The federal g osudarstvennoe budget educational institution of higher education "Orenburgsk RD go St medical RD University Ministry of healthI Russian Federation

Faculty of surgery

DIFFERENTIAL DIAGNOSIS OF CRITICAL

SURGICAL DISEASES Part (II).

Tutorial for medical students, Pediatric,

medical-preventive and dental faculties

Orenburg, 2017

UDC 617 089-071 (075.8)

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"The most important differential diagnosis of surgical diseases. Part II. Tutorial for medical students, Pediatric, medical-preventive and dental faculties.-Orenburg, 2017.-68 pages.

Abstract:

In the educational-methodical manual for students represented the most important differential diagnosis of surgical diseases. It is the section differential diagnosis raises students ' difficulties in the preparation for practical classes in the Faculty of surgery. Scholastic-methodical allowance provides basic clinical data needed 4 course students of medical universities to prepare for practical classes in the Faculty of surgery and especially while working with clients sick. the topic is given theoretical reference, briefly describes the pathology and allowing to perform differential diagnosis with similar diseases clinic. Such methodical building tutorial will allow students to present more clearly the algorithm of thinking required for diagnosis. We believe that the information will be useful for students of medical universities. The bibliography contains the necessary sources, which will improve the quality of knowledge and enough to fully prepare for classes.

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Manual considered and recommended the publication of FIGURE OrGMU.

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**CORONARY HEART DISEASE**

**Theoretical reference.**

Coronary heart disease is caused by a disorder of the coronary circulation of myocardial lesion that occurs as a result of the imbalance between the coronary blood flow and metabolic needs of the heart muscle. Atherosclerotic coronary arteries leads to a gradual narrowing and reducing the blood supply to the myocardium.

**Classification Of ISCHEMIC HEART DISEASE (**VKNC, ACADEMY Of MEDICAL SCIENCES Of The Russian Federation).

o Sudden Cardiac death (reanimating);

o Sudden Cardiac death (death);

o Angina pectoris;

o Stable Angina (functional class);

o For the first time by having angina pectoris;

o Vazospastical stenocardia;

o Unstable angina (classified according to the severity of Braunvaldu);

o Myocardial infarction;

o Cardiac arrhythmia;

o Postinfarction cardiosclerosis;

o Heart failure

**The clinical picture**. Characterized by bouts of angina — chest discomfort, pain irradiiruet in the left shoulder, arm, neck, jaw, teeth. Noted difficulty in breathing. Patients experiencing the fear of traffic. The skin appears pale, cold sweat on the skin of the forehead. After taking everything goes koronarolitikov.

In the diagnosis of ISCHEMIC HEART DISEASE there may be difficulties and two kinds of errors: Angina is not recognized and accepted for any other illness or diagnosis it put patients who have chest pain not associated with coronary pathology.

**Differential diagnosis**.

Angina as a form of IBS should be differentiated from stroke, as other diseases, nozologicheski not related to ISCHEMIC HEART DISEASE. This is coronary arteries of various Genesis as a result of systemic disease (polyarteritis, rheumatic fever, sepsis, syphilis) and diseases in which angina due to hemodynamic disorders (aortic lesions valve).

Chest pain myocardial origin can be observed in mitral valve prolapse, mitralnom Vice heart, hypertrophic cardiomyopathy, myocarditis different Genesis, for morbid sport heart and alcohol the defeat of the heart.

Chest pain aortic origin (manifestations of aneurysm, delamination and rupture of the aorta). Chest pain can be associated with diseases of the pericardium.

Most differential diagnostic problem is pain in the hearts of psychogenic.

Differential diagnosis of angina requires exclusion of diseases of the lung and pleura. Chest pain can be a manifestation of pulmonary branches of the pulmonary artery with the development of heart attack the lungs, as well as a sign of pnevmotorksa, pnevmomediastinuma or Pleurisy. Chest pain also occurs in bronchial asthma, chronic bronchitis and primary pulmonary hypertension.

Cause pain in the chest can be gastrointestinal diseases, particularly lesions of the esophagus. Kardiospazm, diseases of the esophagus (esophageal ahalazija), diverticula and esophageal tumors can also cause pain in the sternum.

A common cause of kardialgij happens a hiatal hernia. From other gastrointestinal diseases causing cardialgia include diseases of the stomach (peptic ulcer, tumor), gall bladder, pancreas and intestines.

Some patients with typical angina clinic and positive load tests, while coronary angiography does not find any changes in the coronary arteries. In these cases, you can talk about IBS with unmodified coronary arteries. Studies show that these patients significantly reduced the ability of arteries to dilation.

In patients with hypertrophic cardiomyopathy pain not as clearly related to physical activity, they are longer in cold weather and more likely to pass than amplified. It is possible to identify this disease increased significantly thanks to echocardiography, which allows you to set the thickening of the upper part of the Ventricular septal more 1.5 cm.

Mitral valve prolapse syndrome can be gloomy or stinging pain in the (III) - IY intercostals space to the left of the sternum. Rarely, pain is localized behind the sternum or the tip of the metasternum. Not intense pain can last for hours, adding after the physical and emotional stresses. Assume that mitral valve predisposes to coronary spasms. Diagnosis of mitral valve prolapse has been greatly improved, thanks to the wide application of ultrasonic techniques in the clinic research of the heart.

For nonspecific aortoarteriita characterized by common inflammatory lesion of aortic arch, thoracic and abdominal aorta, divisions and its branches. In some patients, possibly spreading the inflammatory process in the coronary vessels. For nonspecific aorto-Arteritis, the most characteristic lesion of mouth of the coronary arteries, but may involve the proximal and distal.

When aortic arch anevrizme, put the correct diagnosis help related symptoms caused by squeezing adjacent organs (cough, dysphagia, hoarseness, impaired vision, fainting).

When you bundle the aorta, the pain from the very beginning has a maximum intensity. Typical of the largest irradiation illusion: pain in the sternum, started irradiiruet in the neck, back, abdomen, spine, and even legs.

Pain in the heart are the most common and one of the early symptoms of myocarditis. They are diverse, lasting for hours, day and night, virtually constant. When troubleshooting, you must consider the relationship with the newly transferred infection, fever, leukocytosis, increased both ventricles of the heart.

When retrosternal pain localization pericardite recalls the pain of angina, but unlike strokes it lasts 24 hours or longer. in pericardite, the pain gets worse when breathing above the heart, pericardium, friction noise heard which is held by 1-2 week. Unlike a heart attack saved teeth R, there is no pathological teeth Q. Important diagnostic value of echocardiography data to identify the liquid layer adjacent to the front or rear wall of the left ventricle.

Heart pain is frequent in individuals suffering from alcoholism. It is often diagnosed disease, and pain as angina. Difficulties in diagnosing the sick hide alcohol abuse. When x-rays detected the expansion of the heart. ECG-dilatation of the left ventricle. Diagnosis of alcoholic cardiopathy is facilitated when concurrent signs of liver damage.

For ISCHEMIC HEART DISEASE very often take kardiopaticheskij syndrome in patients with circulatory dystonia. Pain when NDCS basically stabbing or aching, localized mainly in the apex of the heart, or in (II) - IY intercostals space to the left of the sternum pain docked or reduced admission valokardina, validola, sedated. Along with kardialgicheskim syndrome in patients unable to identify other closely related syndromes-tahikardialnyj, neuroticeski, vegetative-distonicheskij, asteniceski. The person with the NDCS would never feel fully healthy, they have always some syndrome. The prolonged existence of cardiovascular disorders, without a clear organic pathology of heart-in favor of diagnosis. NDCS

It is often necessary to differentiate cardialgia, related to Osteochondrosis of the cervical and thoracic spine with angina pectoris. Vertebrogennaja cardialgia **is** quite intensive and prolonged pain. Draws the attention of the relationship of pain appearance with the uncomfortable position of the body, with a turn of the head, change of body position, movement of the left hand.

By palpation of neck-chest area, and shoulder girdle, some patients are marked with common soft-tissue soreness, increasing tone and contracture of some muscles. Mandatory examination of the patient is to call symptoms tension cervical nerves.

X-rays can detect sclerosis zamykatelnyh plates, osteophytes in the area of the affected disc, reducing the intervertebral.

For exudative Pleurisy is characterized by acute onset as acute pain in his side and raise the temperature to 39 degrees Celsius. Notes the relationship of pain with the Act of breathing.

Pain caused by esophageal spasm, angina trudnootlichimy. Zagrudinnaya pain localization, positive use of nitroglycerin, eliminating pain during a spasm of the esophagus, the differential diagnosis difficult. Frequent communication with pain can galvanize dysphagia doctor to suggest "pishhevodnoj" strokes.

For tumors of the esophagus in patients with divertikulah and mark pain associated with food intake and bring on dysphagia.

When ezofagitah,tenderness in the course of the esophagus occurs in connection with the admission of acute and hot food.

Peptic ulcer of esophagus pain occurs not only when swallowing, but when belching.

**Test questions**:

1. Specify the disease, you must differentiate ISCHEMIC HEART DISEASE.

2. What are the modern methods of diagnosing IIH.

3. List changes on ECG characteristic of IBS.

4. What are the most informative examination methods of the patients with CORONARY HEART DISEASE before an online treatment.

**Tests for self-control**:

Patient's 52 years, IBS, stenocardia rest during 4 months. Takes nitroglycerin tablets 40-45. specify research methods to be applied to determine diagnosis and treatment tactics: 2

1. perform computed tomography

2. perform coronarography

3. run veloergometry

4. make GASTRODUODENOSCOPY

Specify by using any of these methods, you can define the indications for surgical treatment of ISCHEMIC HEART DISEASE: 4

1. x-ray heart

2. echocardiography

3. myocardial scintigraphy

4. coronary angiography

5. ventriculography

Patient 49 years suffers from exertional angina. On koronarogrammah segmental stenosis (about 70% lumen) of the anterior interventricular artery. Select treatment tactics: 3

1. enhance medication

2. to recommend to the sanatorium-and-spa treatment

3. recommend surgical treatment now

4. recommend surgical treatment after

inpatient therapy

Sick 56 years suffers from angina pectoris at rest. On koronarogrammah stenosis (more than 75% clearance) of the anterior interventricular artery. Choose the tactics of treatment: 2

1. medication

2. surgical treatment now

3. surgical treatment after inpatient medical

treatment

4. sanatorium-and-spa treatment.

**COMPLICATIONS of gastric ulcer and 12 duodenal ulcer**

**(I) . GASTRODUODENAL BLEEDING**

Acute gastrointestinal bleeding (HMO) is a complication of many diseases of the gastrointestinal tract, gastric ulcer and 12 duodenal ulcer accounts for up to 75-80% of bleeding. It is essential to distinguish between bleeding ulcerative nejazvennogo and Genesis. To nejazvennym causes include esophageal varicose veins of the esophagus varices in portal hypertension syndrome, Mallory-Weiss, disintegrating tumors of the stomach, hemorrhagic gastritis. Intestinal bleeding can occur when nonspecific yazvennom kolite, bruchnom tife, jekzofitnoj colon tumors, blood diseases nature (haemophilia, the disease Verlgofa), arsenic poisoning, acids and alkalis.

**The clinical picture.** On clinical flow distinguish latent and clear (c) bleeding. Hidden hemorrhage manifesting weakness, reduced working capacity, drowsiness, fatigue, paleness of the skin and mucous membranes. Patients often within a few days or even weeks do not seek medical help. And only the appearance of black stool causes them to come to the doctor. In a survey of their peripheral blood detected signs of gipohromnoj anaemia (decrease in hemoglobin, gematokrita, the number of red blood cells, color) and in the study of Kala-positive reaction Yens Gregersen collection. On EXAMINATION detected ulcer.

When you explicitly bleeding there are **common symptoms of blood loss** (hypotension, tachycardia, weakness, dizziness, loss of consciousness, until increasing paleness of the skin and mucous membranes). The severity of symptoms depends on the number of acute blood loss blood the foregone, intensity and duration of bleeding. The patient is pale, concentrated, a person afraid. He is afraid to move, so as not to cause resumption of vomiting blood. A person can be (with considerable krovopotere) shrouded in cold, sticky afterwards.

It is accepted to allocate three degrees of severity of acute HMO-mild, moderate and severe, which is primarily determined by subjective and objective condition of the patient, the degree of tachycardia and the level of blood pressure (BP). So when blood loss to 20% Bcc (~ 500 ml to an easy degree), the patient's condition does not change significantly, appears weak in physical exertion, tachycardia up to 100 beats/min, systolic hell not below 100 mm Hg. Blood loss up to 30% (up to ~ 1 litre) determines the average severity: appears sharp paleness, dizziness, noise in the ears, "flies" flickering eyes, patients sometimes lose consciousness. Pulse rate 100-120 BPM, content and voltage decreases the radial artery, sometimes the pulse is defined only in the area of the carotid arteries, hell progressively reduced from 100 to 80 mmHg With severe blood loss (over 30% of Bcc, more 1 liter) patient's condition heavy or extremely heavy, lost consciousness, paleness, pronounced facial features seen with an earthy undertone tachycardia greater than 120 beats/min, systolic HELL below 80 mmHg, diastolic may not be detected.

**Local signs of blood loss:** vomiting blood or mixed with coffee grounds "(education in the stomach soljanokislogo gematina), liquid" tarry "feces black, Melena (black color is due to the emergence of iron sulfate in the passage of blood through the small intestine). Tongue wet, often on the lips, tongue and gums are visible the remains of bloody vomit. The belly is not swollen, the front abdominal wall is soft and practically painless in all departments.

Most patients indicate ulcerative anamnesis, symptoms of peptic ulcer disease (heartburn, pain, vomiting, etc.). For the clinical picture explicitly characterized by bleeding ulcer **symptom Bergman** -stihanie typical ulcer pains at the start of bleeding (izlivshajasja in the lumen of the stomach blood neutralizes acidic gastric contents) and the emergence of vomiting "coffee grounds".

In the study of peripheral blood detected by lower hemoglobin, gematokrita, the number of red blood cells, a color indicator. The number of platelets is normal. In patients with bleeding ulcer extension is missing gemorroidalnah veins and veins of the anterior abdominal wall, as portal hypertension syndrome complicated with bleeding from esophageal varices. Preceding intoxication and growing stomach cancer are inherent, cachexia and gastric ulcer and 12 duodenal ulcer have not been observed. Finally determine the source of the bleeding allows EXAMINATION, during which the canker is found or swelling, rupture of mucous or esophageal varicose veins cardio-jezofagealnogo transition.

**Differential diagnosis**.

The differential diagnosis should be carried out: Mallory Weiss Syndrome, bleeding in stomach cancer, portal hypertension syndrome, haemorrhagic gastritis jerozivnym, Verlgofa disease, pulmonary hemorrhage.

**Mallory-Weiss Syndrome** occurs more commonly in perfectly healthy people as a result of the sharp increase of intragastric pressure (when strong vomiting associated with poisoning surrogates alcohol, hypertensive crisis, epilepsy, marine disease). Bleeding occurs when rupture of mucous membranes and other segments of the Cardia of the stomach. Unlike bleeding ulcer bleeding main symptom in this case will be vomiting, gastric contents unchanged initially and then see the vomit, blood veins and "coffee grounds". There is no ulcer history. When EXAMINATION identifies erosion breaks the Cardia of the stomach Mucosa, the absence of ulcers.

**Bleeding in stomach cancer** in the majority of cases observed in the later stages, when the breakup and izjazvlenii tumors. Unlike ulcers, stomach cancer is more often observed: "small signs", old age patients, progressive weight loss and cachexia, increasing weakness, belching rotten. May palpirovatsja Nodular swelling in the stomach, projection determined by metastases in the left supraclavicular region (Virchow), navel (metastasis nurses Joseph) Cystic-prjamokishechnoe deepening (Schnitzler), ovary (Krukenberga).

Profuznomu bleeding in stomach cancer is preceded by a period of latent haemorrhage and anaemia patient. When EXAMINATION detected dense bugristoe education, bleeding, fragmentirujushheesja. The final verification of the diagnosis is carried out when the biopsy and histological biopsy.

