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Simultaneous Operations in Gynecology and Surgery in Women of Reproductive Age

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Abstract The presented work presents the concept of simultaneous operations, a review of domestic and foreign literature on the problems of performing simultaneous operations in gynecology - issues of terminology, classification, features of performing combined operations when combining gynecological diseases with another surgical pathology.

Key words: *simultaneous operations, gynecology, surgery.*

Introduction

Simultaneous (combined, one-step) operations are operations in which up to five different surgical procedures are performed simultaneously during one surgical intervention. Most often, such operations are found in general surgery, gynecology, vascular and plastic surgery. The main advantage is the ability to reduce the burden on the patient's body, reduce the time of treatment and recovery. In some cases, such operations are not the surgeon's choice, but are dictated by the need, for example, in traumatology or in complex lesions.

Benefits of Simultaneous Operations

• Reducing the number of hours under general anesthesia. No matter how gentle the anesthesia is, it does not pass without leaving a trace for the body, in particular, for the vessels and the brain. Also, according to patient surveys, the most stressful moment of surgical intervention is precisely anesthesia.

• Possibility of simultaneous treatment of gynecological, surgical and urological pathology. For example, the simultaneous removal of the gallbladder and the treatment of gynecological diseases.

• Saving time. The recovery period after surgery is on average from a day to 10. One-stage operations allows the patient to reduce the total time spent in the hospital.

• Cost savings. In the case of surgical interventions in a paid clinic, simultaneous operations can significantly reduce the total cost of treatment.

• Psychological comfort. For the patient, a simultaneous operation is perceived as one surgical intervention, which significantly reduces the stress and anxiety levels before and after the operation.

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Simultaneous operations in surgery

Simultaneous (simultaneous, combined) operations are surgical interventions, during which several procedures are performed at once. Combined operations can solve several health problems at once. According to WHO statistics, about a third of all surgical patients need simultaneous operations.

Indications and benefits

Simultaneous operations are shown to the patient in the case when several pathologies are found in him at once, requiring surgical treatment.

The main advantage of a simultaneous operation is to minimize the negative consequences of anesthesia. Since in the course of one session it is possible to treat several pathologies at once, the load on the body decreases, the area of influence and the degree of tissue trauma decreases, and it is also possible to avoid a repeated recovery period. And modern surgical equipment, the use of laparoscopic methods with low-traumatic access and the professionalism of surgeons make it possible to achieve the maximum efficiency of the operation.

Carrying out a one-step surgical intervention can reduce the patient's stress caused by the fear of surgery and anesthesia. And it will also reduce the cost of treatment, since there will be no need to undergo preoperative preparation several times, pay for repeated anesthesia and hospital stay.

Contraindications and disadvantages

Before the intervention, the patient must undergo preoperative preparation. It is necessary for the doctor to get a complete picture of the patient's health and to be able to make an informed decision about the possibility of carrying out simultaneous surgical interventions.

Whether the patient's body is ready for anesthesia depends on the presence of chronic diseases and the general state of health of the patient. Unfortunately, for some diseases, long-term anesthesia is not recommended.

Preparation for a simultane surgery

Preoperative preparation for a simultaneous operation includes the following examinations:
• blood tests (general, biochemical, coagulogram, tests for hepatitis, syphilis, HIV);
• general urine analysis;
• ECG;
• fluorography.

The general list of procedures depends on the history and medical history of the patient. Also, during preparation for the operation, the patient will discuss with the surgeon all the features of the upcoming operation, the doctor will tell you about all the risks and answer your questions. In addition, the patient will have a consultation with an anesthesiologist. The specialist will select the most effective and safest type of anesthesia.

In recent years, in the provision of gynecological care to patients, in addition to purely medical aspects, much attention has been paid to the intensification of the work of gynecological hospitals, the rational use of beds, reducing economic costs, and expanding the volume of surgical interventions. Due to the increase in the life expectancy of women, the improvement of diagnostic technologies, there has been a tendency for an increase in the number of patients with 2–3 concomitant surgical diseases.

