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EPIDEMIOLOGICAL SITUATION OF DERMATOMYCOSES IN AZERBAIJAN FOR 2017–2019 ACCORDING TO THE NEW CLASSIFICATION

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During the period 2017–2019, 128 episodes of referral to skin and venereological institutions in Baku and 1358 episodes in the Republic of Azerbaijan were recorded. The classification of dermatomycoses is unstable due to the constant revision of certain provisions in mycology. Of the 128 episodes of superficial skin mycoses based on the traditional form No. 9, mycosis of the scalp is in the first place – 23.8±1.19 %, mycosis of smooth skin – 20.9±1.16 %. multicolored lichen – 15.8±1.12 %. Thus, microscopic diagnostics makes it possible to detect the mycelium, and not the specific identity of the mycotic agent. This is the main imperfection of the classification based on the reporting form No. 9. A modified classification of superficial mycoses of the skin is proposed, combining two approaches. The greatest incidence of mycosis of the scalp was 475 episodes (35.2±1.1 %), mycosis of smooth skin – 390 episodes (26.8±1.1 %), multicolored lichen – 291 episodes (21.6 %±0.8). Thus, the modified clinical structure of superficial skin mycoses, taking into account the tissue and topographic localization of the mycotic process, makes it possible to significantly simplify the clinical diagnosis of superficial skin mycoses and facilitates the work of dermatologists.
Key words: dermatophytes, saprophytes, lichen, classification.

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ЕПІДЕМІОЛОГІЧНА СИТУАЦІЯ ДЕРМАТОМІКОЗІВ В АЗЕРБАЙДЖАНІ ЗА 2017–2019 ЗГІДНО НОВОЇ КЛАСИФІКАЦІЇ

За період 2017–2019 зафіксовано 128 звернень до шкірно-венерологічних закладів у м. Баку та 1358 звернень в Азербайджанській Республіці. Класифікація дерматомікозів є нестабільною у зв'язку з постійним переглядом окремих положень у мікології. Зі 128 епізодів поверхневих мікозів шкіри на основі традиційної форми №9, на першому місці мікоз волосистої частини голови – 23,8±1,19 %, мікоз гладкої шкіри – 20,9±1,16 %. різнокольоровий лишай – 158±112 %. Таким чином, мікроскопічна діагностика дозволяє виявити міцелій, а не видову приналежність мікотичного агента. У цьому всь головна недосконалість класифікації з урахуванням звітної форми №9. Нами запропоновано модифіковану класифікацію поверхневих мікозів шкіри, яка об'єднала два підходи. Найбільше звернень зафіксовано з приводу мікозу волосистої частини голови – 475 епізодів (35,2±1,1 %), мікоз гладкої шкіри – 390 епізодів (26,8±1,1 %), різнокольоровий лишай – 291 епізод (21,6±0,8 %). Таким чином, модифікована клінічна структура поверхневих мікозів шкіри з урахуванням тканинної та топографічної локалізації мікотичного процесу дозволяє значно спростити клінічну діагностику поверхневих мікозів шкіри та полегшує роботу дерматологів-клініцистів.
Ключові слова: дерматофітії, сапрофіти, лишай, класифікація.

Mycoses are fungal diseases of humans and animals caused by various genera and species of pathogenic and conditionally pathogenic fungi. According to WHO, mycoses affect from 1/5 to 1/3 of the world's population [13]. Lesions of the skin and its appendages by fungal infection are classified as dermatomycoses and are one of the most important problems of modern dermatology. Dermatomycoses account for 37–42 % of all dermatoses [10].

The high incidence of dermatomycosis is often caused by a mixed fungal infection with frequent addition of bacterial flora. Often, mycotic infection occurs against the background of chronic diseases such as psoriasis, atopic dermatitis. Somatic pathology in the form of metabolic syndrome also serves as a predictor of the development of fungal infection [6, 7, 15].