**Portal hypertension Syndrome** is characterized with splenomegaly, abdominal "dropsy", violation of portal venous drainage and consequently expansion of portokavalnyh anastomosis. Bleeding occurs when breaking varikozno expanded veins oesophagus and bottom of the Cardia of the stomach. There is a massive, rapid bleeding mouth full, practically unchanged. While ulcerative bleeding increasingly concentrated "coffee grinds. At a bleeding from varikozno expanded veins oesophagus lacks ulcerative anamnesis. The most common form of hepatic portal hypertension (cirrhosis). Visually zheltushnye skin, there are "spider veins", "liver Palms", expansion of subcutaneous abdominal veins as "head of Medusa", palpable enlarged liver and spleen, is determined by the free fluid in the abdominal cavity (ascites) data there are no changes in gastroduodenalnom bleeding ulcer Genesis. In jezofagogastroskopii there has been an increase in esophageal and gastric kardiii, the absence of ulcers.

**Hemorrhagic erosive gastritis** develops against the backdrop of chronic gastritis with the formation of the erosion of the stomach lining. In some cases it occurs against the background of the prolonged use of drugs (non-steroidal anti-inflammatory drugs, hormones crust napochechnikov). Differential diagnosis is based on the absence of ulcer history and objective signs of ulcers. Bleeding with hemorrhagic gastritis usually have included minor, has the character of a "coffee grounds", noted black Chair. However, unlike ulcerative bleeding weakness does not comes to collapse, because bleeding is usually not profuznogo nature. The most reliable method of research, allowing to differentiate this bleeding fibrogastroduodenoscopy, is that gives the opportunity to discover the erosion of the stomach lining.

**Verlgofa Disease** is more common in women at a young age. Unlike gastric ulcer and 12 duodenal ulcer detected bleeding in the skin ("spotted" disease), bleeding of mucous membranes (nose, gingival, etc.). Characterized by changes in the blood: thrombocytopenia, coagulation time and duration of bleeding, impaired blood clot retraction. Unlike ulcerative, bleeding disease Verlgofa is not sharp and not accompanied by collapse, exposing the positive symptoms-plucking and tow. When GASTRODUODENOSCOPY in stomach or duodenal ulcer bleeding 12 is not detected.

**Pulmonary bleeding** heart diseases observed with symptoms of stagnation in the small circle of blood circulation, in destructive lung diseases (tuberculosis, abscess, lung cancer, bronchiectasis). Unlike the ulcer, gastrointestinal bleeding, pulmonary cough begins with a first allocation of veins blood in the sputum, and then red blood mixed with air bubbles, accompanied by pronounced shortness of breath, cyanosis, no vomiting and Melena. When radiography of thorax organs detected pockets of destruction of lung tissue, lung cancer with the collapse, increasing heart borders. If swallowed by a patient blood vomiting may occur with an admixture of blood or coffee grounds, as well as the black color of the feces.

**Test questions**:

1. What are the causes of gastrointestinal bleeding.

2. Define the criteria for the assessment of the severity of gastroduodenal bleedings.

3. What are the main methods of diagnostics of gastroduodenal bleedings.

4. Spend the differential diagnosis of different types of gastroduodenal bleedings.

5.

**Tests for self-control**:

Spitting up frothy blood bright red, increasing cough typical for: 4

1. bleeding stomach ulcers

2. the Cardia tumor

3. Mallory-Weiss Syndrome

4. pulmonary hemorrhage

Determine the source of bleeding gastroduodenalnogo allows: 5

1. x-ray examination of gastric

2. laparoscopy

3.-gastric probe

4. redefinition of hematocrit and hemoglobin

5. EXAMINATION

Mallory-Weiss Syndrome is: 3

1. varicose veins of the esophagus and Cardia,

complicated bleeding

2. bleeding from mucous membranes on the soil of hemorrhagic

Vasculitis (Rendu-Osler disease)

3. gap mucous in Cardia have the Department of a stomach bleeding

4. haemorrhagic erosive gastroduodenitis

The disappearance of pain and the appearance of "meleny" with duodenal jazveharakterno for: 4

1. piloroduodenalnogo stenosis

2. perforation of ulcer

3. malignization ulcers

4. bleeding

5. penetration in pancreas

For a bleeding ulcer of duodenum 12 not typical: 2

1. vomit color coffee grounds

2. increased pain in the abdomen

3. drop in hemoglobin

4. Melena

5. reduction of BCC

**(II) . GASTRODUODENAL PERFORATION**

Perforation (CPMSR)-an acute violation of the integrity of the lining of the stomach or duodenum 12.

CPMSR occurs in 12-14% of cases the flow of gastric ulcer and 12 duodenal ulcer. Perforating ulcers occur more often in men than in women.

**Classification**. Clinically distinguish:

1. CPMSR free abdominal cavity with the formation of widespread peritonitis;

2. atypical CPMSR grease bag or retroperitoneal space kletchatochnoe;

3. veiled CPMSR.

**The clinical picture** includes three periods: a) Jet (phase a painful "shock")-a period of sudden sharp pain response, sympathoadrenal system voltage expressed the reaction of peritoneum; b) imaginary well-being; in the present progressive) peritonitis.

**Phase of a painful "shock".** In the early hours of the perforation occurs sharp "" "pain is characterized by involuntary position the patient on his side, hunched over, with preloaded to belly legs (" embryo "pose), aetiology and hypotension (due to vagus nerve irritation). You should be aware of the triad-Knigina-Mondor ("pain, ulcerative doskoobraznyj anamnesis, abdomen).

**Phase perceived well-being.** 2-6 hours later, the pain decreases, which is connected with the neutralization was at the time of perforation of the abdomen acid gastric contents with an effusion of peritonealnym alkaline pH Decreases pain reaction, belly becomes more gentle. "patient Subjective improvement" and sometimes it can serve as a diagnostic error in the interpretation of clinical symptoms. Especially one between imaginary well-being while veiled perforation, as fully can subside the pain and only at deep palpation indicated rigidity in the upper right quadrant of the abdomen (symptom Ratner-Wenner).

**Phase of peritonitis.** In a subsequent progresses intoxication, signs of paralytic ileus (bloating). During all periods of its development of ulcers in the stomach detected by palpation symptom Shchyotkina-Bljumberga and perkutorno symptom Spizharnogo.

When perforation of ulcer in zabrjushinnuju tissue there is retroperitoneal abscess triad of symptoms: soreness and stiffness in the lumbar region, sponginess integument and thickening of the skin folds in the lumbar region, scoliosis in the direction of formation the abscess. While painting the belly for a long time remained calm and true diagnosis sometimes cannot be determined only after ljumbotomii.

The most informative in the diagnosis of probodnoj ulcers is abdominal radiography review in which taped free gas in the form of a Crescent strips under right dome diaphragm. If this symptom screening with a view to establishing the diagnosis of resorting to receive Mayo (introduction of air into the stomach through the probe) or ESOPHAGOGASTRODUODENOSCOPY (with subsequent verification review radiography of abdominal cavity) or runs diagnostic laparoscopy. Perforativnaja ulcer is subject to immediate surgical treatment.

**Differential diagnosis**.

The differential diagnosis should be: with severe appendicitis, acute cholecystitis, acute pancreatitis, renal colic, acute violation of mezenterialnogo circulation, myocardial infarction.

**Acute appendicitis** is characterized initially moderate pain in the epigastria followed their migration into the right area of the ileum (a symptom of Kocher-Volkovich). Patients for a long time may be satisfactory. In a survey of belly pain localized in the right iliac region are positive symptoms Rovzinga, Sitkovskogo, Karavaevoj, Bartome-Mihelsona, etc. Under fluoroscopy no free gas in the abdominal cavity. Covered perforation when poured a small quantity of gastric contents with its subsequent migration to the right side to the right channel of the ileum area can simulate symptom Kocher-Volklvicha. When questionable clinical picture issue is resolved in favor of the execution of diagnostic laparoscopy.

**Acute cholecystitis** often ill women with overweight, pain associated with an accuracy in the diet in history can reveal a jelchnokamennouu illness. Characterized by pain in the right podreberie, defining positive symptoms Ortner, Murphy, Kera, Zaharin, sometimes palpated zoomed sickly gallbladder. Typical multiple vomiting bile not bringing relief that little is typical for perforation of the stomach or duodenum 12. If ULTRASOUND detected the stones increase and thickening of gallbladder wall.

**Acute pancreatitis** -like perforativnaja ulcer with pain in epigastria, but they are gradual, incremental, not have a sudden "kyndzhalnyy on" character, and surround. Characterized by multiple, painful vomiting, not inherent in its throat, swelling of the upper half of the abdomen. Identify symptoms Kerte, Mayo-Robson, Resurrection, with progression of pancreatic necrosis can be defined in terms of "colored" Gray-symptoms-Turner-Mondor. When UZI pancreas increased, anecdotal, can be detected by a free liquid in sealing the bag. In the analysis of urine-increased diastase. When peritoneal clinic resorted to diagnostic laparoscopy to exclude perforation of a hollow body.

**Renal colic** is characterized by sudden intense pain in the lumbar region radiating into the back, groin and genitals, dizuriei. Patient restless, rushes. In contrast, the patient with its ulcer takes a forced position and is pursing the legs to the stomach. Stomach in case of renal colic most often mild, sometimes seen psevdoperitonealnyj syndrome, which disappears after the novokainovoj blockade of the spermatic cord on Lorin-Jepshtejnu or introduced the embargo. In the analysis of urine-hematuria, when renal ultrasound-pieljektazija, the shadow of concrements. Sometimes justified hromocistoskopija. Diagnostic laparoscopy is rarely used.

**Acute mezenterialnogo blood circulation** (ACCD) occurs suddenly and desperately, similar to its ulcer. However, this is against the backdrop of a soft abdomen, missing the aetiology. Patients are restless, tossing from the pain. Characteristic identification in history and one of the clinically embologenity disease (atrial fibrillation or, less frequently, other pathology of the cardiovascular system). Quickly accrues bloating, decrease, and then the lack of peristalsis of the bowel, progressing intoxication. In the analysis of blood-giperlejkocitoz with toxic shift. While maintaining and increasing pain in the first hours of shows a diagnostic laparoscopy in order, firstly, to exclude perforation of a hollow body, and secondly to determine the condition of the intestines and the need for surgical intervention.

**Myocardial infarction** (abdominal, gastralgicheskaja, form) is more common in elderly people suffering from IBS. The overall condition of the grave. Pulse frequently, aritmichnyj. Lowered blood pressure. Heart tones deaf. There is no tension and pain during palpation of the abdomen. ECG-signs of damage to the myocardium. Diagnostic laparoscopy is used in very rare cases, when a very strong suspicions of abdominal catastrophe (Leukocytosis buildup, muscle tension of the abdominal wall, the presence of abdominal ULTRASOUND when free liquid).

**Test questions**:

1. What are the typical symptoms of stomach ulcer and its 12-duodenum.

2. Select the main periods of clinical course of its ulcer.

3. List of diseases, which should differentiate perforativnuju ulcer.

4. Specify instrumental techniques used in the diagnosis and differential diagnosis of its ulcer.

**Tests for self-control**:

For its ulcer characteristically: 2

1. rest pain

2. symptom Spizharnogo

3. repeated vomiting

4. the dramatic bloating

5. symptom Kocher-Volkovich

In the diagnosis of its ulcer apply: 1

1. review x-rays of the abdomen

2. intravenous urography

3. x-ray studies tract with barium

4. angiography

5. novokainovuju blockade

In the differential diagnosis of its ulcer and acute appendicitis the most informative is: 3

1. blood analysis

2. symptom Shchyotkina-Bljumberga

3. diagnostic laparoscopy

4. digital rectal examination

5. passage of barium kishechniku

Its clinic ulcer following periods: 6, 2, 5

1. hemodynamic violations

2. imaginary well-being

3. toxic

4. Terminal

5. spilled peritonitis

6. shock

**(III) . PILORODUODENALNY STENOSIS**

Piloroduodenalny stenosis-the narrowing of pyloric Department of stomach or primary Division 12 duodenal ulcer. This complication occurs in 10-40% of patients with peptic ulcer. The cause of piloroduodenalnogo stenosis often are 12 ulcers duodenal ulcer, rarely prepiloricheskie ulcers and sores pyloric Canal.

**Classification**. Depending on the time of occurrence and severity, distinguish three stages: stenosis

1. compensated stenosis

2. subkompensirovannyj stenosis

3. decompensirovanny stenosis

**The clinical picture**. Patients with piloroduodenalnam stenosis have complaints of fatigue, exhaustion, repeated vomiting, stomach contents, which are stagnating brings temporary relief. They often cause vomiting. Phase compensated stenosis symptoms are not expressed, the sick note only the feeling of overcrowding in the stomach, gravity epigastrii. This is accompanied by heartburn, belching acidic. In phase subkompensirovannogo stenosis symptoms increase, belching acquires the smell of rotten eggs. Periodically bother colicky pain associated with gastric peristalsis, progressing the weight loss process. In Decompensated phase of stenosis patients dramatically depleted, the skin is dry, skin fold thinned. Dehydration and electrolyte loss resulted in severe condition, up to the development of adinamii and klonicakih convulsing. Vomited mass become malodorous nature and contain the decomposing mass food, eaten the day before. A typical symptom of abdominal examination is "succussion" in the stomach, detected on an empty stomach. The contours of a large curvature of the stomach is defined far below physiological borders, up to gipogastrija. Motility of the stomach auskultativno not heard (atony stomach). There has been a small and frequent pulse, low blood pressure, but because of violations vodno-elektrolitnogo balance-gipokaliemia, gipohloremia, metabolic alkalosis, decreased urine output. Potassium loss leads to violation of cardiac activity, decreased tonus of vascular wall. When alkaloze plasma ionized calcium level decreases, resulting in changed neuromuscular excitability, and in severe cases, develops gastrogennaja tetany: General convulsions, Lockjaw, mixing fingers hands (hands symptom obstetrician» Trousseau), twitching facial muscles when pokolachivanii in the area of the trunk of the facial nerve (a symptom of Hvosteka). Gipohloremicski alkaloz gipokaliemicheskij and combined with increasing azotemia, that plagued the overall condition of the patients.

When conducting an x-ray of the stomach with barium observed phenomenon gastrostaza, delays evacuation of barium from the stomach up to 6:00 (compensated stenosis), to 12-18 hours (subkompensirovannyj stenosis) and more 12:00 am (Decompensated stenosis).

**Differential diagnosis**.

Differential diagnosis between stenosis ulcerative origin stenosis with piloroantralnom gastric cancer and stenosis during germination of pancreas head tumor in 12-duodenum.

In patients with ulcerative pyloric stenosis has a long history of origin of chronic recurrent ulcer, seasonality of exacerbations (spring-autumn), a characteristic relationship with meal-pain: hungry or appearing after 15-30 minutes After eating, wearing, non-persistent circadian rhythm. May also be familiar with the instructions earlier endoscopy stomach and 12 duodenum with ulcer detection. By palpation of the left nadkljuchichnoj area and the digital rectal study pathological infiltrative entities do not. When EXAMINATION detected chronic ulcers, stenozirutaya and distorts the gatekeeper and 12 duodenum, while the biopsy no atypical cells.

Unlike ulcerative, **tumorous nature stenosis** has a shorter history. Faster depletion occurs. Identifies small clinical symptoms "A.i. Savitsky: reduced efficiency, progressive weight loss and emaciation, refusal of food, particularly meat and fish, fatigue, etc. Pain, in contrast to ulcers, in the beginning is missing, and then acquires a dull, constant, not removed inflammatory drugs. By palpation taped tight, tumorous formation in the projection of the stomach, malopodvizhnoe or not smeshhaemoe. Can be identified in pleural foci navel (metastasis Joseph) node in the left pane nadkljuchichnoj (Virchow), in the area of Douglas Pocket (Schnitzler), ovary (Krukenberga). When an ULTRASOUND of the liver, spleen and paraaortalnoj zones identifies the metastatic foci infiltrative.

Stomach roentgenoscopy with barium in stenozirujushhem stomach cancer gives a characteristic picture of symptom "Hourglass".

For **tumors of the pancreas head**, prorastajushhej in 12-duodenum, characterized, first of all, triad Courvoisier (painless jaundice, aholija Kala, palpiruemyj painless enlarged gall bladder) with a possible combination with the previous "small signs" syndrome.