The presence of combined surgical and gynecological diseases in many patients, which,

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according to the WHO, account for 20-30%, poses the task of simultaneous correction of this pathology for surgeons and gynecologists. An increase in the effectiveness of treatment of gynecological patients requiring surgical intervention, if they have a combined surgical pathology, is achieved by performing simultaneous operations. The use of combined operating approaches (laparotomic / laparoscopic, hysteroscopic, vaginal) in the surgical treatment of patients with combined gynecological and surgical diseases allows eliminating all identified surgical pathology within the framework of one anesthetic aid, eliminates reoperations and associated operating rooms, after operating surgical and anesthetic procedures. complications and emotional stress; excludes the occurrence in the early postoperative period of exacerbation of uncorrected concomitant disease, improves the quality of life of patients (physical activity, mental state, role, social and sexual functioning). However, in the scientific literature, evidence-based studies on this problem are rare, although in practice many surgeons and gynecologists note the need to perform such operations. Nevertheless, simultaneous operations are performed more often as accidental, and this is most common in emergency gynecological pathology. At the same time, a rather large percentage of postoperative complications remains, in addition, many gynecological departments are located in obstetric hospitals without surgical departments and are not ready to perform such surgical interventions. Many problems associated with performing simultaneous and combined operations in planned gynecology also remain unresolved. These include issues related to the classification of simultaneous surgical interventions, the determination of indications and contraindications to them, the early diagnosis of concomitant diseases at the preoperative stage, the choice of the surgical approach, the method and scope of the operation, the sequence of the main and simultaneous stages, the assessment of the operational and anesthetic risk, the features post-aggressive reactions in the postoperative period, the management of the postoperative period in this category of patients, as well as the socio-economic efficiency of combined surgical interventions. Further development of this problem will expand the indications for simultaneous and extended operations in gynecology, optimize the technique of their implementation and management of the postoperative period, and improve the quality of life of patients. The concept of "simultaneous operation" was introduced by M. Reiffersceid in 1971 and was first mentioned in his article "Simultaneous intervention in the abdominal cavity: surgical aspects", in the Russian-language literature this term was used by L.I. Khnokh and I.Kh. Feltshiner in 1976. The first report of the simultaneous performance of two operations dates back to 1735, when Claudius, operating on an 11-year-old child, performed appendectomy and hernia repair. In 1922 A.V. Vishnevsky was the first in the Russian literature to describe the simultaneous execution of nephropexy with appendectomy. In the former USSR, simultaneous operations were widely recognized thanks to the works of V.D. Fedorov, who developed the classification, methodology of such interventions, indications and contraindications for their implementation. The term "simultaneous" comes from the Latin word simul - "simultaneously, at the same time, together with", from the French word simultane - "simultaneous, simultaneous", eng. simultaneously - "simultaneously". Currently, under simultaneous operations is understood as a surgical intervention simultaneously performed on two or more organs for etiologically unrelated diseases. A number of authors insist on the term "combined operations", citing the fact that simultaneous operations are performed by teams of surgeons at the same time, although most researchers consider the terms "combined" and "simultaneous" operations to be

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synonymous. At the same time, the concept of simultaneous operations is still vague today: they include interventions for multiple primary malignant tumors, and radical mastectomy and oophorectomy for breast cancer, and hysterectomy and bilateral salpingectomy (which, in our opinion, is not is correct). Simultaneous operations do not include operations on two or more organs affected by one pathological process (multiple traumatic lesions, purulent-inflammatory processes, common forms of endometriosis, etc.). Combined and extended operations, the purpose of which is to increase the volume of intervention for the treatment of one disease, also cannot be equated with simultaneous operations. For the first time these terms were used by I.P. Dedkov et al. in 1975. A combined operation is the performance of two or more independent operations for different manifestations of one disease, an extended operation is an intervention in which an increase in the standard volume is due to the spread of the disease (in particular, tumor growth) to neighboring organs.

Simultaneous operations are divided into emergency and planned, the main and concomitant stages are distinguished, according to the indications, they distinguish between absolute, preventive, diagnostic and forced, according to the timing of execution - simultaneous-simultaneous operations, which are performed simultaneously by several surgical teams at a significant distance from each other of the anatomical zones that need in surgical correction, and one-step sequential, performed one after another by one or more teams in the same anatomical region. The sequence of performing simultaneous intervention is determined individually, depending on the volume, technical features of the forthcoming operations, topographic and anatomical features and the nature of pathomorphological changes in the lesions.