Laboratory research has shown that in patients with moderate psoriasis with concomitant metabolic syndrome, the systemic inflammatory process plays an important role, which is accompanied by the development of insulin resistance, impaired lipid and nitrogen metabolism and regulation of vascular tone. In addition, an increase in the intensity of systemic inflammation is accompanied by an increase in skin lesions, an increase in systolic blood pressure and a violation of lipid and carbohydrate metabolism. [15]. This fact significantly complicates their course, distorts the clinical picture, determines the frequency of abortive forms and complicates the tactical approach to antifungal therapy [4].

In the Republic of Azerbaijan, in different years of the XX and XXI centuries, the prevalence, features of the clinical and mycological course of dermatomycosis, and the effectiveness of antifungal therapy were studied [8, 9].

Our studies were conducted in patients with superficial mycoses of the skin.

Superficial skin mycoses make up a significant part (up to 46 %) of dermatomycoses and are extremely common in the Republic of Azerbaijan, which is explained by the climatic and geographical conditions of the region and has been confirmed in our studies [1, 5]. The Republic of Azerbaijan has a semi-desert climate, dry steppe climate, subtropical, medium and cold climate. Most of Azerbaijan is located in the subtropical zone. The dry subtropical climate is characteristic of Absheron and the Kura-Araks lowland. Humid subtropical climate is observed only in the south of the Talysh Mountains [2, 3].

The purpose of the study was to perform a substantive analysis of the nosological structures of dermatomycoses, in light of the newly modified classification of superficial skin mycoses for 2017–2019.

Material and methods. The study covers the period 2017–2019. The analysis of the current documentation of the Republican Skin and Venereological Dispensary (outpatient cards, case histories, notices, traditional reporting form No. 9 "On patients with STIs, fungal skin diseases and scabies", approved by the State Statistical Committee of the Republic of Azerbaijan dated 14.08.2009 No. 29/5, 30.01.2012 No. 6/09) is based on the comparative effectiveness of the new modified classifications. For the period 2017–2019. 128 episodes of referral to skin and venereological institutions in Baku were recorded, as well as 1.358 episodes in the Republic of Azerbaijan (traditional reporting form No. 9). Patients are classified according to gender, age and nosological criteria.

The classification of dermatomycoses of form No. 9 adopted in 2011 in the Republic of Azerbaijan was based on the topographic fixation of the mycotic process and objectively increased the number of episodes. Two points: 1. Trichophytia, 2. Microsporia, were replaced by items based on topographic localization: superficial mycoses of the skin, mycoses of the scalp, beard and mustache, mycoses of the nail plate (onychomycosis), mycoses of smooth skin, multicolored lichen (keratomycosis), candidiasis of the skin. The above classification is not sufficiently meaningful. There are no items in it: mycosis of the folds, mycosis of the trunk, mycosis of the upper and lower extremities, mycosis of the hands, mycosis of the feet. A modified subject nosological classification of superficial skin mycoses is proposed.

The advantages of the developed modified classification of SSM (superficial skin mycoses) in comparison with the reporting data of the traditional reporting form No. 9 of the Ministry of Health of the Republic of Azerbaijan, taking into account the topographic fixation of the pathological process, are obvious and applicable in practice by clinicians.

The classification of dermatomycoses is unstable, due to the constant revision of certain provisions in mycology. Depending on the depth of the pathological process and the involvement of internal organs, there are:

– Superficial dermatomycosis synonym for superficial skin mycoses (SSM) is characterized by primary skin lesions at the level of the epidermis.

– Deep subcutaneous dermatomycosis is characterized by primary skin lesions at the level of the dermis/hypodermis and underlying soft tissues.

– Deep systemic dermatomycosis is characterized by primary damage to internal organs and skin involvement in hematogenic and lymphogenic dissemination.