Leading diagnostic step is endoscopic examination of the stomach with biopsy. Cytological biopsy detected atypical cells. These changes are not typical for stenosis of ulcerous etiology. Often resolve the question definitively about the nature of piloroduodenalnogo stenosis, (chronic kalleznaja ulcer or cancer) is very difficult. In this case, perhaps the application of diagnostic laparoscopy or laparotomy, in which emergency doctor study on biopsied material is determined by the operabelnost and the amount of intervention-radical- gastrectomy, gastrectomy, or palliative, draining the stomach operation.

**Test questions**:

1. Tell the classification of pyloric stenosis.

2. What are the clinical manifestations of piloroduodenalnogo stenosis in stages of its development.

3. Enumerate methods of instrumental and laboratory diagnosis in piloroduodenalnom stenosis.

4. Spend the differential diagnosis of stenosis of ulcer and tumor Genesis.

**Tests for self-control**:

Compensated stenoses privratnika is characterized by: 2

1. "Daggers" pain after eating

2. blunt, nojushhego nature, pain after eating

3. pain in the lower back

4. constipation

For Decompensated pyloric stenosis are not typical: 2.4

1. vomit food eaten on the eve

2. abdominal muscle strain

3. "succussion" in the stomach on an empty stomach

4. scleral and skin

For the diagnosis of pyloric stenosis does not apply: 1, 2, 3

1. holetsistografia

2. sigmoidoscopy

3. bronhografia

4. gastric radiography with barium

Pyloric stenosis occurs in the main role of disease: 4

1. acute pancreatitis

2. acute gastritis

3. acute gastroenteritis

4. chronic ulcer stomach pyloric Department

**(IV) ULCER PENETRATION.**

Penetration of ulcer-peptic ulcer complication in the form of the proliferation of destructive process from the wall of the stomach or duodenum 12 in thickness of a neighbouring authority-the head of the pancreas, the liver the duodenum bunch, small gland. Possible penetration of canker not only in these organs (most often), but also the liver, gallbladder, colon cross with internal Fistula formation and cross-bryzhejku of the colon.

**Classification**. In the process of building penetration into three stages:

1. vnutristenochnoj penetration;

2. fibrous adhesions;

3. complete penetration to a nearby organ.

**The clinical picture of** penetration develops gradually, long. The main sign of ulcer penetration is to change the rhythm of pain-she takes a permanent character. And it reflects the more often the body defeats clinic in which penetriruet ulcer. So, if the pain localized over the navel, in the left hypochondrium and worn shingles character irradiiruja in the left lumbar region, penetriruet ulcer in the pancreas.

If the patient perform x-ray examination 12 a stomach and duodenum with barium, then detected deep niche "beyond the body. When EXAMINATION detected deep ulcerative defect. Penetration of ulcers in hollow organ, usually leads to pathologic and soustja between the stomach and rectum, colon cross-12 duodenal gut and a bilious bubble. Clinically, it has been accompanied by pain in the projection of the affected organ, the advent of vomiting from intestinal detachable or bile. X-ray investigation with barium or other contrast medium reveals its getting into cross-colon through fistulas or horizontal fluid level with gas (a symptom of ajeroholii) in the projection of the gallbladder with receipt of barium in gall bladder.

When penetration 12 ulcers duodenal ulcer in renal and hepatic duodenal bunch noted the appearance of obstructive jaundice due to compression and deformation of the common bile duct and violations of the passage of bile into the duodenum 12. Clinically, this is reflected increasing pains in the right hypochondrium, nausea, vomiting, increased body temperature, ikterichnostju skin and sclera, darkening of urine and feces aholichnym. If ULTRASOUND indicated expansion in diameter of the common bile duct, change its contours due to compression of the penetrating ulcer. Penetration of ulcers in the retroperitoneal space usually occurs when its localization in "weak" areas 12-duodenum, not covered by peritoneum (rear panel). Clinical symptoms of this complication is characterized by symptoms of purulent-septic process (expressed intoxication, weakness, sweating, fever, shivering, pain in the lumbar region, anemia, high Leukocytosis with left shift, high ESR). Diagnosis is very difficult-applied x-ray stomach and 12 duodenal ulcer, ultrasound, computed tomography.

**Differential diagnosis**.

Differential diagnosis of penetrating ulcers: with chronic pancreatitis, gastric tumor with spread to adjacent organs.

For **chronic pancreatitis** is characterized by communication of pain with the reception of oily, spicy foods, alcohol. Expressed pain, localized in the projection of the gland, radiating into the back, carrying shingles nature. In acute pain quickly intensifies, and ulcerative process does not happen: highlights the positive symptoms, Chukhrienko Kerte, Mayo-Robson, Voskresensky,-Mondor, Grey-Turner, Cullen. In blood and urine and urinary amylase increased content. When UZI pancreas size enlarged, changes its jehogennost. In contrast, when the penetration of ulcers in the pancreas in the patient has a long history of ulcerative pain syndrome is modest. Rhythmic pain (day, night), associated with the intake of any food, then gradually become permanent. As a result of developing secondary pancreatitis may be increasing the level of urinary in urine. When the x-ray study of the stomach and duodenum 12 with barium taped deep niche.

**Gastric cancer with germination** into neighbouring organs clinically verified quite simply. For cancer of stomach lesions also is characteristic of long-lasting pain in podlojecna area, the left hypochondrium. The pain is constant, dull, aching, but unlike ulcer penetration is not as intense, as a rule, is not the nature of the zoster. Patients have the changing nature of supply (renunciation of meat-eating, fish), progressive emaciation (cachexia cancer), belching and vomiting rotten.

When the x-ray study of the stomach with barium is found not deep "niche" and "filling" defect with Depot barium in it, Cliff folds, absence of peristalsis in this phase of the stomach. When EXAMINATION with biopsy confirmed the nature of the tumor (atypical cells), and the absence of their shows in favor of Chronic Ulcerative process.

If stomach cancer is often detected by palpation, dense, bugristoe, malopodvizhnoe education in the projection of the stomach. Detection of distant metastasis, Virchow Schnitzler, Krukenberga, anterior abdominal wall (belly button) is also demonstrated in favor of stomach cancer.

**Test questions**:

1. What are the main types of complications of gastric ulcer and 12 duodenal ulcer.

2. Define penetrating ulcers.

3. Tell the clinical picture of penetration.

4. List methods that can be applied to confirm the penetration.

5. Name the diseases to differentiate penetrirujushhuju stomach ulcers or 12 duodenal ulcer.

**Tests for self-control**:

Dull, aching, belting the nature of pain in left hypochondrium characteristic: 3

1. acute appendicitis

2. acute pancreatitis

3. chronic pancreatitis

4. perforation of a hollow organ

5. 12 a stomach ulcer-duodenal ulcer

6. penetration of ulcers in pancreas

To diagnose penetrating ulcers do not apply: 2, 3, 4

1. radiography 12 a stomach and duodenum

2. laparoscopy

3. skull radiography

4. x-ray of thorax

5. ESOPHAGOGASTRODUODENOSCOPY

6. ULTRASOUND

Specify the main clinical signs of penetration ulcers in the pancreas: 3

1. pain when swallowing

2. multiple, exhausting vomiting

3. pain of a permanent nature, rising after taking any food, spreading in the lumbar region

4. pain in the chest

Following radiological sign indicate the penetration of ulcers: 6

1. filling defect in round shape of the body of the stomach

2. a small "niche" in the piloricheskom Department of a stomach

3. Klojbera Bowl

4. falcata Strip Strip under right dome of diaphragm

5. gas bubble in the area of the bottom of the stomach

6. deep niche "beyond body

**(V) MALIGNIZATION.**

Malignant transformation of gastric ulcers is a pathological process, based on the appearance of genital epithelium defects foci of cell proliferation with atipiej epithelium. This complication is not uncommon and is from 2 to 35%. The longer there is an ulcer (2-3 years or more) than the more proximally located more than its size ( -2 1.5 cm. or more), all the more reason for suspicion at malignizatiou. So chronic, "kalleznyh" ulcers with a diameter of more than 2 cm. cancer is formed by more than 10% of cases, and ulcers, localised in Cardia have the Department of a stomach, malignizirujutsja in 30-48% of cases.

**The clinical picture**. Suspect the transition process of ulcerative cancer in patients with peptic ulcer, it is far from easy. Development of cancer sores is accompanied by a kind of change in the clinical picture, as the attentive, thinking, the clinician must remember. First of all, decreases severity controlling pain that is perceived as patients improved condition. Gradually disappearing bouts of pain, and the pain becomes moderate in intensity, but permanent. They are only slightly amplified after eating. And then the link pain with food completely disappears. Cyclical changes of pain by time of day, season of exacerbations (spring and autumn) also disappears. Increased or normal appetite decreases, and soon appears and an aversion to food, especially meat and fish. Quite characteristic for transition sores in cancer is the syndrome of "small signs", described by Igor Savitsky A.i.: loss of interest in work, to family, to the environment, uncaused (from the point of view of the patient), weakness, fatigue, rapid decline efficiency, restless sleep, paleness of the skin. Gradually manifest themselves and other symptoms typical to this process: gravity in epigastralna area, lack of satisfaction from eating, gastric discomfort, unpleasant smell from the mouth, progressive ishudanie, pallor and earthy colors person.

**Differential diagnosis**.

Differential diagnosis of malignizirujushhejsja ulcer: with chronic anatidian gastritis, stomach cancer.

When chronic gastritis patients celebrate pain in podlojecna area, the left hypochondrium, nausea, bad breath, weight loss, weakness. The clinical picture may resemble malignizatiou ulcers. Crucial in the differential diagnosis is EXAMINATION with biopsy in Dynamics amid conservative anti-inflammatory therapy.

Cancer detection of ulcers is often znachitelnye difficulties. It is hardly possible to clinically set a clear line when ulcerative process and ends of ulcers cancer arises.

Differential-diagnostic algorithm should include the following points:

1. A thorough medical history, ascertaining the duration of diseases, treatments and their effectiveness;

2. Clarification of complaints and altering their nature ("small signs");

3. Laboratory tests: KLA (anaemia, moderate shift leukocyte formula left accelerated ESR), blood Biochemistry (hypoproteinemia), analysis of lavages from the stomach to the atypical cells;

4. Instrumental examination:

A very important and essential is the EXAMINATION in dynamics with compulsory taking biopsies of suspicious places (at least 6-8) for histological study. But downplayed the possibilities listed methods, do not-they also give a certain percentage of errors. Only the sum of all of the clinical symptoms and the survey data allows you to make a diagnosis. This is certainly the most important is the direction and focus of the doctor.

Stomach roentgenoscopy can detect if there are niche, marginal defect filling», rigidity of the surrounding Mucosa, flatness of folds, absence of peristalsis, the graininess of the edge of niche.

**Test questions**:

1. List the complications of gastric ulcer and 12 duodenal ulcer.

2. What are the main clinical symptoms of peptic ulcer disease.

3. Enter the stomach ulcers that often malignizirujut.

4. What are the clinical signs of malignization.

5. List diagnostic methods that are most informative in the differential diagnosis of cancer and ulcers.

**Tests for self-control**:

The main malignization are everything except: 1, 2, 4

1. Horner's syndrome

2. Knigina-triad-Mondor

3. the syndrome of "small signs"

4. Courvoisier syndrome

The following methods must be used when suspected malignizatiou ulcer: 4

1. analysis of sputum

2. analysis of saliva

3. analysis of bile

4. analysis of lavages from the stomach to the atypical cells

Of these methods the most informative at diagnostics of cancer sores: 4

1. stomach roentgenoscopy

2. x-rays of the skull

3. lung roentgenoscopy

4. EXAMINATION with biopsy

Clinical symptoms of malignization ulcers are not: 1, 2, 3

1. pain in the right hypochondrium

2. headaches

3. pain in the calf muscles during walking

4. dull, aching, persistent, not related to eating in

epigastrium

5. uncaused weakness, malaise, weakness, disgust

to meat food, weight loss

6. gravity in podlojecna area, belching rotten, nasty

the smell from the mouth.

**ABDOMINAL HERNIA**

**Theoretical reference.**

A hernia is called protrusion of an internal organs covered with peritoneum through natural or artificial pathological holes into neighbouring cavity or under the skin. If under the skin or outside vypjachivajutsja bodies covered with parietal peritoneum, this pathology is called jeventracija (subcutaneous or full) or false hernia.

**Classification**:

1. the place of education, the hernia is divided into external and internal. To the outside: inguinal, Femoral, umbilical hernia, midline, lumbar, sitting, promezhnostnye, postoperative ventral.

2. On the etiology of the hernia may be congenital and acquired.

3. the clinical picture emit partly vpravimye vpravimye:, nevpravimye, complicated and uncomplicated.

4. Complications of hernias: nevpravimost, impairment, inflammation (Phlegmon hernial SAC).

In the pathogenesis of acquired hernias relies on a combination of predisposing causes and producing essential of which has increased intra-abdominal pressure. Elements of hernias is called: hernial gate hernial SAC contents gryzhevoe. In cases where one of the elements of the hernia is the wall of the bladder cecum and rarer sigmoid-it is called sliding hernia.

**The clinical picture**. Uncomplicated hernias are characterized by: moderate pain in the area of stress, especially reinforcing discomfort during physical exercise, positive symptom "kashlevogo jolt. Physical examination of patients spend in two positions-lying and standing. If you encounter the most frequent complications

-infringement, there is severe pain in the area of hernias ' and in the abdomen, nevpravimost and previously vpravimoj strain hernia, absence of symptom kashlevogo Jolt, the clinic of acute intestinal obstruction (if impaired bowel loop). Laboratory and instrumental Diagnostics when the hernia has no independent meaning, but only allows you to diagnose or complication or differentiate disease.

**Differential diagnosis**.

**Inguinal hernia** should be differentiated:

1. Hydrocele (Hydrocele), which also has a tumorous formation. But it occurs and increases gradually, over time, is not changed in the prone position (when vpravimoj hernia disappears), has a dense texture. There is no indication of physical exercise in history, symptom kashlevogo push negative. Recognition helps diafanoskopii method.

2. Inguinal lymphadenitis, where there is a history of inflammatory processes, mainly on the lower extremities. Palpated a painful education, dense otgranicennoe from the outer holes of the inguinal Canal, the skin over it more often fluorescence improves overall body temperature. In the analysis of blood noted leucocytosis, increased ERYTHROCYTE SEDIMENTATION RATE, whereas in patients with uncomplicated hernias these changes.

3. Varicose veins of the spermatic cord (varicocele), which is more common on the left, under-age teenagers. By palpation identifies "grozdevidno" dilated veins in the spermatic cord along the way. Varicocele is sometimes combined with a manifestation of proteinuria, mikrogematurii.

**Femoral hernia**, is below the pupartovoj ligament is more common in women, it should be differentiated from the following diseases:

1. benign tumors (lipomas, fibromas) and Metastases of malignant neoplasms in which three-dimensional palpable education firm, painless, has clear boundaries, the abdominal cavity was not vpravlyaetsya, hernia gate. For the purpose of diagnosis or exclude pelvic tumors need to conduct a study of the rectum, uterus.

2. Varicose veins disease lower limbs in which occurs a significant expansion of the great saphenous vein in its mouth (oval Fossa). But for varicose veins is characterized by bluish color of the skin over the vypjachivaniem, the absence of symptom kashlevogo Jolt, varicose veins in the lower limbs in the distal part.

3. Tuberculosis natechnik, which differs from the femoral hernia in a characteristic clinical presentation of TB of the spine is the deformation of the spine (kyphosis), x-ray changes-wedge shape bodies affected vertebrae, narrowing mocrowave slit, positive tuberculin sample.

**Midline Hernia** should be differentiated from predbrjushinnoj Lipoma where tumorous education has clear boundaries, plotnojelasticheskoe, midline defect has a minimum size;

Nevpravimye **, umbilical** hernia should be differentiated from metastatic stomach cancer implant nature in the abdominal wall and the navel. If you do not want to include the cancer indications EXAMINATION, ultrasonography, computed tomography.

