INTRODUCTION.

Treatment of esophageal burns and their effects for many years continues to be an important issue. This is due to the fact that the number of victims each year is not decreasing but increasing.

MATERIALS AND METHODS

From 1980 to 2009 in thoraco-abdominal department of the National Scientific Center of Surgery named after A.N. Syzganov shunt esophagocoloplasty was produced for 109 patients with post-burn cicatricial narrowing of the esophagus. Among them were 52 men (47.7%) and 57 women (52.3%), aged 16 to 71 years, the average age was 45 years old. The cause of chemical burns of the esophagus, throat and stomach was the use of caustic chemicals inside. 69 (63.3%) patients with burns of the upper gastrointestinal tract appeared in the form of accidental use, 27 (24.8%) patients – with suicidal aims, the remaining 13 (11.9%) – intoxicated with alcohol. In 67 (61.5%) cases patients were poisoned by acids. Poisoning alkali was noted in 33 (30.3%) cases, burns with unknown chemical agent in 9 (8.2%) cases. 72 (66.1%) patients had the combined lesion of the esophagus and stomach. 25 (22.9%) patients were observed combined post-burn cicatricial narrowing of the pharynx and esophagus, and 12 (11.0%) patients revealed isolated cicatrical stenosis of the esophagus. Of these, 7 patients developed esophageal stricture extended as a result of alkali burns, and 5 patients had a history of perforation of the esophagus, which arose as a result of blind bouginage undertaken by place of residence.

The vast majority of patients came to us had a deficit of body weight.

Diagnosis of cicatricial stenosis of the esophagus in most patients did not cause any difficulties. In all cases, the implementation of one-stage reconstructive-restorative operations were not possible. Because of the pronounced metabolic disorders, by the first stage it was made gastrostomy, with the purpose to establish enteral feeding. Many patients (mainly in the group of combined lesions of the esophagus and stomach, n = 78), in the first stage were carried out various surgical interventions except gastrostomy. Thus, for 15 (13.8%) patients were made gastric resection, in 3 (2.8%) cases, patients suffered thoracotomy, due to perforation of cicatrical narrowing of the esophagus, for the remaining 60 (55.1%) patients were made gastroenterostomy.
Reconstructive-restorative intervention for all patients were made in the second stage, after 4-5 months after the first phase of treatment.

RESULTS AND DISCUSSION

After preoperative preparing, or all 109 patients were made shunt esophagocoloplasty. In most cases, the formation of colotransplantat (artificial esophagus) were measured from the left half of the colon, feeding medial or left colon arteries. The left half of the colon has been used in 62 (56.9%) cases, the left half of the additional connecting segment of sigmoid colon in 46 (42.2%) patients, in one case (0.9%) for the creation of an artificial esophagus was used the right department colon. Formed colotransplantat placed in the anterior mediastinum, retrosternal. Blood supply of artificial esophagus in 57 (52.3%) cases carried out by the middle colonic artery, in 31 (28.4%) cases perfusion was carried out at the expense of the middle and left colonic artery, in 21 (19.3%) - due to the left sigmo-colica and the first sigmoid artery.

According our experience, we believe that patients with the effects of alkali burns of the esophagus (especially with a total constriction) as well as individuals who have suffered perforation cicatricial narrowing of the esophagus and mediastinitis, there should be no resection or extirpation of the esophagus, followed by plastic by stomach. In such circumstances, this intervention is not justified, due to its traumatic.

Thus, 12 (11.0%) patients with isolated cicatricial stenosis of the esophagus as performed shunt esofagocoloplasty.

Anastomotic leakage in the neck (formed from the esophagus or pharynx) was observed in 11 (10.1%) cases. Long-term results were studied in 102 (93.6%) patients in the period from 5 months to 15 years. Good ultimate result achieved in 85% of patients. Anastomotic stenosis at the neck was observed in 20 (18.3%) patients. Transfer function of anastomosis was restored by bouginage. Four patients died after esofagocoloplas, mortality is 3.7%.

CONCLUSION

Thus, adequate preoperative verification of the nature of the lesions of the esophagus and stomach, the basic principles of training to intervene and statement of objective evidence to a particular type of reconstructive and restorative treatment can achieve positive results in virtually all cases.

REFERENCES