In connection with the widespread use of laparoscopic technologies in surgery, new opportunities are opening up in carrying out simultaneous operations. Low trauma, quick rehabilitation period, good cosmetic effect with a large volume of surgical intervention makes minimally invasive methods preferable for simultaneous operations on the organs of the upper and lower abdominal floors. In cases where a simultaneous operation includes a combination of technically complex and volumetric interventions, or one of the operations is performed in a complex anatomical area with a limited viewing ability, it is advisable to use standard puncture points for each operation separately. The use of the principle of "migrating port" in standard simultaneous interventions makes it possible to reduce the trauma of the laparoscopic approach by reducing the number of trocars used. Today, single-port simultaneous operations (cholecystectomy + hysterectomy, cholecystectomy + ovarian cystectomy) are widely introduced into clinical practice. Discussions continue about the indications and contraindications for simultaneous operations. The use of laparoscopic technologies significantly reduces the trauma of surgical intervention, which makes it possible to expand the scope of surgery in gynecological patients up to 2-3 simultaneous operations without significant damage to the patient's health. Surgical treatment for pelvic floor dysfunction is the main one. In recent years, with combined diseases of the internal genital organs and urinary disorders, surgeons prefer planned simultaneous operations using synthetic implants. Surgical correction of genital prolapse, combined with stress urinary incontinence, by means of mesh plasty of the vaginal walls using the Prolift technique and loop surgery using the TVT technique or colpourethrosuspension with threads is an effective method of treating this combined pathology. At the same time, a number of authors note that the immediate and long-term results of using synthetic implants are ambiguous and require further study. When combining genital prolapse with rectocele, many methods of surgical

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correction of the disease have also been proposed, which are aimed at eliminating the bulging of the anterior rectal wall and strengthening the rectovaginal septum using various surgical approaches (transvaginal, perineal, transanal, abdominal). The rapid development of reconstructive plastic surgery of the pelvic floor in recent years has opened up new ways to prevent postoperative relapses: the use of minimally invasive techniques, the simultaneous correction of all functional disorders of the pelvic organs, the use of modern synthetic materials for the restoration of defects in the pelvic fascia. Discussions continue about the feasibility of simultaneous reconstructive surgery for plastic surgery of the pelvic floor and plastic surgery, while some authors show that these operations increase the duration of the intervention, the number of postoperative complications and the postoperative bed-day.

If gynecological patients have varicose veins of the lower extremities, it is optimal to perform simultaneous surgical interventions, while simultaneous surgical interventions in gynecological patients with varicose veins of the lower extremities are preferable to start with an operation on the veins of the lower extremities. It was shown that simultaneous surgical intervention in women with lesions of the veins of the lower extremities in combination with gynecological pathology slightly increases the time of the operation, does not aggravate the course of the postoperative period and does not lead to an increase in the number of complications. The post-aggressive reaction after combined operations in gynecological patients with varicose veins of the lower extremities differs little from that after isolated surgical interventions. Planned combined operations in gynecological patients with varicose veins of the lower extremities are an important method of intensifying the work of a surgical hospital.

The expediency of performing simultaneous operations in gynecological oncology continues to be debated. A number of authors have shown the efficacy and safety of performing panniculectomy in patients with pelvic tumors; this intervention reduces the incidence of intraoperative complications and postoperative wound infection without significantly increasing the operation time and the volume of intraoperative blood loss, and significantly expands the volume of paraaortic lymphadenectomy in patients with endometrial cancer. The expediency and safety of performing simultaneous cholecystectomy in patients with cholelithiasis who undergo radical surgery to remove malignant gynecological tumors have been proven, J. Malfetano et al. showed that the incidence of complications associated with performing cholecystectomy in gynecological cancer patients is 2.2%.

Conclusions.

Thus, when preparing women with diseases of the pelvic organs for surgical interventions, it is necessary to expand the standard of preoperative examination for the diagnosis of combined extragenital diseases that require surgical correction. The issue of performing a planned simultaneous surgical intervention must be agreed with the patient without fail, written informed consent must be obtained for its implementation. A comparative assessment of one-stage and simultaneous operations showed that with the correct individual selection of patients with combined pathology, adequate preoperative preparation of patients, taking into account the compensatory capabilities of the body and a decrease in the degree of operational risk, an individualized choice of the method and volume of the operation, an increase in the volume of surgery does not affect the frequency after operating complications, leads to significant savings in financial resources both at the hospital and outpatient stages.

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