**Postoperative ventral hernias** occur in places previously performed surgeries and depending on the location of the median can be (upper and lower), lateral (top, bottom, left and right). Postoperative hernia is formed due to prolonged tamponade and drainage of the wound or festering. In place of the postoperative scar gradually develops an outpouching, which increases over time, becoming a multi compartment and nevpravimym due to adhesions in gryzhevom bag.

**Test questions**:

1. List the factors that contribute to the development of anterior abdominal wall hernias.

2. What are the main clinical manifestations of external abdominal hernia.

3. List the diseases with which to differentiate the inguinal, Femoral, umbilical hernia and midline.

4. What are the signs of infringement of a hernia.

**Tests for self-control**:

The contents of the hernial SAC can be everything except: 3

1. small intestine

2. stomach

3. the pancreas

4. liver

5. urinary bladder

When sliding hernia one of walls of the hernial SAC is: 1

1. bladder

2. great seal

3. stomach

4. bud

5. small intestine

When razushhemivshejsja hernia correct would be: 2

1. immediate operation

2. dynamic monitoring

3. antibiotic therapy

4. laparoscopy

5. all the name

For differential diagnosis of inguinal hernia and testicle wrappers dropsy shown: 4

1. radiography

2. digital rectal

3. ULTRASOUND

4. transillumination

5. all answers are incorrect

**ACUTE APPENDICITIS**

**Theoretical reference.**

Acute appendicitis is the acute non-specific inflammation of the vermiform process cecum.

Acute appendicitis is the most common acute abdominal disease. His clinic is not always typical and depends on the location of the process, the nature of the inflammatory process, its duration, the reactivity of the organism of the patient. The disease has its particular manifestation in children, pregnant women, elderly people.

**Classification**. According to the classification proposed by V.i. Kolesov, entails the following forms of acute appendicitis:

1. Appendikuljarnaja colic

2. Simple (superficial) appendicitis

3. Destructive flegmonoznyj, gangrenous appendicitis:, perforativnyj

4. Complicated appendicitis: infiltration by appendikuljarnym, appendikuljarnym, pileflebitom, purulent peritonitis, abscess, pelvic mezhkishechnymi by, retroperitoneal flegmonoj.

**The clinical picture** of the disease varied, so surgeons call it the "monkey all illnesses". Acute appendicitis usually starts among the full health, with the emergence of the escalating pain in epigastria, near the navel, or even across the stomach. However, in about half of cases the pain initially localized in the right iliac region. The pain is often accompanied by nausea, multiple vomit. The pathological process evolves through 2-3 hours or later (this depends on the reactivity) pain shifted right ileum region (p-m Kocher-Volkovich), amplified when walking, irradiiruet in the right leg, right lumbar area.

In the first hours of the disease (with kataralnom appendicitis) patient's condition satisfactory subfebrilnaya temperature ( -37.8 37.4), pulse 80-90 beats/min blood pressure does not change language slightly wet with Belly whitish bloom, not swollen, the front abdominal wall soft participates in the breath, but painful at palpation in the right iliac region. Notes the positive symptoms: Sitkovskogo, Rovzinga, Bartome-Mihelsona.

When flegmonoznom appendicitis patient's condition moderate febrile temperature ( -38.5 38.0), the patient restless, trying less to move. 90-100 Pulse beats/min Language is paved with white bloom is noted by palpation. muscle tension and sharp pain in the right iliac region. Determined by positive symptoms: Karavaevoj, dolina, Sitkovskogo, Rovzinga, V.razdolskiy, Voskresensky, Bartome-Mihelsona, Shchyotkina-obrazcova, Bljumberga.

When gangrenoznom appendicitis condition of the patient is usually heavy. It's sluggish, aims to take a comfortable position so as not to exacerbate the pain in the abdomen, body temperature is 38.5 -39.0  pulse 100-120 BPM, language dry, densely lined with grey touch. Belly breathing practically does not participate, the anterior abdominal wall sharply painful in the right half with a muscle strain dramatically positive appendicitis symptoms and irritation peritoneum (V.razdolskiy, Karavaevoj, Voskresensky, Valley, obraztsova, Bartome-Mihelsona, Shchyotkina-Bljumberga, etc.). Bowel motility is not being heard, gases do not depart. Pronounced phenomenon of intoxication.

Acute destructive appendicitis may be complicated by peritonitis, appendikuljarnym infiltration, appendikuljarnym asbcessom, pileflebitom.

In the diagnosis of acute appendicitis in addition to ascertaining the anamnesis, complaints, patient examination results, in which rectal examination necessarily, have a value of laboratory evidence of the development of inflammatory process, phenomenon intoxication: in the blood rise blood leukocyte and shift left, EMS the ESR. Laparoscopy is essential.

**Differential diagnosis**.

The differential diagnosis of acute appendicitis must be conducted primarily with:

1. pathology of right kidney (renal kolica);

2. pathology of female genital organs;

3. intestinal infection;

continue with its acute pancreatitis, stomach ulcer and 12 duodenal ulcer, acute cholecystitis, acute ileus.

Right renal colic. Typical for right-handed renal colic is a sharp pain in the lower back, irradiirujushhaja in his right groin, restless patient behavior, frequent urination with rezju and pain in small portions with an impurity of blood. By palpation-pain along the course of the ureter. Positive symptom of Pasternackogo. Symptoms of irritation of the peritoneum. In the urine-protein and fresh blood. Review urography-may be the shadow of concrements. When hromocistoskopii is delayed or even indigokarmina selection facility. ULTRASOUND: detected symptoms of renal hypertension (pieljektazija) and calculus.

Acute pathology female genital mutilation is divided into inflammatory (endometritis, adnexitis, etc.) and "bleeding (ectopic pregnancy, ovarian rupture, stroke right ovarian cyst)

Acute left adnexitis as acute appendicitis is characterized by lower abdominal pain, fever. Unlike with pain disorders, appendicitis radiating in the sacrum, the lower back. In history there are indications on the menstrual cycle or postponed earlier inflammatory disease of appendages. By palpation tenderness is defined at the bottom of the abdomen on the right side. Possible false positive local symptoms of acute appendicitis may strain the muscles of the anterior abdominal wall. When the vaginal inflammatory tumor detected study appendages, which is closely related to the uterus. Defines a positive symptom Promptova-pain when sometimes the uterus during vaginal or rectal. Can be determined by positive symptom Zhendrinskogo-reducing pain in the right iliac region when you change the status of the patient (from a lying position in sitting position). Characterized by inflammatory discharge from the vagina. Differential diagnosis for clinical and laboratory signs are often complicated, requiring laparoscopic study.

Ectopic pregnancy, unlike acute appendicitis **is characterized by blood clinic** with strong, sharp pains in the abdomen, above the vagina accompanied by dizziness, weakness, nausea, vomiting, transient fainting episodes. Identify signs of pregnancy available: delayed menstruation, bloating mammary glands. Marked spotting from your vagina. The skin is pale. Frequent heartbeat, weak content. Blood pressure lowered. The abdomen is moderately swollen, not involved in the Act of breathing, painful in the lower divisions, while it may be pain around belly (if massive blood loss). May be determined by the tension of the muscles of the anterior abdominal wall. Positive symptom Schetkina-Bljumberga. Percussion-free fluid in the abdominal cavity. Puncture of posterior FORNIX confirms or excludes the diagnosis of ectopic pregnancy. ULTRASOUND: a free fluid in the abdominal cavity (blood).

Ovarian apoplexy on time **coincides with ovulation** (mid cycle) can be of two types: pain form and haemorrhagic form.

When pain form blood loss is minimal signs of intra-abdominal bleeding No. Characterized by dramatically by having pain in the right iliac region. Possible false positive local symptoms of acute appendicitis symptoms of irritation of the peritoneum are missing. Leukocytosis with left shift is missing.

When haemorrhagic form characterized by a local clinic and clinic blood loss, described in an ectopic pregnancy.

Ovarian cyst rupture occurs without any connection with the menstrual cycle, often associated with physical activity, sexual intercourse. Depending on the volume of blood loss form can be painful and hemorrhagic stroke, as when an ovary with a similar clinic.

**Intestinal infection (salmonellosis, food poisoning).** Typical beginning of acute intestinal infections is frequent loose stools, abdominal cramps, nausea, vomiting, hyperthermia. the clinic is growing fast. Gradually become constant pain, localized in epigastria, okolopupochnoj area, right iliac region. Diarrhea with vomiting can kupirovatsja. At the moment it seems a intestinal infection simulate clinic of acute appendicitis, including local appendicitis symptoms and symptoms of irritation of the peritoneum in the right iliac region. Crucial detail and correctly assembled anamnesis **(onset).**

**A typical** **perforated ulcer** of stomach and duodenum 12, owing to the rapidly growing and vibrant clinic is not, as a rule, differential-diagnostic difficulties, but that was not the case of **perforation of the veiled.** The flow ofa small amount of gastric contents into the abdomen does not cause sharp expressed (finally) pain that simulates the jepigastralnuju phase. Move the effusion on the right lateral Canal leads to pain in the right iliac region-visibility symptom Kocher-Volkovich. Typically, in such cases, the intervention is taken for acute appendicitis, which identifies the true pathology.

**Acute pancreatitis** is also characterized by the emergence of pain in epigastria, but unlike the appendicitis pain intensity significantly stronger. Pain radiating to the back, worn shingles nature. Precedes the pain syndrome diet-drinking large amounts of spicy and fatty foods, and alcohol.

Pain syndrome accompanied with acute dispepticheskimi disorders in the form of nausea and repeated, not facilitate, vomiting. The condition of patients with progressive deteriorating: the skin of the face is pale grey, dry language, with greyish-Brown. The abdomen is moderately swollen bowel motility is weak or not listening, not depart-the phenomenon of dynamic ileus. Defines the positive symptoms of the resurrection, Kerte, Mayo-Robson, Shchyotkina-Bljumberga, Cullen,-Mondor, Grey-Turner. Notes the shortness of breath, tachycardia, reduction in blood pressure.

When the laboratory examination blood leucocytosis is detected with the lejkoformuly shift to the left, high ESR. In biochemical research-hyperglycemia, gipocalziemia, increased blood amylase. Growing up to high numbers (512, 1024, etc.) urinary incontinence. If ULTRASOUND detected the characteristic signs of acute pancreatitis, often liquid in sealing the bag and the abdominal cavity. When rentgenoskopicheskom study is determined by the reduction of trips of the diaphragm, the presence of fluid in the peritoneal and pleural cavities.

It should be remembered that often epigastric phase of acute appendicitis is treated as acute pancreatitis, which leads the on-call surgeon on a false diagnostic and therapeutic path.

**Acute cholecystitis** in some cases should be differentiated with acute appendicitis: high, podpechenochnom, location of the vermiform process or during pregnancy, when the Processus pushed back up, as well as with a low bottom location of the gall bubble-"hanging a bilious bubble. All of these options are difficult in diagnostic terms.

It should be remembered that the acute cholecystitis usually starts after taking a large amount of spicy and fatty foods, with the appearance of sharp pain in the right podreberie, accompanied by nausea and repeated vomiting with jelchew, little facilitates State the sick man. Acute cholecystitis frequently suffer from overweight women aged 45-50 years. Irradiation illusion is characterized by pain in the right arm, shoulder, and nadpleche shoulder. The belly is not swollen by palpation of the anterior abdominal wall indicated expressed pain and muscle strain in the right podreberie, where one can often detect testovatoj consistency-seal palpiruemyj gallbladder. Determined by positive symptoms Ortner, Murphy, Kera, Zaharin, Mussy-St George, Shoffara, Baking. In the peripheral blood leucocytosis is detected with the lejkoformuly shift to the left. When ULTRASOUND: detects gallstones, the layering of wall and other signs of lesions of the gallbladder.

**Acute intestinal occlusion** have to differentiate from acute appendicitis, in cases where the pain is localized in the right abdomen, e.g. when the ileocecal intussusception (children). There is the emergence of pain shvatkoobraznogo character, nausea, vomiting, a delay of flatus and stool. The belly is usually swollen, but there is no abdominal palpation of its tension. In the ileocecal region is defined by maloboleznennoe, kolbasovidnoe mobile education-invaginat. Percussion of the abdomen-timpanit. Quite often when rectal study find mucus with blood-symptom of "raspberry jelly.

Acute intestinal obstruction in adults is usually preceded by diet, for example-receiving abundant, rough food after the preceding fasting. Therefore, acute intestinal obstruction, especially stranguljacionnuju, called "disease wars". History can be abdominal operation.

Bowel obstruction can be caused by a tumor, helminthic invasion, the inversion of the intestines, uzloobrazovaniem or invaginaciej. Patients complain of sharp, cramping in the abdomen without explicit localization, nausea, vomiting repeatedly. In the final stage in the development of peritonitis, vomiting is "kalovyj". For intestinal obstruction characterized by asymmetric bloating, lack of stool and gas. Determined by positive symptoms Valya, Hose, Sklyarov (succussion), Spasokukockogo, Obukhiv hospital. When the review of abdominal radiography detected Bowl Klojbera.

In conclusion, it should be further emphasis on the need for knowledge on the main diseases of physics jepigastralnuju phase of acute appendicitis: covered gastroduodenal perforation, acute pancreatitis, acute gastritis, increased chronic gastroduodenal ulcer.

**Test questions**:

1. What are the clinical signs and symptoms of acute appendicitis.

2. Enter the laboratory and instrumental research methods used for differential diagnosis of acute appendicitis.

3. Tactics of the surgeon in acute appendicitis.

4.

**Tests for self-control**:

For acute appendicitis is not specific symptom: 3

1. Rovzinga

2. Resurrection

3. Murphy

4. Obraztsova

5. Bartome-Mihelsona

Specific to appendicitis symptom is: 1

1. Kocher-Volkovich

2. Rovzinga

3. Sitkovskogo

4. All three symptom

5. None of them

To peritonealnym in acute appendicitis symptoms include: 4

1. Resurrection (symptom of "shirt")

2. Schetkina-Bljumberga

3. V.razdolskiy

4. All of these symptoms

5. None of them

Acute appendicitis should be differentiated with all

listed diseases, except: 1

1. Glomerulonephritis

2. Acute pancreatitis

3. Acute Gynecologic diseases

4. Acute gastroenteritis

5. Right renal colic

Primary gangrenous appendicitis most often occurs in: 5

1. Children

2. Heavy patients

3. Men

4. Women

5. Elderly patients

Decisive in differential diagnosis of acute

appendicitis with ectopic pregnancy is: 5

1. Symptom Kocher-Volkovich

2. Symptom Promptova

3. Dizziness and fainting

4. Symptom Bartome-Mihelsona

5. Puncture of posterior FORNIX of vagina

**ACUTE CHOLECYSTITIS**

**Theoretical reference.**

Acute cholecystitis is an acute inflammation of the gallbladder wall.

In the majority of cases (95%) cause of acute cholecystitis is obturation cervical gallbladder konkrementom (acute calculous cholecystitis). Cause of acute beskamennogo cholecystitis (5%) most often a violation of blood circulation in the wall of the gallbladder.

Currently, acute cholecystitis on frequency takes the second place after an acute appendicitis. Get sick more often women than men (3:1).

**Classification.** Distinguish between uncomplicated and complicated acute cholecystitis. When uncomplicated cholecystitis secrete kataralnuju and destructive (flegmonoznuju and gangrenoznuju) form of inflammation.

Complications:

-perforation;

-generalized peritonitis;

-okolopuzyrnyj infiltration;

-okolopuzyrnyj abscess;

-purulent cholangitis;

-obstructive jaundice;

-Biliary fistula (internal and external).

**The clinical picture**. Acute cholecystitis manifests attack intense pain of a permanent nature in the right podreberie radiating to the right supraclavicular area, and shoulder, usually occurring after acute intake and fatty foods. Marked nausea, repeated vomiting. Body temperature rises. By palpation detects local soreness in the right podreberie, determined by positive symptoms: Ortner, Kera, Zaharin, Murphy, George-Mussy, Shoffara, Baking. If Bluetongue form of inflammation of the muscles of the anterior abdominal wall no, symptom Schetkina-negative Bljumberga.