The obtained digital data were subjected to statistical processing by methods of medical statistics. The methods of variational (mean values of the obtained samples (M), their standard deviations (σ), standard errors (m), minimum (min) and maximum (max) values of the series) and discriminant (sample fractions (p), their errors (mp) analyses are applied. Absolute indicators were accompanied by frequency intensive indices (p %) and their standard errors (±mp %). To estimate the statistical difference between the sample shares, the parametric t-Student criterion was used, and the average difference between the samples, pairwise related variants, was the t–Student and discriminant analysis criterion. Calculations were carried out on an MS EXCEL spreadsheet and the SPSS-20 statistical package. The accepted confidence level is at least 95 % ($p<0.05$).

Results of the study and their discussion. Superficial mycoses of the skin (SSM) ICD – 10: B35; B36; B37 are infectious diseases of fungal etiology affecting the surface layers of the skin, hair and nail plates.

The deterioration of the environmental situation, the unsatisfactory sanitary and hygienic condition of saunas, baths, showers, swimming pools, premises rented for sports sections, fitness clubs, gyms contribute to the increase in the incidence of SSM. Occupational factors actively influence the increase in the risk of morbidity of SSM. Among the adult population of SSM, servicemen, athletes, miners are more likely to suffer, due to special production conditions (crowded, closed collective, closed premises, the use of rough shoes, overalls, shared showers and changing rooms), as well as hairdressers, farmers, gardeners, cooks in contact with infected sources of the disease and objects. Among the child and adolescent population, the risk group is patients engaged in contact sports in sections (wrestling, judo, aikido, karate, sambo, etc.).

The main types of fungi that cause SSM are dermatophytes of the genera Epidermophyton spp., Trichophyton spp., Microsporum spp. and yeast–like fungi of the genus Candida spp. and Malassezia spp.

Dermatophytes are a group of pathogenic fungi, similar in characteristics, capable of living exclusively on the stratum corneum. Their ability to form molecular bonds with keratin and use it as a source of nutrients allows them to colonize tissues with a high content of keratin, including the stratum corneum of the epidermis, hair, nails of humans and animals. The source of dermatophytes can be human – anthropophilic dermatophytes (endothrix) (Epidermophyton floccosum, Trichophyton interdigitale, Trichophyton rubrum, Trichophyton violacem, Trichophyton tonsurans, Trichophyton schoenleinii, Microsporum ferrugineum, Microsporum audouinii), animals and birds - zoophilic dermatophytes

(ectotrix) (Trichophyton verrucosum, Trichophyton gypseum, Trichophyton simii, Microsporum canis, Microsporum distortum), soil - geophilic dermatophytes (Microsporum gypseum, Microsporum nanum). Some types of zoophilic dermatophytes parasitize in human skin, hair and nails, they are referred to as zooanthropophilic dermatophytes. SSMs caused by dermatophytes are called dermatophytes.

Many dermatologists from different countries adhere to the classification of fungal skin diseases (dermatomycosis) by A.M. Arievich (1966), improved by N.D.Sheklakov (1976), taking into account the terminology of nosological forms of diseases and their pathogens proposed by WHO. SSM, according to the classification of dermatomycoses by N.D.Sheklakov, represent 3 groups from this classification: keratomycosis, dermatophytosis, candidiasis.

Classification of dermatomycosis ICD-10:B35-B49

ICD–10:B36 Keratomycosis

– ICD–10: B 36.0 Multicolored lichen (Pityriasis versicolor sin. Tinea versicolor), the causative agent of Malassezia furfur/Pityrosporum orbiculare.

– ICD–10: B 36.8 Nodular trichosporia sin. piedra (Trichosporia nodosa sin. Piedra), pathogens of Trichosporon beigelii, Piedraia hortai.

ICD–10: B35 Dermatophytiae (Dermatophytiae sin. Tinea).

– ICD–10: B35.6 Inguinal epidermophytia (Epidermophytia inguinalis in. Tinea cruris), the causative agent of Epidermophyton floccosum.

– ICD–10: B 35.1, B 35.3 Epidermomycosis stopsin. athlete's foot (Epidermomycos pedis sin. Athlete's foot, Tinea pedis), the causative agent of Trichophyton mentagrophytes var. T. interdigitale.

