



Evaluation of the Quality of Life of Patients with Cirrhosis after Surgical Prevention of Bleeding from Varicose veins of the Esophagus

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Abstract The basis of the scientific work is the experience of endoscopic ligation of varicose veins of the esophagus (HRVP) in 65 patients with cirrhosis of the liver with portal hypertension syndrome. The degree of HRVP was established in accordance with the classification of K.J. Paquet (1982). Varicose veins of the esophagus III and IV degree were recorded in 58 (89.2%) patients. For a comprehensive assessment of the degree of liver failure, the Child-Pugh scale (1973) was used. 11 (16.9%) patients were assigned to class A, 23 to 35.4% (35.4%), and 31 patients (47.7%) to class C. The effectiveness of endoscopic ligation in the prevention of bleeding was 92.2%. Relapse of gastrointestinal bleeding in the near term occurred in 3 patients. Hospital mortality was 4.6%. In the distant period after endoscopic eradication, recurrence of varicose veins of the esophagus was diagnosed in 27.8% of patients. Endoscopic ligation of varicose veins of the esophagus is an effective method of stopping and preventing bleeding in patients with cirrhosis.

Keywords liver cirrhosis, portal hypertension syndrome, varicose veins of the esophagus, prevention, endoscopic ligation

Introduction

The frequency of detection of the syndrome of portal hypertension reaches 90% with the developed cirrhosis of the liver. The most frequent and most formidable complication of hypertension in the portal system is bleeding from varicose veins of the esophagus and stomach. At the same time, mortality during the first episode of bleeding exceeds 50% [1, 12, 13]. In 30% of patients, repeated bleeding leads to a sharp decompensation of liver function. In general, mortality in patients with liver cirrhosis with gastroesophageal bleeding reaches 30-60% [1, 4, 7, 10].

Endoscopic ligation is one of the modern minimally invasive methods of treatment and prevention of esophageal-gastric bleeding in portal hypertension syndrome [5, 6, 8, 11]. The growing interest in this method of eradication of varicose veins is based on the technical prostate and the relative safety of the method, as well as the introduction of many devices for ligers.

- study, assessment of the effectiveness of endoscopic ligation (EL) in the prevention of bleeding from varicose veins of the esophagus (EJV) in patients with liver cirrhosis with portal hypertension syndrome.

Materials and Methods

A retrospective analysis of the treatment of 65 patients with liver cirrhosis with portal hypertension syndrome was examined in the period from 2014 to 2019. Of these, there were 37 men (56.9%), 28 women (43.1%), the age of patients ranged from 27 to 69 years. The main number of follow-up fell on patients in the most active working age -



from 28 to 55 years. Liver cirrhosis was caused by chronic viral hepatitis B in 39.8% of patients, antibodies to hepatitis C virus were detected in 28.6%, and markers of hepatitis B and C were detected in 24.5% of patients. Of these, almost every second suffered 2 or more episodes of hemorrhage. The remaining 48 (73.8%) patients had no history of bleeding. All patients were hospitalized for preventive correction of portal hypertension. All patients, after premedication and local anesthesia with lidocaine, the esophagus and stomach were examined with a Fujinon video gastroscope. The degree of ERVP was established in accordance with the classification of K.J. Paquet (1982). Varicose veins of the esophagus of III and IV degrees were recorded in 58 (89.2%) patients.

For a comprehensive assessment of the degree of liver failure, the Child-Pugh scale was used (1973). 11 (16.9%) patients were assigned to class A, 23 (35.4%) to class B, 31 (47.7%) patients to class C. To prevent bleeding from varicose veins of the esophagus, 64 patients underwent endoscopic ligation. To perform the latter, a multi-charge ligator manufactured by SAEED Multi Band Ligator Cook was used, consisting of a cylinder with ligatures fixed on it, which was attached to the distal end of the endoscope.

The cylinder was connected through the biopsy channel of the endoscope with the handle, with the help of which the fixed elastic ligatures were released alternately. An endoscope with a ligation device was inserted into the esophagus and brought to the most problematic area of the varicose vein. Using an aspirator, a negative pressure was created in the cavity of the cap and a vein was sucked into it together with the adjacent mucosa. By rotating the traction mechanism, the stretched latex ring was fired from the attachment onto the vein, pulling it in the form of a stranglehold. As a result, a "venous ball" with a ligature at the base was formed in the lumen of the esophagus. In one session, from 3 to 6 ligatures were applied.

Endoscopic eradication of varicose veins was combined with the appointment of nitro drugs or β -blockers, antiulcer drugs for 5-7 days. In the presence of multiple nodes, the endoscopic ligation session was repeated for 2-3 days. After 3-4 weeks, in the absence of complications, control fibroesophagogastrosocopy was performed and the adequacy of the previous session was determined [2-3, 9].

Results and Discussion

To assess the effectiveness of endoscopic eradication of varicose veins of the esophagus, all patients underwent a control endoscopic study in order to prevent bleeding in the immediate and long-term postoperative period, if necessary, on 3-4 days or 7-10 days, as well as after 2-3 months, repeated endoscopy of II-IV grade of ERVP was performed. At the time of admission to the hospital, grade IV esophageal varicose veins were detected in 23 patients, grade III esophageal varices were found in 35 patients, grade II - in 6, grade I - in 1. All patients of grade II-III-IV varicose veins had one session of endoscopic ligation ... Endoscopic paravasal sclerotherapy was performed in 1 patient with grade 1 EVD. Relapse of gastroesophageal bleeding in the nearest follow-up period developed in 3 (4.6%) cases. Of these, in 2 patients with frequent relapses of hemorrhage in the anamnesis.

In all cases, varicose veins of the esophagus were the source of bleeding. The main reason for the development of bleeding was early rejection of the ligatures. As a result of repeated EL, stable hemostasis was achieved in 2 cases. In 1 case, despite the ongoing hemostatic therapy and repeated repeated sessions of endoscopic ligation, the patient died due to the failure of the measures taken. In 2 more cases, the cause of death was progressive hepatic failure, both patients belonged to Child-Pugh class C. Hospital mortality was 4.6% (n = 3). According to a number of researchers, the use of minimally invasive technologies in a complex of therapeutic measures aimed at preventing relapse and preventing esophageal-gastric bleeding of portal genesis in cirrhosis of the liver shows their high efficiency, which is relatively safe and improves the quality of life of this difficult contingent of patients.

To reduce the likelihood of early rebleeding, 7-10 days after EL, it is necessary to perform a control endoscopic examination and, if necessary, additionally ligate "suspicious" varixes. During the follow-up period of up to one year or more, after EL, a relapse of esophageal varicose veins was revealed in 27.8% of cases.



Conclusions

Thus, endoscopic ligation of varicose veins of the esophagus is a highly effective method in the prevention of recurrence of esophageal-gastric hemorrhages in portal hypertension syndrome. It is necessary to carry out prolonged (repeated courses after 2-3 months) treatment, followed by control endoscopic examination.

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