When destructive cholecystitis with local or General peritonitis increase body temperature to 39-40° c, pulse frequency to 100-120 BPM, dry furred tongue, muscles of the anterior abdominal wall, expressed symptoms Ortner, Kera, Murphy, Zaharin, positive symptom Schetkina-Bljumberga.

**Differential diagnosis**.

Differential diagnosis: with acute pancreatitis, acute ileus, right-handed renal colic severe appendicitis, probodnoj stomach ulcer and 12 duodenal ulcer.

Acute appendicitis in contrast to acute cholecystitis occurs equally often among men and women, mostly in young and middle-aged adults. For appendicitis is characterized by localization of pain in the right iliac region, where there is a protective muscle tension of the anterior abdominal wall, determined by positive symptoms Kocher-Volkovich, Rovzinga, Sitkovskogo, Obraztsova, Resurrection, Karavaevoj, Bartome-Mihelsona and Shchyotkina-Bljumberga symptom is detected.

Perforated gastric ulcer and 12 duodenal ulcer is more common in men. There is a "history of" aggravation-ulcerative process in autumn-spring period, increased pain in connection with meals. The moment of perforation is accompanied by a sharp pain comparable to "blow a dagger." Ill try to lie motionless, more often on the right side, with preloaded to belly legs. Unlike acute cholecystitis, normally there is no vomiting. Muscles of the anterior abdominal wall is diffuse nature and expressed much more sharply («doskoobraznyj» belly). Defines a positive symptom Spizharnogo-disappearance or reducing liver dullness, radiological sign-falcata Strip Strip under right dome diaphragm. The important thing to remember about triad-Knigina-Mondor: ulcerative history, "pain, stomach doskoobraznyj.

Acute pancreatitis is especially intense pain in epigastria (the left hypochondrium) radiating to the back, early uncontrollable vomiting. There is swelling of the upper half of the abdomen, abdominal aortic pulsation is not determined (a symptom of the Resurrection). A painful resistance in the area epigastralna (Kerte symptom). There is also tenderness in the left costal-spinal corner (a symptom of Mayo-Robson). Identify color symptoms:-Mondor, Grey-Turner-Holstead's, Grunwald. In blood and urine analyses detected increasing levels of amylase and Diastasis. X-ray study allows you to install indirect signs of pancreatitis-restriction of mobility left the dome of the diaphragm, the liquid in the left sinus determination. When the SONOGRAM visible changes in the structure of the pancreas may be liquid in sealing the bag.

Acute intestinal obstruction characterized by shvatkoobraznymi pain, growing with peristalsis, without irradiation, abdominal distention. Noted multiple vomiting, there is a delay of the stool and gas. Determined by positive symptoms valia Sklyarov, Hose, Kivulja, Spasokukockogo. Review of Abdominal radiograph discover Bowl Klojbera. When giving the water suspended barium stated violation of his movement on the bowel.

Renal colic peculiar to sharp, not stihajushhie pain in the lumbar region radiating them in the side area of the anterior abdominal wall, the area causing the thigh muscles, the sexual organs. Patients do not find space from pain, restless. Appear more frequent urination accompanied by rezju and pain in the urethra. Defines a positive symptom of Pasternackogo. When ULTRASOUND is determined pieljektazija at the review urogramme can be defined in calculus. In the urine analysis reveal the presence of fresh red blood cells, white blood cells, protein.

**Test questions**:

1. What are the causes that lead to acute cholecystitis.

2. Specify the symptoms characteristic of acute cholecystitis.

3. List the complications in acute cholecystitis.

4. Name the diseases with which to differentiate acute cholecystitis.

5.

**Tests for self-control**:

Acute cholecystitis usually begins with: 3

1. Temperature increase

2. Induce vomiting

3. Pain in the right hypochondrium

4. Disorders of stool

5. Gravity in epigastralna area

The primary method of study patients with uncomplicated cholecystitis is: 3

1. Infusion holegrafija

2. ERCP

3. ULTRASOUND of the gallbladder

4. Laparoscopy

5. Gastroduodenoscopy

Complications of acute cholecystitis is not: 1

1. Varicose veins of the esophagus

2. Mechanical jaundice

3. Cholangitis

4. Podpechenochnyj abscess

5. Peritonitis

Kamneobrazovaniju in the gallbladder helps everyone except: 5

1. Bile in a bubble

2. Metabolic disorders

3. Inflammatory changes in the gallbladder

4. Diskenezii biliary tract

5. Violations of pancreatic secretion

For the clinic of acute cholangitis is not characterized by: 5

1. High temperature

2. Pain in the right hypochondrium

3. Jaundice

4. Leukocytosis

5. Volatile liquid stool

**ACUTE PANCREATITIS**

**Theoretical reference.**

Acute pancreatitis-acute and emerging phase leaky autoliticheskij degenerative inflammatory process of the tissues of the pancreas due to its activation vnutriprotokovoj proteo and lipolytic enzymes, characterized by severe disorders of homeostasis and the functions of vital organs and body systems.

Among the acute surgical diseases of the abdominal cavity organs acute pancreatitis currently occupies one of leading places, women are affected more often than men. Most observations of acute pancreatitis is associated with a limited number of etiological factors of alcoholic, biliary, post traumatic origin. Mechanism of development of autoliza nature of pancreatic tissue due to razermetizacii ductal system and activate their own proteolytic and lipolytic profermentnyh systems that can disrupt cellular and tissue structure inside and outside of the ducts.

**Classification**.

1. Otechny (intersticialny) pancreatitis;

2. Sterile pancreatic necrosis;

and necrosis in nature)-fatty, bloody, mixed;

b) scale destruction-melkoochagovyj, krupnoochagovyj, subtotalno-total;

3. Complications of acute pancreatitis:

a) peripankreaticheskij infiltration

b) infected pancreatic necrosis

in) peritonitis: enzymatic (abakterialnyj), bacterial

g) pancreatic abscess

d) mechanical jaundice

e) pseudocyst: clean infected

f) arrozivnoe bleeding

w) purulent Phlegmon retroperitoneal fiber

and) internal and external digestivnye fistulas.

**The clinical picture**. Patient makes complaints about cruel, encircling the standing character of pain in epigastria, relentless vomiting, not with ease. History of patients may be an indication of jelchnokamennouu disease. The disease can be caused by errors in the diet, frequent consumption of large quantities of alcoholic beverages and their surrogates. The pain starts suddenly, irradiiruet in the back, "rest", sometimes unbearable, the patient restless, rushes. Body temperature is normal or subfebrilnaya. Language dry, densely lined with white-Brown coating. Pulse uchashhen to 90-110 beats/min, blood pressure (BP) is not stable, with progression of the disease is developing hypotension. Swollen belly in epigastria, in the Act of breathing involved limited, by palpation is determined by the zone of pain and resistance in the area epigastralna (Kerte), irradiation illusion of pain in the left costal-vertebral angle (Mayo-Robson), sharply weakened or not transfer is defined abdominal aortic pulsation (Resurrection). Cyanosis is noted persons (s.-Mondor), melkotochechnye abdominal haemorrhage (Grey-Turner). Perkutorno-timpanit in the upper abdomen and dulling in lateral sloping ground.

If auscultation heard languid Peristaltic noises (bowel paresis). The progression process show signs of irritation of the peritoneum (Shchyotkina-Bljumberga). When forming the infiltration stuffing bags palpated tight, painful, tumorous formation in epigastria, when abscedirovanii supported gekticheskaja fever. Infected pancreatic necrosis flows extremely difficult. Against the background of the progression of the disease quickly growing intoxication (septic pulmonary injury status, peritonitis).

The buildup is detected in the blood of Leukocytosis, shift left formula, increased ERYTHROCYTE SEDIMENTATION RATE, marked hyperglycemia and hypocalcemia. Informative laboratory tests indicating the degree of enzyme toxemia are the determination of the level of amylase blood and urinary incontinence, which increase or decrease even to 0. Often experience increased blood bilirubin in connection with severe toxic liver lesion.

When the review of abdominal distention reveal retgenografii transverse colon, slurring the outline the left psoas major (s. Gobia), duodenostasis and deployed a horseshoe 12 duodenal ulcer. Radiography of the thoracic cavity allows you to set the reduction in tours of the diaphragm, reactive effusion in pleural sinus left.

When the ULTRASOUND there has been an increase in the size of the pancreas, increasing its echogenicity oteke, pockets of uneven density and softening in tissue destruction of the gland, the expansion of the common bile duct. Calculus can be identified in the gall bladder and bile ducts. Additional methods that enable Diagnostics instrumentelnoj clarify the picture of defeat can be computed tomography, diagnostic laparoscopy.

**Differential diagnosis**.

The differential diagnosis should be carried out: with its stomach ulcer and 12 duodenal ulcer, acute thrombosis mezenterialnah vessels, acute ileus, acute appendicitis, acute cholecystitis, acute gastritis, left renal colic, myocardial infarction.

When carrying out differential diagnosis of acute pancreatitis and **its sores** should remember that forthe last characteristic of gastric anamnesis, sudden onset, "" pain, "forced the situation of a patient lying on right side with the knees to the stomach ("embryo" posture), doskoobraznyj retracted belly, bradycardia, vomiting rare or one-time. Perkutorno is defined by the disappearance of liver dullness (Spizharnogo). When the review of abdominal x-rays detected gas under right dome diaphragm. When the cover-up perforation occurs erased characterized by only pain in epigastria, absence of gas under the dome of the diaphragm that simulates the clinic of acute pancreatitis. With a view to the diagnosis of perforation, ESOPHAGOGASTRODUODENOSCOPY is shown covered with repeated x-ray research or diagnostic laparoscopy.

**Thrombosis mezenterialnah vessels** differentiate from acute pancreatitis is difficult due to the presence of common symptoms of intoxication, paresis bowel. Thrombosis develops, usually in patients with elderly and senile age, suffering from heart disease, endocarditis, violation of rhythm, atherosclerotic lesions of aorta and its visceral (mesenteric) branches. Pain occur suddenly, are kolikoobraznyj in nature, there is local soreness in the projection of the pancreas. Notes with a touch of liquid stool blood. Vomiting is rare, with the occasional dash of "coffee grounds", which is not typical for acute pancreatitis. In the analysis of blood coagulation increase activity. Blood urine diastase and amylase, unlike acute pancreatitis, often not promoted. Crucial for the differential diagnosis are diagnostic laparoscopy and selective mezenterikografija on Seldingeru, a diagnostic laparotomy.

**Acute intestinal obstruction** has a number of common symptoms with acute pancreatitis: repeated vomiting, sudden onset of abdominal pain, bloating, and gas delay. But the pain is shvatkoobraznyj nature around the stomach, while the pancreatitis is localized pain in the area epigastralna, is shingles character constant. In acute intestinal obstruction identifies positive symptoms valia Sklyarov, Hose, Spasokukockogo, rectal examination indicated an empty rectal ampulla (Obukhovskaya hospitals) that are not typical for acute pancreatitis, where there is dynamic paresis and cross swelling of the colon. Radiographically, with scoping study of abdominal cavity defined by bowls and Klojbera violation of passage of barium kishechniku in acute intestinal obstruction.

**Acute appendicitis** often starts with pain in epigastralna area, which later 3-4 hours are moved to the right podvzodshnuju area (c. Kocher-Volkovich). In acute pancreatitis the pain also arise in epigastria, but do not move are brutal, surround and radiating to left costal-vertebral angle (c. Mayo Robson). General condition when appendicitis is usually satisfactory. In acute pancreatitis, especially serious, the State is always difficult. Vomiting in acute appendicitis usually one-double, in pancreatitis frequent, uncontrollable. Belly in acute appendicitis often not swollen when pancreatitis usually bloating in the upper divisions. For appendicitis is characterized by symptoms of Rovzinga, Sitkovskogo, obraztsova, Bartome-Mihelsona, Karavaevoj. In acute pancreatitis these symptoms but negative positive symptoms Kerte, Voskresensky, Mayo-Robson-Mondor. Urine diastase when appendicitis was normal, with pancreatitis. ULTRASOUND detects modified tissue echogenicity gland, increasing its size, presence of effusion in stuffing the bag and the abdominal cavity. When diagnostic laparoscopy in acute pancreatitis: c3b inactivator-hemorrhagic effusions, plaques steatonekroza in the abdominal cavity, whereas in acute appendicitis identifies changes in the shoot, cherveobraznom effusion by-fibrinous or purulent in the right iliac region.

**Acute cholecystitis** also accompanied by frequent vomiting and pain syndrome. But the pain is localized in the right podreberie, irradiiruet in the right supraclavicular area, and shoulder often determined by palpation. enlarged, painful gallbladder, positive symptoms Murphy, George-Mussy, Kera, Zaharin, Ortner. In acute pancreatitis is pain in epigastria rest and spreading around the stomach. Define symptoms, Voskresensky Kerte, Mayo-Robson-Mondor. Acute cholecystitis normally does not leak with rapidly increasing signs of intoxication, collapse and shock, and bloating and paralysis intestinal occlusion appear in connection with the development of peritonitis after 1-2 days. ULTRASOUND reveals, in most cases, specific signs of acute cholecystitis: vklinennyj in the neck of the gallbladder konkrement, increase in size and thickening of the bladder wall.

**Acute gastritis**, as acute pancreatitis is characterized by the sudden appearance of abdominal pain, vomiting. For gastritis pain more frequently localized without irradiation, not as sharp as with pancreatitis. At first the plan for gastritis serve diarrhoeal disorders-belching, poor appetite, nausea, heartburn, vomiting. The condition of the patient with gastritis often satisfactory. The abdomen is soft, moderate pain in the area epigastralna, asymptomatic Kerte, Voskresensky, Mayo Shchyotkina Bljumberga-Robson. Diastase in urine is not enhanced. When ULTRASOUND is not detectable changes in the pancreas. EXAMINATION gives a picture of localized or widespread lesions of gastric mucosa.

Renal colic has a number of common symptoms with acute pancreatitis, especially when pathologic process is localized in the area of the tail of the pancreas, or in her head. However, in case of renal colic pain is sudden and sharp, radiating to the groin, thigh, scrotum, and removed the introduction of spasmolytics, blockade the spermatic cord. History-guidance on the urinary system pathology, urolithic bolez, dizuriceskie disorders. The patient with renal colic is restless, rushes. Identifies positive symptom Pasternackogo. In the analysis of urine in the patient with renal colic fresh red blood cells may be protein cylinders, leukocytes. When hromocistoskopii selection indigokarmina slowly or is not on the side of the lesion. When renal ultrasound-signs of urodynamics, pielojektazija, hydronephrosis, dense inclusions in the ureters-lohanochnoj system. In case of difficulties in the differential diagnosis of resorting to diagnostic laparoscopy.

Myocardial infarction (abdominal) sometimes accompanied by severe pain in the area epigastralna, followed by shock or collapse may occur. However, myocardial infarction there is no vomiting, no pain during palpation in the area of the pancreas, no bowel paresis stomach not swollen. The patient's situation enforced sitting or lying down. Expressed by the paleness of the skin, shortness of breath. The pulse is weak, broken heart rhythm, heart deaf. In contrast, the patient with acute pancreatitis restless, rushes, stomach swollen, painful in the area epigastralna, determined by positive symptoms Kerte, Voskresensky, Mayo-Robson, Koolena,-Mondor, etc. In the study of blood in the patient with acute pancreatitis there is Leukocytosis, toxic formula shift to the left. Identifies the increase in urinary incontinence, and myocardial infarct, those changes are not available. Diagnosis of myocardial infarction must be clinically and confirm jelektrokardiograficheski.