– ICD–10: B35.1; B 35.2; 35.3; 35.4 Rubromycosis (Rubromycosis), the causative agent of Trichophyton rubrum.

– ICD–10: B35.0; B 35.1; B 35.4 Trichophytia (Trichophytia sin. Trichophytosis).

– ICD–10: B 35.4 superficial trichophytia of smooth skin (trichophytia superficialis cutis glabrae).

– ICD–10: B 35.0 superficial trichophytia of the scalp (trichophytia capillitii superficialis).

– ICD–10: B 35.0; B 35.1; B 35.4 dırnaq trichofitozu da daxil olmaqla xroniki trichofitoz (trichophytia chronica, trichophytia unguium); Trichophyton violaceum, T. tonsurans var trichophytia yuxarıdakı formalarının patogenləri. T. crateriformis.

– ICD–10: B 35.0; B 35.4 ichthyological trichophytia (trichophytia profunda); pathogens Trichophyton verrucosum var., T. faviforme, T.mentagrophytes var., T. gypseum, T.simi, T.erinacei.

– ICD–10: B 35.0; B 35.4 havus (favus); pathogen Trichophyton schoenleinii.

– ICD–10: B 35.0; B 35.4 snail mycosis syn. tokelo (mycosis imbricata sin. tokelo); the causative agent of Trichophyton concentricum.

– ICD–10: B35.4 Microsporia syn. Microsporosis (Microsporia sin. Microsporosis) caused by:

– anthropophilic fungi; pathogens Microsporum audouinii, M. ferrugineum;

– zoophilic fungi; pathogens Microsporum canis, M. distortum;

– geophilic fungi; pathogens Microsporum gypseum, M. nanum.

ICD–10: B37 Candidiasis (Candidosis sin. Candidiasis, Moniliasis), pathogens – conditionally pathogenic, yeast-like fungi of the genus Candida (Candida albicans, C. tropicalis, etc.).

– ICD–10: 37.0; 37.2; 37.3; 37.4 Superficial candidiasis of mucous membranes, skin, nail rollers and nails.

– ICD–10: 37.0; 37.2;37.3; 37.4 Chronic generalized (granulomatous) candidiasis.

– ICD–10: B 37.7 Visceral candidiasis.

ICD–10: B 38 – B 49 Deep mycosis (Mycosis profunda).

1. ICD–10: B 40 Blastomycosis (Blastomycosis)*:*

– Cryptococcosis; the causative agent of Cryptococcus neoformans;

– Blastomycosis North American; causative agent of Blastomyces dermatitidis;

– Blastomycosis is South American; the causative agent of Paracoccidioides brasiliensis.

2. ICD–10: B 38 Coccidioidosis (Coccidioidosis), causative agent of Coccidioides immitis.

3. ICD–10: B 48 Mycetomas of fungal etiology (Mycetoma mycosis); pathogens Madurelle mycetomi, M.grisea, etc.

Pseudomycosis:

–ICD–10: l08. 1 Eritrasma

– Sublinar trichomycosis

–ICD–10: A42 aktinomikoz

– Nokardioz

In accordance with the classification of N.D.Sheklakov, the clinical diagnosis of SSM must be confirmed by additional diagnostic methods: examination under a Wood lamp and laboratory research methods (microscopy, culture study). Taking into account the above factors and the mode of work of dermatologists – clinicians, who in daily practice need to make a clinical diagnosis of SSM within a short

time within the framework of clinical protocols and confirm it with laboratory tests, N.D.Sheklakov's classification, despite its uniqueness and uniqueness, does not meet these requirements. Nosological gradation in the classification of N.D.Sheklakov – epidermophytia, rubrophytia, trichophytia, microsporia requires, in addition to microscopic diagnostics, cultural diagnostics, which is not always available and, in addition, requires a long time of staging (up to 2 weeks).

