTRODUCTION

Simultaneous operations due to their technical, economic, and psychological benefits were the subject of a comprehensive study over a long period and currently do not cause debates in the literature [Zemlyanov & Malkov, 1986]. Despite this rare diagnosis of comorbidities in the preoperative period can be explained by the fact that the identification of only one of the diseases usually satisfies the doctor and the patient stops further inspection [Lobanov et. al]. One of the most common diseases, which are performed Combined operations using endoscopic techniques in gynecology is calculous cholecystitis [Ilyashevich].

The purpose of study. The aim of our study was to study performing simultaneous operations with a combination of gynecological pathology and cholecystitis laparoscopic access.

Material and Methods

In the department of Endoscopic Surgery at MD of Samarkand city for the period of 1996-2014, to 508 patients (I group) were conducted simultaneous operations in gynecological and surgical pathology, and to 1548 patients (II group) was performed isolated laparoscopic cholecystectomy. Both groups of patients matched for age: the average age of the patients was respectively $39,4 \pm 2,8$ and $40,2 \pm 4,5$ years (the difference is statistically insignificant, $p < 0,01$), i.e. presented by women of childbearing age.

Group I of patients was distributed as follows (Table No. 1):

Laparoscopic cholecystectomy combined with surgical sterilization was performed in 588 women. In 10 cases, the intervention extended by hernia repair of an umbilical hernia. In 110 patients cholecystitis was combined with competing genital disease as cystoma ovary. In 20 cases the operation was combined with conservative myomectomy. The follicular ovarian cyst was the cause of simultaneous operations in 22 patients.

Table 1: Distribution of patients in group I by type of operations performed

Name of operation	N
LCE+XC	588
LCE+ herniotomy +XC	10
LCE+ salpingo-oophorectomy	110
LCE+ conservative myomectomy	20
LCE+ resection of the ovary	22
LCE+ hysterectomy with appendages	32
Total	782

Source: Authors

In group II, all operations are produced by laparoscopic access of the standard 4 points.

To all gynecological patients before surgery was performed ultrasonography of the liver and gallbladder, and all patients with calculous cholecystitis were examined by gynecologist for the presence of gynecological pathology. Examination and preparation of patients for surgery was conducted on an outpatient basis.

Results and discussion

All operations were performed on laparoscopic equipment the company «Karl Storz» (Germany) under Intubation anesthesia.

In group I, the most frequently performed laparoscopic cholecystectomy with surgical sterilization (588 patients). Moreover, surgical sterilization was performed in the presence of 3 or more children of different sexes, aged over 35 years and with the written informed consent of both spouses.

Laparoscopic surgical sterilization was carried from the same points as in the LCE without additional puncture. Statistically significant increase in the duration of the operation is not revealed ($p < 0,001$).

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When conducting simultaneous operations in addition to standard points for the production of LCE was performed additional 5 mm puncture in the left and right iliac region. We can not agree with the opinion of some authors [Khatkov et. al, 1997] that for simultaneous operations at LCE right 5 mm trocar is placed at the level of the anterior spine of the right iliac region, as it complicates cholecystectomy. At the same time the extreme right port set for cholecystectomy, it allows manipulation of the uterine appendages.

In addition to the LCE was made laparoscopic salpingo-oophorectomy for ovarian cystoma about 110 patients. Of them 22 - regarding cystoma dermoid ovarian wherein preparations removed from the abdominal cavity through the rear colpotomy hole order to prevent the contents of the abdominal cavity of teratomas. In these cases through the posterior vaginal fornix was injected 11 mm trocar to avoid the loss of pnevmoperitoniuma. After removal of the surgical material the posterior fornix was sutured on the part of vagina by nodal dixon seams with the installation of pelvis drainage.

LCE was combined with resection of ovarian regarding follicular cysts and secondary infertility in 22 patients.

LCE with surgical sterilization and plasticity of the umbilical ring regarding umbilical hernia was performed in 10 cases. In the presence of this pathology intervention began with the isolation and dissection of the hernia sac. Trocar for the laparoscope was set into the abdominal cavity, after sealing the previously imposed on the fascia nodal silk sutures. Operation was completed by plastics umbilical ring at Mayo. According to i.e. Hatkova, A. A. Nikolaenko, V. S. Datsenko [Lobanov, et. al] it is better to remove the gallbladder from abdominal cavity through the hernial ring. In our opinion, better when gall bladder removed from the the abdominal cavity through a median 11 mm trocar, because removing it through the hernial ring in the navel ring can lead to infection with the development of further recurrence of hernia.

CONCLUSION

1. There must be a testimony to the conservative and surgical treatment and to establish the amount of surgery when performing simultaneous operations.
2. In order to reduce the length of hospital stay in the preoperative period the maximum examination is necessary in the outpatient setting.
3. Joint work in the same compartment of surgeons and gynecologists gives the opportunity to apply new types of surgical intervention and, in particular, to produce simultaneous, different profile operations to reduce the length of stay of patients in the hospital for several times.

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