**Test questions**:

1. What are the causes and mechanism of acute pancreatitis.

2. List the major clinical symptoms of acute pancreatitis.

3. Name the reliable methods of laboratory and instrumental Diagnostics of acute pancreatitis.

4. Spend the differential diagnosis of acute pancreatitis with other acute surgical and non-surgical illnesses.

**Tests for self-control**:

Pain by palpation in the left costal-spinal corner characteristic symptom: 2

1. Resurrection

2. Mayo-Robson

3. -Mondor

4. Grey-Turner

Development of flatulence in patients with acute pancreatitis is caused by: 3

1. Squeezing 12-duodenum swollen pancreas head

2. Frequent uncontrollable vomiting

3. Paresis of intestine

4. Hormone Deficiency APUD- System

5. Enzymatic pancreatic insufficiency

The inability to determine the ripple of the abdominal aorta in the epigastrium in acute pancreatitis is called symptom: 5

1. Mayo-Robson

2. -Mondor

3. Kera

4. Cullen

5. Resurrection

To acute pancreatitis include all forms except: 2

1. Edema

2. Psevdotumoroznogo pancreatitis

3. Pancreatic necrosis Fat

4. Hemorrhagic pancreatic necrosis

The most informative methods of research in acute pancreatitis are: 3.5

1. Diagnostic pnevmoperitoneum

2. Panoramic x-ray of abdomen

3. Laparoscopy

4. Amylase blood and urinary incontinence,

5. ULTRASOUND

The most common symptom of acute pancreatitis is: 5

1. Nausea and vomiting

2. Hyperthermia

3. Jaundice

4. Bloating

5. Pain in the left upper abdomen

**ACUTE INTESTINAL OBSTRUCTION**

**Theoretical reference.**

Bowel obstruction-disease characterized by partial or total breach of content promotion moves through the path.

Acute ileus belongs to the Group of acute surgical diseases of the abdominal cavity, requiring immediate diagnostic and therapeutic measures.

**Classification**. Distinguish between dynamic and mechanical intestinal obstruction. In turn, the mechanical intestinal occlusion can be: obturative, stranguljacionnoj and mixed high and low tonkokishechnoj, colonic. Dynamic occlusion bowel and spastic paralysis happens.

**The clinical picture of** acute mechanical intestinal obstruction include: pain in the abdomen shvatkoobraznogo nature, nausea, bloating and vomiting repeatedly asymmetry belly, violation of flatus and stool. Depending on the reasons for and the level of obstruction of these symptoms can vary. The rapid development of pain attack and repeated painful vomiting are the beginning of acute intestinal obstruction high localization. Conversely, low, colonic obstruction, begins with exfoliation of the violations and gases, then align the bloating and pain. Vomiting is when this late and prognostically unfavorable sign.

Dynamic spastical occlusion occurs relatively rarely and develops in a spasm of a particular piece of intestine, leading to narrowing of its lumen. Clinically this form is characterized by mild pain syndrome, the feeling of bloating, nausea, vomiting, Chair. There may be uneven bloating. The belly is usually mild, by palpation can palpate spazmirovannyj plot. Tapped Peristaltic noises of the bowel. The general condition of the patient is relatively satisfactory, violations on the part of the cardiovascular system. Blood and urine tests are within normal limits.

Paralysis intestinal occlusion develops due to paresis or paralysis of the muscle layers of the intestine in early postoperative period, as a result of chemical or bacterial effects on the intestine, at peritonitah. Clinically it is gradually increasing constant abdominal pain, nausea, vomiting, delayed emission of gas and stool. Belly usually evenly swollen, the front abdominal wall is soft, but painful at palpation. Can be determined by symptom Shchyotkina-Bljumberga. Uchashheny pulse and breathing. In blood leucocytosis, and in severe cases and lejkoformuly shift to the left. When review x-rays of the abdomen can be detected by a Klojbera Bowl and diffuse intestinal flatulence. Both forms do not require surgical treatment, and usually are cured using conservative events.

In the clinical course of acute mechanical intestinal obstruction decided to allocate three stages:

In (I) stage (hemodynamic disorders or ileusnogo scream ") is dominated by pain syndrome and General disorders. The patient behaves in a restless, there are: shvatkoobraznaja abdominal pain, repeated vomiting, tachycardia, unstable blood pressure (BP). The tongue dry, lined with white bloom. Belly swollen, often asymmetric, in the Act of breathing involved uneven, not depart Gaza, no chairs. Can be determined visually expressed peristalsis (Hose) asymmetry of the abdomen, bloated guts and loop over it timpanit (Val). When bumped, anterior abdominal wall taped "succussion" (s. Sklyarov). Perkutorno over hyped bowel loops indicated timpanit with metallic tint (c. Kivulja). Auskultativno can be listened to "the noise of falling drops" (Spasokukockogo).

Digital rectal examination is required, which can be determined by an empty rectal ampulla (Obukhovskaya hospital). Analysis of peripheral blood and urine (I) stage substantially unchanged. Radiographically defined bloated loops of the intestines, "arch", Bowl Klojbera, p-m Casey (lateral pectoral small intestine-"skeleton of a herring").

     (II) stage (intoxication) is characterized by further circulatory disorders in the wall of the intestine, common violations hemodynamics, the main types of Exchange (protein, water and electrolyte, vitamin), increasing signs of intoxication. Marked by persistent pain, vomiting, auskultativno-sharp weakening or absence of peristalsis of the bowel noises, weakness. Then pain is decreasing because of the destruction of the nerve endings in the intestinal wall ("imaginary well-being"), vomiting less abundant, but with the rotten smell, thirst. The facial expression of suffering. Earthy skin-gray color. Pulse uchashhen, weakened by filling in the peripheral arteries, blood pressure progressively reduced, sometimes there is a collapse. In addition to the above symptoms observed in I stage begins to be determined symptom Shchyotkina-Bljumberga, perkutorno taped free fluid in sloping field of abdomen. X-ray picture is characterized by multiple bowls Klojbera. In the blood increases leucocytosis with toxic leukocyte shift to the left.

     (III) stage (Terminal). At this stage the phenomenon expressed intoxication. dire condition of the patient, increasing already, confusion or loss of consciousness. Facial features seen (face of Hippocrates), sick grumpy adinamichen, kontakten, not indifferent to own status and others. Hemodynamic parameters dramatically violated, low blood pressure, pulse, frequent, low voltage and filling. Vomiting acquires kalovyj smell. Picture of the abdomen is a classic picture of widespread peritonitis. There are no noises of the intestinal peristalsis (symptom of "absolute silence). Blood analyses-high Leukocytosis, pronounced shift towards lejkoformuly immature forms are detected toxic graininess. Increasing urea and creatinine levels, signs of acute Hepatorenal failure.

**Differential diagnosis**.

Acute intestinal obstruction should be differentiated with acute pancreatitis, acute thrombosis of mesenteric vessels, its stomach ulcer and 12 duodenal ulcer, renal colic.

**Acute pancreatitis** characterize the unbearable, pain in epigastralna area spanning, whereas when intestinal obstruction pain colicy. Common symptom is bloating. However if pancreatitis there is swelling in the upper division of the abdomen the acute intestinal obstruction bloating occurs in different departments, depending on the level and type of obstacles, there is an asymmetry of the abdomen. In acute pancreatitis vomit the agonizing, often mixed with bile and intestinal obstruction in it in the early hours of the profuse, bringing short-term relief, and then acquires kalovyj smell. In acute pancreatitis are determined by positive symptoms: Mayo-Robson, Kerte, Resurrection, and there are no symptoms: "noise succussion" Sklyarov, Valea, Hose, Kivulja. There was an increased level of blood amylase, urinary incontinence, which is not typical for acute intestinal obstruction. When you review the abdominal x-ray found reduced tours aperture, duodenostasis and deployed a horseshoe 12-duodenum, unlike bowls Klojbera characteristic of intestinal obstruction. ULTRASOUND reveals a violation of pancreatic structure echogenicity, resizing, the presence of fluid in the abdominal cavity bag stuffing.

When **acute tromboze mezenterialnah vessels** also raises strong, sharp pain, bloating, vomiting. The pain is permanent, kolikoobraznyj, nature without explicit localization. Acute coronary mezenterialnah blood vessels often occurs in patients with elderly and senile patients with disturbances of the heart rhythm, arteriosclerosis, heart disease. Notes with a touch of liquid stool blood, whereas in acute intestinal obstruction Chair and Gaza detained. Vomiting is rare, with the occasional dash of "coffee grounds", but when repeated vomiting, ileus with fecal odor. Auskultativno in acute mezenterialnom trombose noted oppression peristalsis, while the intestinal obstruction in initial stage of peristalsis strengthened. Radiographically, with scoping study of abdominal cavity in tromboze mesenteric vessels marked as and in acute intestinal obstruction, Klojbera Bowl "arches". When ULTRASOUND is determined by the fluid in the abdominal cavity-free. Diagnostic laparoscopy allows you to verify the diagnosis.

For **its ulcer** stomach and 12 duodenal ulcer is characterized by a sharp, sudden onset, the "kinzhalnogo" nature of the pain, apply immediately around the abdomen, anterior abdominal wall dramatically tense-"belly doskoobraznyj" (remember the triad Knigina--Mondor). Often patients have ulcerative anamnesis. Such pain in the beginning attack of acute intestinal obstruction. Vomiting when its throat is rare, there is a reflex, does not have a kalovogo smell like in acute intestinal obstruction. In the first minutes and hours of the perforation in the patient condition, there is pallor of the skin, cold sweat, aetiology. Retracted belly due to reactive muscle tension, and in intestinal obstruction, by contrast, has a bloating. When its ulcer percussion notes the disappearance of liver dullness (Spizharnogo), which is not typical for acute intestinal obstruction. When the review of screening in its abdominal cavity ulcer is determined by free gas under right dome diaphragm. And for acute intestinal obstruction characterized by bowls, intestinal Klojbera "arches".

**Renal colic** -begins abruptly strong bouts of pain. This raises the tension of muscles of the anterior abdominal wall, sometimes false symptoms of peritonitis, moderate bloating, vomiting, which is a similar sign of acute intestinal obstruction. But in case of renal colic pain constant, irradiiruet in the groin, thigh, scrotum, removed introduction spasmolytics, and when intestinal obstruction the pain is shvatkoobraznyj nature, do not leave Gaza, no chairs. In case of renal colic taped positive symptom in acute Pasternackogo ileus symptoms valia Hose, Kivulja, "succussion" (s. Sklyarov). When review x-rays of the abdominal cavity in patients with renal colic in pathology is not detectable in acute intestinal obstruction-multiple bowls, Klojbera "arches". In the analysis of urine in patients with renal colic fresh erythrocytes, leukocytes, cylinders, when there are no changes to the data of intestinal obstruction. When renal ultrasound pielojektazii signs, presence of concrements in the ureters-lohanochnoj system, hydronephrosis, demonstrating in favor of Urologic pathology.

**Test questions**:

1. What are the main causes of acute intestinal obstruction.

2. Tell the pathogenesis of peritonitis in this disease.

3. Specify different downstream obturazionnaya and stranguljacionnaja intestinal obstruction.

4. List the methods of abdominal x-rays, which are used in the diagnosis of acute intestinal obstruction.

5. What are the main clinical stages of acute intestinal obstruction.

6. List of diseases, which need to differentiate acute intestinal obstruction.

**Tests for self-control**:

Provoke acute intestinal obstruction may: 4

1. Weak abdominal muscles

2. Alcohol abuse

3. The use of oily and spicy food

4. Eating lots of food rich in fiber

5. Psychological trauma for the

For all types of acute intestinal obstruction characterized by: 3

1. Intense abdominal pain

2. Sharp increase peristalsis

3. Delay stool and gas

4. Asymmetry of the abdomen

5. Abdominal muscle Strain

To low of colonic obstruction characterized by all except: 5

1. A gradual build-up of symptoms

2. Abdominal distention

3. The emergence of bowls Klojbera

4. Delay stool

5. Quick (within 24 hours) dewatering

The main symptom of ileus obturative is: 2

1. Persistent pain in the abdomen

2. Abdominal cramps

3. Vomiting colors "coffee grounds"

4. Bloating

5. Melena

In case of acute intussusception occlusion primarily produced: 1

1. Panoramic radiography of abdominal cavity organs

2. Study on passage of barium kishechniku

3. Esophagogastroduodenoscopy

4. Laparoscopy

5. Biochemical blood analysis

**PERITONITIS**

**Theoretical reference.**

Peritonitis is an acute or chronic inflammation of the peritoneum, accompanied by local or shared symptoms of the disease, impaired function of major organs and body systems. Peritonitis in 99% of cases, is a complication of acute surgical diseases of the abdominal cavity organs, that is secondary. Spontaneous, primary peritonitis (1%), is a consequence of the gematogennoj translocation of microorganisms into the peritoneum from other bodies. Chronic peritonitis, basically, is specific-tuberculosis, parazitarnyj, kankroznyj, ascites-peritonitis.

**Classification**.

(I). On clinical flow-acute and chronic.

II. the nature of penetration of microflora in the abdominal cavity.

A. Primary peritonitis, where infection enters hematogenic osteomyelitis, limfogennym, or through the fallopian tubes (rare, about 1% of cases).

B. Secondary peritonitis is caused by the penetration of microflora due to acute surgical diseases or injuries of the abdomen, we differentiate between:

-infectious-inflammatory peritonitis, which is a consequence of abdominal disease ([acute appendicitis](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fappendicit.htm), [acute cholecystitis](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fholecistit.htm),[acute intestinal obstruction](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fkishechnaya_neprohodimost.htm), [acute pancreatitis](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fpankreatit.htm), pulmonary vascular mezenterialnah, diverticulitis, intestinal tumors, Gynecologic diseases);

-perforativnyj peritonitis, which develops due to [perforating ulcers of stomach and duodenum](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fhirurgiya_zheludka.htm), and similarly, ulcers and bowel rest (tifoznogo, dizenterijnogo, o.r., cancer and any other origin); When [obturative intestinal obstruction](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fkishechnaya_neprohodimost.htm), with foreign bodies of the gastrointestinal tract; [stranguljacionnoj furrow when bowel obstruction](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fkishechnaya_neprohodimost.htm), [herniorrhaphy abuses](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Fgrizhi.htm); plot of necrosis due to gut thromboembolism mezenterialnah vessels;

-traumatic peritonitis, which develops in [open and closed abdominal injuries](https://www.microsofttranslator.com/bv.aspx?from=ru&to=en&a=http%3A%2F%2Fgarbuzenko.narod.ru%2Ftravmi.htm) with hurt and without damaging the internal organs;

-postoperative peritonitis, which occurs as a result of insolvency seams anastomoses after abdominal operations, infection of the abdominal cavity during the operation, defects of overlay ligatures on large tracts of the omentum and bryzhejki with subsequent necrosis of tissues distal to the ligature, mechanical damage of the peritoneum, it dries; hemorrhage in the abdomen with low free safe gemostaze.

C. tertiary peritonitis, (1-5%) -progressive, slow, persistent, is a consequence of weakening mechanisms anergicheskogo response. Its progressive course called, typically, for the following reasons:

• immunosuppression,

• refrakterny endotoxicosis,

• multiple organ dysfunction.

III. On microbiological characteristics.

1. Microbial (bacterial) peritonitis:

-baby, caused by the microflora of the gastrointestinal tract;

-specific is caused by germline, unrelated to the gastro-intestinal tract (gonokocchi, pnevmokocchi, hemolytic Streptococcus, Mycobacteria tuberculosis).

2. Aseptic-is the result of exposure to toxic agents and enzyme peritoneum of noninfectious origin (blood, zhjolch, gastric juice, hiljoznaja liquid, pancreatic juice).

3. a special form of peritonitis (kanceromatoznyj, parazitarnyj, Rheumatoid, treatment).

IV. the nature of peritoneal exudate:

-serous;

-fibrinous;

-meningitis;

-bloody.

V. on the nature of the defeat of the surface of the peritoneum.

1. local-no more than two anatomic areas:

-Limited (abscess or inflammatory infiltrate);

-unlimited.

2. Common-more than two anatomic areas.

VI. the phases of development.

|  |  |
| --- | --- |
| **Ym Lopukhin V.s. Saveliev**  **Phase:** | **K. Simonyan, 1971**  **Phase:** |
| 1. no signs  sepsis | 1. Reactive (first, 12:00 am 12:00 for perforativnogo peritonitis) |
| 2. Sepsis | 2. Toxic (24-72 h., 12-24 h. for perforativnogo peritonitis) |
| 3. Severe sepsis (presence of multiple organ failure) | 3. Terminal (over 72 hours, more than 12:00 am for perforativnogo peritonitis) |
| 4. Septic (infectious and toxic) shock |

**The clinical picture** . During peritonitis emit 4 clinical phase:

1. no signs of sepsis, reactive phase (12-24 hours)-maximum local manifestations and the reaction of the simpatadrenalovoj system of the body (primarily pain);

2. Sepsis, toxic phase (24-72 hours)-stihanie local manifestations, the prevalence of common symptoms of intoxication;

3. severe sepsis (over 72 hours) is the presence of multiple organ failure.