We have developed a nosological structure of SSM, built in compliance with the etiological factor, tissue and topographic localization of the mycotic process, using which dermatologists can make a clinical diagnosis and confirm it with microscopic diagnostics. And only in the case of resistance to antimycotic therapy, cultural diagnostics are resorted to.

MODIFIED CLASSIFICATION (nosological structure of SSM):
– Multicolored lichen B36.0;
–Mycosis (dermatophytia B35.1, candidiasis B37.2);
– Mycosis (dermatophytia B35.0) scalp and facial hair;
– Mycosis (dermatophytia B 35.4, candidiasis B37.2) of smooth skin of the face, trunk;
– Mycosis (dermatophytia 35.6, candidiasis B37.2) of folds;
– Mycosis (dermatophytia B35.2, candidiasis B37.2) of the hands;
– Mycosis (dermatophytia 35.3, candidiasis B37.2) stop;
– Mycosis (candidiasis) of the mucous membranes of the oral cavity (In 37.0) and urogenital organs (In 37.3; 37.4).

The proposed modified classification contains 8 distribution points for patients with mycotic lesions of various localization. In contrast to the previous classification, according to which the distribution of patients was based solely on the identification of the pathogen to the species and contains more than 30 points of distribution of patients by nosology.

As a result of studies according to the proposed modified classification, 128 cases of SSM were recorded in Baku in 2017–2019. In 2017, the number of episodes of SSM was 30 (23.5 ± 1.2 %), in 2017 the number of episodes increased to 42 (32.9 ± 1.3 %), and in 2019. – 56 (43.6 ± 1.2 %). Thus, an increase in morbidity was recorded. The gender factor was in favor of men and amounted to 76 (59.4 ± 2.12) compared with women – 52 (40.6 ± 1.8 %) cases.

The distribution of patients with SSM by age aspect determined the proportion of patients aged 11–20 years – 36 (28.1 ± 3.3 %) in the first place, then the group aged 0–10 years – 28 (22.0 ± 3.2 %), then in descending order – 21–30 years – 22 (17.2 ± 2.98 %), 31–40 years (14.0 ± 1.68 %), 41–50 years 12 (9.3 ± 1.56 %), 51–60 years 9 (7.0 ± 1.36 %), 61–70 years – 3 (2.4 ± 1.28 %).

The mean age of patients is 16.1 ± 0.3 years, the age aspect was from 1 year to 76 years. Out of 128 episodes with SSM in two age groups of 11–20 years – 36 patients and in the group from 0–10 years – 28 patients.

The clinical characteristics determined the most frequent incidence of mycotic lesions of the scalp – Continuing the clinical analysis of SSM in Baku for the period 2017–2019, the predominant number of patients with diagnoses of mycosis of the scalp was 32 (23.8 ± 1.19 %), mycosis of smooth skin – 26 (20.9 ± 1.16 %). The remaining pathologies were distributed as follows: multicolored lichen – 20 (15.8 ± 1.12 %), combined mycosis of smooth skin and scalp – 16 (12.6 ± 0.98 %), onychomycosis – 1 3 (10.1 ± 0.86 %), purulent-infiltrative mycosis – 11 (8.8 ± 0.68 %), candidiasis skin – 5 (4.3 ± 0.48 %), mycosis of the feet – 3 (2.3 ± 0.36 %), inguinal epidermophytia – 2 (1.4 ± 0.28 %) episodes.

Thus, out of 128 episodes of SSM recorded in Baku in 2017–2019 on the basis of the traditional form No. 9, mycosis of the scalp is in the first place – 23.8 ± 1.19 %, mycosis of smooth skin – 20.9 ± 1.16 %. multicolored lichen – 15.8 ± 1.12 %. The above nosologies correspond to the contingent of 11–20 (28.1 ± 3.3 %) years and 0–10 years (22.0 ± 3.2 %), which are marked as the most vulnerable contingent for SSM in the conditions of Baku.

