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«YUMSHOQ TO'MALAR XIRURGIK INFEKTSIYASI DOLZARB MUAMMOLARI»

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Acute Anaerobic Paraproctitis. Problems and Ways to Solve Them

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BACKGROUND

Acute paraproctitis is widespread everywhere and has been the subject of lively discussions on the pages of literature for many decades. The most frequently discussed are ischiorectal, pelviorectal, retrorectal and horseshoe abscesses, which, according to various sources, occur on an impressive scale - from 5% to 58% of acute paraproctitis. For all these reasons, there are no generally accepted surgical tactics for the treatment of complex forms of paraproctitis of aerobic aetiology. The main polemics did not take place on tactical issues but unfolded between supporters of different methods of surgical treatment and the use of different chemical reagents or physical methods of influencing the wound in the postoperative period. If it was impossible to perform urgent radical operations in full, the ligature method was unconditionally used.

MATERIAL AND METHODS

From 2013 to 2024, 522 patients with various variants of acute paraproctitis were operated on in the surgical department of the multidisciplinary clinic of the Surkhandarya region, among which complex forms of the disease were the basis of this study. In most cases, we revealed the presence of an anaerobic aetiology of pararectal tissue lesions. The diagnostic program for this category of patients with complex forms of acute paraproctitis included clinical examination, digital examination, sigmoidoscopy, ultrasonography, bacteriological studies, and morphological examination. The most common comorbidities were haemorrhoids

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(46.1%), various forms of colitis (11.7%), and chronic anal fissures (3.7%). A special group consisted of 106 (31.1%) patients with diabetes mellitus. The criteria for complex forms of acute paraproctitis included the following: pelvic-rectal, posterior-rectal, horseshoe-shaped, inflammatory-infiltrative localisations and forms of abscesses of aerobic aetiology; extrasphincter location of the purulent passage or transsphincter perforation of a deep portion of the external anal sphincter; the degree of cicatricial lesion of the rectal mucosa – ranging from the severity of the process in the area of the internal opening of the purulent passage to the spread to the internal or external sphincters of the rectum; the presence of intoxication; microbial flora - these signs could be both independent (anaerobic infection) and in various combinations.

RESULTS

During the first 2-3 days from the onset of the disease, the clinical picture of all its variants, as a rule, was of the same type: a general somatic inflammatory reaction was predominant: a sudden increase in body temperature, headache, a feeling of weakness, general weakness, sweating. However, with the formation of abscesses of various localisation and prevalence of the inflammatory process, the symptoms changed, and all this was inextricably linked with the topographic and anatomical features of each of the forms. In all situations, a digital examination of the rectum was decisive for the verification of the diagnosis, and in difficult diagnostic cases - instrumental methods (sigmoidoscopy and ultrasonography with a rectal probe). The most difficult to diagnose was the pelvic-rectal form of acute paraproctitis, which is explained by its topography. It is located deep in the pelvis, delimited at the top under the peritoneal fascia and the pelvic peritoneal sheet, and at the bottom by the inner surface of the muscle that raises the anus. In one case, a retrograde migration of purulent contents with its breakthrough under the skin was noted. In all other cases, purulent infiltration of the rectal wall was found, the lower pole of which was detected by digital examination in 75% of cases, and in 8 patients, spontaneous emptying of the abscess into the lumen of the intestine had already occurred, which was diagnosed during sigmoidoscopy.

CONCLUSION

The most pronounced relationship between topographic conditions and the clinical picture was noted in patients with posterior rectal localisation of the purulent process: from the very first days, the forming inflammatory infiltrate and then the abscess manifested themselves with sharp pains at any increase in pressure in the rectum, as a rule, even before the onset of external manifestations. Pathognomonic anatomical features for this form were easily detected by digital examination, although the inflammatory focus itself and its boundaries were often not determined since local changes were masked by a dense anococcygeal ligament. In horseshoe paraproctitis, the inflammatory infiltrate first developed in one of the ischiorectal fossa. The path of the spread of purulent exudate lay towards the loose space behind the rectum, leading to the ischiorectal tissue of the opposite side. The abscess, as a rule, was localised behind the rectum since the ischiorectal fossa does not communicate in front.