4. Septic (infectious and toxic) shock, Terminal phase is irreversible decompensation of the vital functions of the organism.

It is considered that brjushinnyj cover area is approximately equal to the human skin cover. Therefore, developing in the abdominal cavity of Pyo-inflammatory process quickly leads to flood the body with toxins Exo-and endogenous origin. In the pathogenesis of, regardless of the cause of peritonitis, pathogenic e. coli and dominates the cocci. Increasing intoxication leads to the defeat of the vital organs and the development of multiple organ failure: Hepatorenal, then cardiovascular and lung and in end stage lesion of the CENTRAL NERVOUS SYSTEM. Diagnosis usually presents no special difficulties. Set the nearest cause disease (original peritonitis) and then identifies peritoneal symptoms: 1. abdominal pain, 2. abdominal muscle tension and positive symptom Schetkina-Bljumberga, 3. nausea and vomiting, 4. increased body temperature, etc.

If the reactive stage prevails pain syndrome and protective voltage abdominals, the toxic stage these symptoms are less pronounced, but increasing tachycardia, nausea, vomiting, bowel paresis and bloating, febrile morbidity. In the terminal stages of peritonitis symptoms of toxic lesions of CNS-consciences oppressed pointy, facial features. The pulse deficit amid tachycardia, reduction in blood pressure. Significantly, no swollen belly peristalsis of the intestine (symptom of "absolute silence). In laboratory studies of blood detected growing Leukocytosis, which can then change or lakopenia, indicating exhaustion protective forces of the organism, there has been a significant toxic lejkoformuly shift left. Hypo-and desproteinemia also provide evidence of immuno-depletion of protective forces of the organism. In toxic and terminal stages of peritonitis are increasing rates of residual nitrogen. Water-electrolyte loss body leads to thickening of the blood, that the notes on the changes in coagulogram. Increasing intoxication affects the kidneys-observed trace anuria, changes in urine toxic nature. Instrumental research methods do not have any independent significance, but merely complement the main clinical picture: ECG-signs of toxic lesions of the myocardium; radiographically-identifies the Bowl Klojbera, high standing of the dome of the diaphragm and friendly effusion in pleural cavity; Ultrasonic examination of abdominal viscera (by prescription) and free abdominal cavity to detect fluid. Diagnostic laparoscopy is shown in cases of uncertainty in diagnosis.

The basic method of treatment of peritonitis is surgical. Shows how to execute a laparotomy, auditing organs of the abdominal cavity and removal of the hearth, which caused peritonitis, sanitation and drainage of the abdominal cavity, nasogastrointestinal intubation.

In the pre-and aftercare period intensive infusion, dezintoksikatsionnaya, anti-inflammatory, antibacterial therapy, including razlitom peritonitis extracorporeal detoxification methods (ULTRAVIOLET blood hemosorption, plasmapheresis, limfosorbcija, etc.). Correction is performed cardio-vascular, pulmonary, hepatic-renal failure.

In toxic and terminal stages of peritonitis symptoms pronounced, so need to differentiate peritonitis occurs rarely. In reactive stage a short time, the commonality of several symptoms determines the necessity of holding the differential diagnosis of diseases as inflammatory, inflammatory nature.

**Differential diagnosis.**

Differential diagnosis of peritonitis is conducted with urolithiasis, acute pancreatitis, acute ileus, complicated by peptic ulcer and 12 duodenal ulcer, impaired tubal pregnancy, haemorrhagic Diathesis, poisonings heavy metal salts.

**Urolithiasis** (renal kolica) manifested severe pain, nausea, vomiting, bowel paresis and false-positive symptom Shchyotkina-Bljumberga (psevdoperitonealnyj syndrome). However, pristupoobrazny character with the typical pain radiating into the thigh, groin, crotch, presence of dysuric phenomena lack inflammatory reaction of blood, changes in urine (jeritrociturija), renal ultrasound can help in establishing a diagnosis.

When **acute pancreatitis** you can identify some symptoms of peritonitis. But before the development of destructive pancreatitis, complicated currents of pain worn shingles nature, accompanied by painful vomiting, the temperature at the beginning of the disease remains normal. Survey identifies symptoms Kerte, Voskresensky, Mayo-Robson, Cullen,-Mondor. Help blood amylase and urinary incontinence, which increases in acute pancreatitis and is not changed when peritonitis. If ULTRASOUND detected changes in pancreatic jehostruktury effusion in stuffing the bag.

Acute **intestinal mechanical occlusion** clinically different from peritonitis is only in its early stages. Pain initially strong (the so-called "ileusnyj Creek") are shvatkoobraznyj in nature, and when peritonitis permanent. Peristalsis in acute intestinal obstruction first reinforced, defined symptoms Valya, hose, Kivulja, "succussion" Sklyarov. Radiographically detected Bowl Klojbera, a symptom of the "organ pipes", passage of barium slowed down. Subsequently, in the absence of adequate treatment, necrosis and perforation of intestine joins peritonitis.

In acute **gastroduodenal ulcers**, particularly major kalleznyh, penetrirujushhih ulcers can occur pretty intense abdominal pain, some protective muscle tension. However, in contrast, there are small to moderate the peritonitis pain after taking food, water or milk, bowel paresis is not observed, the temperature remains normal, non-existent or minimal changes in laboratory indices of blood. ESOPHAGOGASTRODUODENOSCOPY or barium stomach x-rays confirm the presence of ulcers of the stomach or duodenum 12 (symptom of "niche").

Acute **violation of mezenterialnogo circulation** occurs suddenly without any previous inflammatory reactions and is characterized by initially severe pain in the abdomen. Draws the attention of the pulse irregular, expressed in the history of rheumatic heart diseases or post-infarction etiology. Analyses of blood, the sharp shift giperlejkocitoz notes lejkoformuly, coagulogram changes left. In a subsequent join peritoneal phenomenon. Significant assistance is provided by the early holding of diagnostic laparoscopy.

When **disturbed tubal pregnancy** bleeding occurs in the abdomen, accompanied by signs of acute blood loss: tachycardia, falling blood pressure, collapse and severely caused pain in the abdomen. Symptom Schetkina-Bljumberga missing first, abdominal wall remains soft, characteristic symptom "Vanki-vstanki", i.e. the impossibility of inspecting the patient lying on his back due to increased pain. History of taped delayed menstrual cycle. Diagnosis allows ultrasound, needling the rear body of the vagina in which blood is detected.

**Hemorrhagic Diathesis** (Shenlejn-Genoha) is manifested mainly in young age. There are multiple bleeding under the skin, mucous and serous, including the peritoneum. As a consequence, the occurs pain syndrome. However, there is no history of inflammatory disease. Analyses of blood there is no inflammatory changes and thrombocytopenia. In doubtful cases helps laparoscopy.

In cases of **poisoning by heavy metal salts** may experience strong pristupoobraznaya abdominal pain and even protective tension of the abdominal wall. However, there is no nausea, vomiting, a symptom of Schetkina-Bljumberga is negative. Anamnesticheski detects contact with industrial poisonous substances. Body temperature is normal. In the analysis of blood no inflammatory reaction.

**Test questions**:

1. What are the classification of peritonitis

2. List the clinical symptoms of peritonitis, depending on the stage of the tide.

3. Name of laboratory and instrumental research methods applied to differential diagnosis of peritonitis.

4. List the diseases to differentiate peritonitis.

**Tests for self-control**:

For widespread peritonitis is typical: 4

1. the ring of pain

2. multiple uncontrollable vomiting

3. frequent painful urination

4. symptom Schetkina-Bljumberga

5. Melena

In the terminal stages of peritonitis not typical: 2

1. General dire condition

2. increased peristalsis

3. severe intoxication

4. Hippocratic face

5. bloating

Peritonitis is a complication of all diseases except: 5

1. acute appendicitis

2. acute intestinal obstruction

3. broken ectopic pregnancy

4. acute pancreatitis

5. stenosis papilla

To diagnose abscess Douglas space optimal method is: 3

1. Abdominal ultrasound

2. diagnostic laparoscopy

3. digital rectal

4. radiography of abdominal cavity

5. clinical analysis of blood

**HYDATID DISEASE OF LIVER**

**Theoretical reference.**

**Classification of the**two forms. liver hydatidosis: kistoznuju (gidatidoznuju) and alveolar. Cystic form of the disease represents a bubble stage worm Echinococcus granulosus. alveolar cyst is caused by cestoda Echinococcus multilocularus. Clinical classification of hydatidosis (L.v. Melnikov) highlights: starting (asymptomatic) stage, the second stage is the third stage of clinical manifestations, complications.

**The clinical picture**. Development of the cyst goes very slowly over many years. When gidatidoznoj the form of cyst is formed that contains increases, child and grandchild even bubbles. When alveolar jehinokokkoze liver formed multiple separate small cysts, sprouting in liver tissue possessing the exogenous growth and resembling a malignant tumor.

The clinical picture of liver hydatidosis manifests itself slowly and is determined by the phases of the disease.

The first phase (initial, asymptomatic) lasts since hitting onkosfery in the liver before the first clinical manifestations of the disease. Its duration varies and sometimes it takes a few years. The cyst is located inside the liver, is small, so its very difficult to detect. Disease is discovered secretly and usually accidental. However, children indicated a slowing of physical development, nervousness, increased Allergic sensitivity.

The second stage of clinical manifestations, is characterized by various symptoms. The cyst reaches a considerable size, noted its rapid increase, which leads to pererastjazheniju glissonovoj capsules. Sick note dull pain, heaviness, pressure, tightness in the right podreberie, podlojecna area or in the lower part of the thorax. This is often accompanied by weakness, malaise, decreased appetite, pohudaniem, shortness of breath, periodically there are allergic reactions in the form of hives, nausea, vomiting. Detected an increase in the size of the liver, often right-wing divisions or all sizes with multiple cysts. Is sometimes bulging ventral wall deformation of costal arch and rib like hump. The liver by palpation dense, on its surface are detected education hemispherical shape. Less defined symptom fluctuations. In some cases, when pokolachivanii over the cyst symptom of "gidatid shake is detected. When alveolar jehinokokkoze in the stage of clinical manifestations is determined in the liver, is found very tight education site (symptom Lyubimov). Patients expressed discomfort. Bespokit pressure epigastralna area disappears appetite appear allergic reactions in the form of itching, rashes, sometimes appears transient jaundice. It is noted in the study of blood Eosinophilia (12-25%), the reaction of agglutination LaTeX with jehinokokkovym Antigen positive. When the liver ULTRASOUND determined by cystic liver parenchyma of education.

The third stage is characterized by various complications complications hydatidosis. The most common of these is the festering cysts (15-34%) of patients suddenly appear strong pain in the cyst. By palpation of the anterior abdominal wall indicated a sharp pain in the right podreberie. Temperature rises to 40° c, takes hectic nature. Rapidly growing phenomenon of intoxication accompanied by chills and drenching sweat. Sepsis may develop in the future. Possible breakthrough in abdominal abscess, thoracic cavity or retroperitoneal space. In rare cases, nagnoivshajasja cyst is emptied in one of the neighbouring hollow organs or outside.

Very serious complication is a breakthrough jehinokokkovoj cysts in the abdomen, which can cause anaphylactic shock and its dissemination. With the breakthrough of cysts in the jelchevforodaschie occurs an acute attack of pain in the right podreberie as priholedoholitiaze with obstructive jaundice. Alveolar hydatidosis complications may be mechanical jaundice, portal hypertension, germination in neighbouring authorities-in the diaphragm and lungs, the formation of bile-bronchial fistula. Alveolar Echinococcus like a cancer metastasizes, i.e. germ wraps in other organs.

Diagnosis of hepatic hydatidosis is based on clinical, radiological and laboratory data and special research methods. Along with Eosinophilia and ESR should attach importance to immunological research, Latex Agglutination, indirect haemagglutination and double diffusion in agar gel. The big diagnostic value have computed tomography and ultrasound, therefore significance of laboratory diagnostic methods has lost its former importance.

**Differential diagnosis**.

Differential diagnosis of hepatic hydatidosis is based on a comprehensive survey of the patient with diseases such as cirrhosis, benign liver tumors (Hemangioma, hepatoma), as well as malignant primary and metastatic , non-parasitic cystic lesion of the liver, liver abscesses.

Liver cirrhosis accompanied by an increase in her presence of jaundice, ascites. The data are used in the diagnosis of blood biochemical research, ultrasound, laparoscopy.

You must exclude the liver enlargement in gummoznoj stage of syphilis. However, when the liver has syphilis expressed diarrhoeal phenomenon: digestive disorders, there are weight loss, pain in the liver, back, shoulders. The liver and AIDS in contrast to cyst unevenly through the hilly gumm. Other signs of tertiary syphilis (Wasserman reaction) allow you to eliminate this disease.

Liver cancer-a disease that occurs quite often. Differential diagnosis between liver cancer and hydatidosis its difficult. Primary liver cancer often develops against the background of cirrhosis of the liver. Liver cancer are observed: a sharp decline in body weight, pain in the right hypochondrium, nausea, vomiting, jaundice, anemia is often observed. Finally, when liver cancer is determined by the liver, the liver is enlarged, irregular, painful nodular.

Metastatic liver cancer occurs through skidding of Portal Vienna atypical cells of uterine tumor ". Often metastasises to the liver stomach cancer, colorectal cancer. Perhaps direct germination in liver cancer stomach cancer transverse colon.

Differential diagnosis of hepatic hydatidosis gidatidoznogo and alveolar hydatidosis is based on the characteristic of alveokokkoza clinical picture is the presence of the Rocky site density in liver, frequent complication of jaundice, Portal Hypertension Education zhelchnobronhialnyh fistula.

Chronic calculous cholecystitis and gall bladder hydrops-excluded downstream disease, its development, clinical manifestations, survey (ultrasound). The absence of symptoms of hydatidosis-eozinofilia, negative serological samples-exclude jehinokokkovoe liver. ULTRASOUND data confirm the presence of stones in the gallbladder.

In some cases, hydronephrosis simulates picture hydatidosis, but intravenous urography, renal ultrasound, CT exclude liver damage.

When obscure diagnosis laparoscopy should be performed with the subsequent biopsy.

**Test questions**:

1. Specify the path of the invasion of the parasite in the human liver.

2. List the stages of development of liver hydatidosis.

3. List of diseases, which should be the differential diagnosis of liver hydatidosis.

4. What are the most informative diagnostic methods for liver hydatidosis.

5.

**Tests for self-control**:

For differential diagnosis in a patient with surround formation in the liver, you must perform: 3.4

1. laparoscopy

2. kavagrafiju

3. ULTRASOUND

4. CT

5. aortografiju

Sick 42 years worried about moderate pain in the right podreberie, mounting in a vertical position. Notes the similar symptoms a few years. Sick yourself identified tumorous formation in the right abdomen. Select a disease to which consideration should be given first and foremost: 3

1. cholecystitis

2. liver cancer

3. liver cyst

4. pancreatic cyst

5. right kidney cyst

Liver Hydatid disease is suspected, the following laboratory methods of examination should be used to confirm the diagnosis: 3, 4, 5

1. biochemical blood analysis

2. General blood analysis

3. Latex Agglutination reaction with Antigen

4. indirect gemaggljutinaciju

5. Kaconi reaction

6. Wasserman reaction

Select the complications arising in the liver jehinokokkoze: 1, 5, 6

1. infection of liver cysts

2. intra-abdominal bleeding

3. pleural empyema

4. pericarditis

5. break of parasitic cysts

6. mechanical jaundice

Patient 27 years during examinations with ULTRASOUND of the liver revealed the Cystic formation shaped mustard pot see. Specify additional study methods to be applied for establishing a definitive diagnosis: 1.7

1. computer tomography

2. x-ray examination of gastric

3. reogepatografiju

4. scintigrafiju liver

5. splenoportografiju

6. puncture biopsy of liver

7. laparoscopy

**DISEASES OF THE COLON**

**Theoretical reference.**

**ULCERATIVE COLITIS**

Ulcerative colitis is a Chronic Ulcerative process with the development of ulcer-necrotic changes in the mucosa of the rectum and colon. The disease is associated with the sensibilizaciej of the body and the development of the autoimmune reaction.