Microscopic diagnostics carried out in conditions of skin and venereological institutions allows to determine the presence of a mycotic agent, not its affiliation (Epidermophyton, Trichophyton, Microsporum). At the same time, staged diagnoses – trichophytia, microsporia, epidermophytia, rubrophytia can be made exclusively in academic conditions as a result of sowing on nutrient media (culture diagnostics), in which they are incubated for 10–15 days. Thus, microscopic diagnostics makes it possible to detect the mycelium, and not the specific identity of the mycotic agent. Species specificity is not important for carrying out therapeutic measures and providing medical care to patients. This is the main imperfection of the classification based on the reporting form No. 9.

The proposed modified classification of SSM combined two approaches. Below is an analysis of the indices based on the application of the modified classification.

The difference in the assessment of the epidemiological situation lies in the following figures: the incidence in 2017 was 254 (18.7 ± 0.98 %) episodes, the increased incidence in 2018 was 478

(35.2±1.26 %), in 2019 – 626 (46.1±2.12 %). The detectability during the study period was 1,358 episodes.

Incidence of SSM in Baku for the period 2017–2019:
– mycosis of the scalp – 475 patients (35.2±1.1 %):
–smooth skin mycosis – 390 patients (27.8±1.1 %);
–multicolored lichen – 291 patients (21.6±0.8 %);
–combined mycosis of smooth skin and scalp – 111 patients (8.3±0.6 %);
–onychomycosis – 36 patients (2.7±0.5 %);
– purulent-infiltrative form of mycosis – 23 patients (1.8±0.4 %),
– skin candidiasis – 15 patients (1.2±0.2 %),
– mycosis of the feet – 19 patients (0.9±0.2 %),
–inguinal epidermophytia – 5 patients (0.5±0.1 %).

The largest number of episodes with SSM when applying the modified classification is similar to the traditional reporting form No. 9. The greatest incidence of mycosis of the scalp was 475 episodes (35.2±1.1 %), mycosis of smooth skin – 390 episodes (26.8±1.1 %), multicolored lichen – 291 episodes (21.6 %±0.8). The age contingent and the prevalence of men in the gender aspect are also similar to the analysis data of the traditional reporting form No. 9.

Thus, the proposed modified clinical structure of superficial skin mycoses (SSM), taking into account the tissue and topographic localization of the mycotic process, makes it possible to significantly simplify the clinical diagnosis of SSM and facilitates the work of dermatologists.

In the scientific work of S.A. Burova [2] on fungal pathology in risk groups, nosological forms are indicated taking into account the etiological factor. The work of L.P. Kotrekhova [5], devoted to the peculiarities of mycotic infection at the present stage, the scientific work of T.V. Sokolova [6, 7], describing the clinical status and errors in the tactics of treating dermatomycoses of various localization, are also based on the species identification of the pathogen, which is time-consuming and not always effective therapy. Khamaganova I.V. [9] in her work, she proposed the use of complex antimycotic therapy for mixed-infectious mycotic lesions complicated by bacterial flora. The classification of foreign authors based on topographic localization is convenient and practical from the position of a practical dermatologist [11, 14].

Of course, the effectiveness of the study could be higher, taking into account the topographic localization of the pathological process and more effective in terms of resistance to antimycotic drugs. However, the detectability of mycotic pathology among patients is primarily based on topographic localization and secondly on microscopic diagnostics.

Conclusion

As a result of studies in Baku in 2017–2019, 128 cases of SSM were recorded. In 2017, the number of episodes of SSM was 30 (23.5±1.2 %), in 2018 the number of episodes increased to 42 (32.9±1.3 %), and in 2019. – 56 (43.6±1.2 %). Thus, an increase in morbidity was recorded. The efficacy of the modified classification for assessing the epidemiological situation for 2017–2019 in comparison with the traditional classification is reflected in the following indicators: the incidence in 2017 was 254 (18.7±0.98 %) episodes, the increased incidence in 2018 was 478 (35.2±1.26 %), in 2019 – 626 (46.1±2.12 %). The detectability during the study period was 1,358 episodes and is represented by the following picture: mycosis of the scalp – 475 patients (35.2±1.1 %); mycosis of smooth skin – 390 patients (27.8±1.1 %); multicolored lichen – 291 patients (21.6±0.8 %); combined mycosis of smooth skin and scalp – 111 patients (8.3±0.6 %); onychomycosis – 36 patients (2.7±0.5 %); purulent-infiltrative mycosis – 23 patients (1.8±0.4 %); skin candidiasis – 15 patients (1.2±0.2 %); foot mycosis – 19 patients (0.9±0.2 %); inguinal epidermophytia – 5 patients (0.5±0.1 %).

Thus, the results of the comparative analysis showed that the modified classification of SSM (with corrected sections 1001/2110 of the Reporting Form No. 9 of the Ministry of Health of the Republic of Azerbaijan) allows to expand the scope of the analyzed nosologies, increase the objectivity of statistical data, and thereby more fully reflect the epidemiological situation in the studied region regarding the prevalence of superficial skin mycoses. A complete, objective reflection of the epidemiological situation of SSM in the Republic of Azerbaijan for the period 2017–2019, clearly shown in this study, expands the range of nosologies analyzed.

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THE CHOICE OF THE METHOD OF TREATMENT OF ABDOMINAL ABSCESSES IN ADULT PATIENTS

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The results of a comparative study of 326 patients who underwent various types of surgical treatment of abdominal abscesses in 2014–2022 were evaluated. Abdominal abscesses develop after various kinds of inflammatory pathologies, especially peritonitis. 178 patients (54.6 %) in the main group were treated with invasive methods, and 148 patients (45.4 %) in the control group were treated with open methods. The results in both groups were investigated. In the main group, the indicators of recovery time increased by 1.9±1.2 times, and complications, relapses and mortality decreased by 1.7±0.8 times, 1.2±0.6 times and 1.1±0.4 times, respectively. The results of invasive methods, compared with open methods, are relatively simple, easy, financially cheap, convenient for patients and more effective. Treatment consists in drainage, surgical or percutaneous, the effectiveness of percutaneous drainage of abdominal abscesses reaches 74–96.4 %

Key words: abdominal abscess, laparoscopy, aspiration-puncture under CT and ultrasound control, biopsy, drainage, catheterization.

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ВИБІР МЕТОДУ ЛІКУВАННЯ АБСЦЕСІВ ЧЕРЕВНОЇ ПОРОЖНИНИ У ДОРОСЛИХ ПАЦІЄНТІВ

Оцінено результати порівняльного дослідження 326 хворих, яким було проведено різні види оперативного лікування абсцесів черевної порожнини у 2014–2022 роках. Абсцеси черевної порожнини розвиваються після різноманітних запальних патологій, особливо перитоніту. Інвазивними методами лікували 178 пацієнтів (54,6 %) у основній групі, а 148 пацієнтів (45,4 %) у контрольній групі – відкритими методами. Досліджено результати в обох групах. В основній групі показники часу одужання збільшилися в 1,9±1,2 рази, а ускладнень, рецидивів та летальності зменшилися в 1,7±0,8 рази, в 1,2±0,6 рази та в 1,1±0,4 рази, відповідно. Результати інвазивних методів порівняно з відкритими відносно прості, легкі, фінансово дешеві, зручні для пацієнтів і більш ефективні. Лікування полягає в дренажі, хірургічному або черезшкірному, ефективність надшкірного дренування абдомінальних абсцесів досягає 74–96,4 %.

Ключові слова: абсцес черевної порожнини, лапароскопія, аспірація-пункція під контролем КТ та УЗД, біопсія, дренування, катетеризація.

Qualitative diagnostics and the choice of the optimal variant of the surgical aid in patients with postoperative abdominal complications (PAC), which directly determine the results of surgical treatment, are one of the most pressing problems of modern surgery [2, 5].