**Classification**.

(I). The length of the lesion:

1. distal colitis (proctitis or proctosigmoiditis);

2. left-sided colitis

3. total colitis

II. Severity:

1. light

2. moderate

3. heavy

III. Form of the disease:

1. lightning (usually fatal)

2. acute

3. chronic relapsing

4. continuous (with appropriate treatment, exacerbation of more than 6 months)

(IV) .: Phase

1. aggravation

2. remission

(V) Complications:

1. acute toxic dilation of the colon

2. colon perforation

3. massive intestinal bleeding

4. colon cancer

**The clinical picture** Lightning and severe forms. characterized by diarrhea (up to 40 times per day) with blood and mucus, sometimes pus, severe pain around belly, tenezmami, high temperature body. The patient's condition is grave. Mortality reaches 20%. the chronic relapsing form is characterized by the change of periods of exacerbations and remissions, and periods of remission may reach several years. In chronic continuous form of ulcerative colitis began desperately, slowly, without response, gradually progresses.

For any form of nonspecific ulcerative colitis is characterized by anemia. On examination, the patient is noteworthy in the liver. Severe process accompanied by who had hypoalbuminaemia. Notes the dehydration and hypokalemia. Instrumental Diagnostics methods: sigmoidoscopy, barium enema, colonoscopy.

**DIVERTICULAR DISEASE OF THE COLON**

The disease typically occurs after the age of 40 years. Most often the diverticula are located in the sigmoid colon and the left half of the colon.

**Classification**.

1. Diverticulosis of colon without clinical manifestations

2. Diverticulosis with clinical manifestations

3. Diverticulosis with complicated passage:

and diverticulitis)

b) perf

in the) bleeding

g) ileus

d) internal or (less often) external intestinal fistula

**The clinical picture**. When diverticuli are marked with pain in the abdomen, unstable chair, decreased appetite, nausea. Palpation of the abdomen in the affected area is hurting. Subfebrile temperature may be. In the blood-Leukocytosis. When perforation diverticulum develops a picture of peritonitis. Other complications of diverticulitis are: abscess, Phlegmon retroperitoneal space, internal fistula, peritoneal commissures and intestinal bleeding. Instrumental Diagnostics: barium enema, colonoscopy.

**POLYPOSIS OF THE COLON**

Among all patients with proctologic polyps detected at% 10-12. Men get sick in 2-3 times more often than women.

**Classification**.

1. Prevalence:

a) single

b) multiple

diffuse)

2. On morphological characteristics:

and glandular)

b) ferruginous villous

villous)

g) hyperplastic

d) juvenile

e) fibrous

f) psevdopolipoz

**The clinical picture**. Solitary polyps sometimes occur asymptomatically, or are the cause of complaints from patients in selecting blood and mucus from the rectum, pain in the abdomen, constipation, diarrhea, intestinal discomfort. These symptoms are not patognomonichnymi for polyps, therefore, to identify their needs to use rectoromanoscopy, colonoscopy, irrigoscopy. Polyp biopsy is needed to determine the histological structure of polyps, the presence or absence of malignancy.

**COLON CANCER**

Colon cancer usually strikes older people.

**Classification**

Growth pattern:

1. The right half is exophytic segmental

2. The left half-circular jendofitnyj

Stage of development:

stage 1-the tumor is localized in slizistom or podslizistom. There are no metastases.

2 stage:

A. the tumor takes less polokruzhnosti, does not go beyond the walls of the colon. There are no metastases.

B. the same size Tumor with single metastases in the nearest lymph nodes.

stage 3:

A. the tumor takes more than guts, polokruzhnosti grows its entire wall or adjoining the peritoneum, without regional metastases

B. a tumor of any size in the presence of multiple metastases in regional lymph nodes

stage 4-extensive tumor, germinating in neighbouring authorities with multiple metastases, or any tumor with distant metastasis.

International classification for TNM

T-primary tumor

T is -carcinoma in situ

T1 -tumor grows in the submucosal layer

T2 -tumor grows in the muscular layer

T3 -tumor grows subseroznyj layer

T4 -direct tumor invasion to adjacent organs or germination of visceral peritoneum

(N) -regional lymph nodes

(N) 0 -metastases not identified

(N) 1 -there are metastases in lymph nodes 1-3

(N) 2 -metastases in 4 or more lymph nodes

M-distant metastasis

M0 -no distant metastasis

M1 -there are distant metastases

**The clinical picture**. Depending on the location of the tumor, its size, shape, growth and presence of complications following a form of clinical course of colonic cancer: Toxico-anemicheskuju, jenterokoliticheskuju, dispepticheskuju, obturacionnuju, psevdovospalitelnuju and opuholevidnuju. In a survey of patient should attach great importance to dispepticheskim phenomena, complaints of blunt abdominal pain, intestinal disorders. Pay attention to paleness, weight loss. Digital rectal investigation is necessary for determining the existence of metastases in the pelvic tissue. Colonoscopy allows you to determine the tumor location and take a biopsy. Irrigoscopy complements data kolonoskopicheskogo study.

**Differential diagnosis of diseases of the colon**. The clinical picture of diseases such as colon, ulcerative colitis, diverticulosis, polyps and colon cancer characterized by the pathological secretions.

Ulcerative colitis as opposed divertikuleza manifested fever expressed intoxication during exacerbation. When rectoromanoscopy visible swelling and bleeding of the colon mucosa in the bowel lumen-mucus, pus, blood. Ulcerative colitis is a precancerous condition. Cancer occurs in 40% of patients through 10-20 years from the onset of the disease. Colonoscopy with biopsy allows to conduct the final differential diagnosis.

Colonic polyposis manifests similar symptoms with divertikulami, but unlike them can be accompanied by constipation. Some forms of polyps malignizirujut very frequently (up to 100%) and biopsy data make it possible to establish a definitive diagnosis.

Differential diagnostic signs of diseases of large intestine is presented in table.

Table

|  |  |  |  |
| --- | --- | --- | --- |
| Disease | Signs | | |
| x-ray | Endoscopic | pathological  selection |
| Diverticulosis | Round, oval-shaped protrusion are neck, body, there is asymmetry, pathological gaustr segmentation, spasm, serrated outline | Spasm, rough, high, frequent folds in the form of cavities, mucous membrane in the field of cervical diverticulum round form, when complications around the swelling, hyperemia | Bleeding, rare massive |
| Swelling of the colon  gut | A short segment, narrowing, gut near the tumor is not changed, filling defect | Constriction, rigidity, violation of the folds in the area, near mucous tumors is not changed | Frequently repeated, rarely flationary pressures as Nye |
| Nespecifiches  cue ulcerative colitis | Sawtooth form intestinal symptoms, uniformly grained relief mucous membrane bowel trubkoobraznoe dual circuit contraction | Contact bleeding, absence of vascular pattern, swelling, hyperemia mucous membranes  psevdopolipy, multiple ulcers | Krovjanisto-purulent discharge,  slime |
| Polyps | Multiple defects resemble the honeycomb education | Different sizes and colors of education, sometimes pedunculated | Mucus, sometimes  blood |

**Test questions**:

1. What are the main clinical symptoms of nonspecific ulcerative colitis.

2. Specify the clinical signs of diverticulitis.

3. List the major clinical signs of colon polyposis.

4. What are the basic instrumental methods of diagnosis of cancer of the colon.

5. Name instrumental methods of diagnosing diverticulitis.

6. Specify methods for diagnosis of diseases of the colon, which are currently the most informative.

**Tests for self-control**:

Ulcerative colitis should be differentiated with the following diseases: 1) dysentery; 2) colorectal cancer; 3) prostatitis; 4) Crohn's disease. Select the correct combination of replies: 5

1) 1, 2, 3

2) 2.3

3) 3.4

4) 1, 3, 4

5) 1, 2, 4

To complications divertikuleza not include: 5

1. diverticulitis

2. bleeding

3. Perforation

4. fistula

5. malignant transformation

The main clinical manifestations of cancer recto-sigmoidnogo Division of the rectum are: 1, 2, 3

1. the clinical picture of intestinal obstruction

2. bleeding

3. tenesmus

4. weight loss

5. pain during defecation

Note the most reliable of these techniques in the diagnosis of

colon cancer: 3.5

1. laparoscopy

2. selective angiography

3. barium enema

4. scanning of liver

5. colonoscopy with biopsy

Select the most informative method of roentgenologic examination colon cancer: 3

1. survey radiography of abdominal cavity

2. study passage kishechniku

3. barium enema;

4. pnevmoperitoneum;

5. selective angiography

**DISEASES OF THE RECTUM**

**Theoretical reference.**

**Classification of** diseases of rectum:

1. acute paraproctitis

a) subcutaneous; b) submucosal; ) ishiorektalnyj; g) pelviorektalnyj; d) retrorektalnyj.

2. Chronic paraproctitis (fistulas)-a) intrasfinkternyj; b) transsfinkternyj; ) jekstrasfinkternyj. As well as on the basis of anatomicheskomu-full, partial, external, internal.

3. Hemorrhoidal disease (hemorrhoids): a) internal; b) outer; in).

4. Butt plugs cracks.

5. tumors of the rectum: a) Benign; b) malignant.

**The clinical picture**. Acute paraproctitis-acute purulent-inflammatory process in parirectal fat tissue. Common cause is acute kriptit abscess with a breakthrough in one of kletchatochnyh pararectal spaces. Secrete in localization: subcutaneous, submucosal, ishiorektalnyj, pelviorektalnyj and retrorektalnyj paraproctitis. Main symptoms of acute paraproctitis are: pain, enhancing the overall and local temperature, "stulobojazn". In stage infiltration sick very rarely bring to the surgeon. Should take into account the high propensity to abscedirovaniju due to continuous infection of the rectum. Inadequate treatment or self-medication quite often lead to the development of subsequent chronic paraproctitis.

Chronic paraproctitis clinically manifested by the formation of complex fistular passages between the rectum and the perineal area. Factors of its development are: inadequate treatment of acute perianal abscess, most often his autopsy of small incision and insufficient drainage of abscess kriptogennogo; complex multilevel character of purulent cavities, significantly impairing its adequate audit; heavy related diseases (diabetes, immune deficiency of primary and secondary measures, oncological diseases). Emit: complete and incomplete, intrasfinkternye, jekstrasfinkternye and transsfinkternye fistula.

In the diagnosis of paraproktitov it is necessary to apply the digital rectal, anoskopiju, sigmoidoscopy, fistulografiju.

**Differential diagnosis.**

Differential diagnosis should be made between existing in the classification of diseases, as well as with abscedirujushhimi furunkulami and Perianal area, karbunkulami sharp bartolinitom abscess, pelvic and prostate cancer, epithelial kopchikovym way.

**Abscedirujushhie boils and Carbuncles** perianal area similar in clinical manifestations with subcutaneous form of acute paraproctitis presence of fever, sudden pulsating pain in the perineum, the presence of inflammatory perianalnogo infiltration. Distinguishes these diseases inflammatory infiltrate appearance having strictly superficial localization in the Centre of one or multiple necrotic cores. When digital rectal study infiltration with boils and nausea with the wall of the rectum is not connected. Clarify diagnosis helps abscessografija or introduction to cavity abscess coloring mixture (4% solution indigokarmina) verifying the presence or absence of connection with the opening of the rectum.

**Acute bartholinitis** under abscedirovanija also may resemble acute paraproctitis. When bartolinite abscedirovanie occurs on 7-10 day from the onset of the disease, and acute paraproctitis 2-3 days later. For bartolinita not typical violation of defecation, and for acute paraproctitis this phenomenon typically. Upon careful inspection at bartolinite almost always seen on the eve of the opening of the vagina hole bartolinievoj ductless gland from which at pressing on infiltration, pus comes, there is no connection to kriptami anus channel. In doubtful cases apply diagnostic tests with the introduction of a methylene blue abscess cavity and swab into your rectum is staining the tampon Blue will testify about an abscess cavity with the opening of the rectum.

**Pelvic Abscesses** (Douglas) occur mainly in the postoperative period in patients undergoing generalized peritonitis after 7-14 days after surgery. When the hearth is located in front of the thecal wall of the rectum is not associated with kriptami, mucous all over it is not changed, unsteady. In diagnosis helps a rectal examination, ultrasound of the pelvis.

**Prostate Abscess** is a complication of acute prostatitis, develops depending on the treatment on the 7-16 day of the disease. From acute paraproctitis differs sharp phenomena pollakiurii until infrarenalnoj anurii due to compression of the prostatic part of the urethra, piuriej in the urine, which does not happen with acute paraproctitis. Rectal digital study allows thorough increased sharply painful, the prostate gland with a softening. When an ULTRASOUND rectal abscess cavity is rendered sensor, installed its relationship with the surrounding structures.

**Hemorrhoidal disease** (hemorrhoids)-primary varicose cavernous transformation Taurus outside and inside of the sphincter, can complicate development: phlebitis haemorrhoid, its infringement, cracks, colorectal and acute paraproctitis, Cryptitis chronic anemia as a result of frequent blood loss. Secondary varicose venous cavernous Plexus colorectal area is a sign of portal hypertension. In so doing, characterized by the presence of voltage in the other portokavalnyh anastomoses-anterior abdominal wall ("head of Medusa"), esophageal-cardiac zones, presence of jaundice, ascites.

**Epithelial coccygeal passage** -skin abnormality of sacrococcygeal region caused vtjazheniem skin as a result of the incomplete reduction of former tail muscles. Ulcers are formed in the surrounding tissue, are not associated with the sacrum and tailbone. The transition of the acute phase of inflammation after opening the abscess, characterized by the formation of external fistula, which is not associated with the Colorectal area. In complex cases, dubious uses fistulography.

Benign **rectal polyps** have a similar appearance with gemorroidalnymi nodes, but they appear randomly and with haemorrhoids in typical locations on 3, 7, 11 hours. Palpation is not spadajutsja and not increasing. When the slightest doubts in favor of benign Neoplasms used rectoscopy with biopsy.

**Butt plugs cracks** are more common in women, in 90% of cases are located on the back wall of the anus the Canal. Clinically it is characterized by strong painful pains, stulobojaznju. Digital research impossible due to soreness. When anoskopii is defined by the streak-wall defect anus the Canal and "watchdog" bump on the bottom of its edges.

Colorectal cancer occurs in the mucosa of the colon wall deep is growing and its circumference, clinically characterized by long bessismptomnym (painless). Pain develops during germination of a tumour of a zone rich in nerve endings or in connection with the development of acute obturative intestinal obstruction. An early symptom is the presence of pathological secretions. Anemizacija patients develops gradually. In accordance with the principles of cancer awareness diagnosis should be based on screening examination: digital rectal examination, rectoscopy with biopsy of suspicious origin. During the disintegration of the tumor may accession of purulent-septic complications, education kankroznyh and parakankroznyh abscesses and fistulas.

**Test questions**:

1. What are the classification of diseases of the rectum.

2. List instrumental Diagnostics methods applied at proctologic patients.

3. What are the clinical signs of acute paraproctitis.

4. Spend the differential diagnosis of chronic paraproctitis from colorectal cancer.

**Tests for self-control**:

Cause tolstokishechnogo bleeding most often is: 4

1. invaginacija

2. dysentery

3. polyps

4. hemorrhoids

5. cancer

The first diagnostic admission with suspected disease of the rectum is: 3

1. radiography

2. sigmoidoscopy

3. digital rectal examination

4. ULTRASOUND

5. medical history

Hemorrhoids not typical: 5

1. bleeding

2. drop sites

3. itching

4. flebit node

5. Melena

In case of rectal cancer in the first place, you need to perform: 3

1. ESOPHAGOGASTRODUODENOSCOPY

2. ULTRASOUND EXAMINATION of abdominal cavity organs

3. sigmoidoscopy with biopsy

4. digital rectal examination

5. laparoscopy

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