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SURGICAL PALLIATIVE CARE FOR GASTROINTESTINAL DISEASE

Relevance: Surgical palliativity in adhesive disease (AD) is a balance between therapeutic benefit and the risk of pulmonary embolism (PE). In modern medicine, there is a growing proportion of such interventions aimed at decompression and improving the quality of life of patients. However, venous thromboembolism [1](VTE) remains one of the most threatening complications, capable of negating surgical outcomes. Palliative patients have the highest risk of PE due to immobilization and systemic inflammation. These factors form a specific clinical context in which the prognostic value of generally accepted stratification scales (Caprini, Padua) significantly decreases, requiring a revision of diagnostic approaches. For Ukraine [2] in the period 2020–2026, the problem of palliative treatment of peritoneal adhesive disease has acquired particular urgency. This is due to the synergistic impact of the consequences of the COVID-19 pandemic and the specifics of wartime, accompanied by increased trauma, dehydration, and complex evacuation logistics. Statistical data [3] for this period indicate that intra-abdominal adhesions form in 67–93% of patients who have undergone laparotomy. About 30% of patients operated on for adhesiolysis require re-operation due to recurrence. Mortality from the consequences of adhesive disease (including acute obstruction) in complex cases can reach 30% among patients.

Objective: To define criteria for safe surgical intervention where relieving the patient's condition with adhesive disease will not lead to fatal thromboembolic complications.

Results: In palliative surgery, as in general surgery, the "gold standard" is the Caprini Scorex[4], which allows for the identification of up to 75% of cases of latent thrombosis in patients with AD. However, in the conditions of Ukraine (2020–2026), the baseline risk of PE has increased by 40–60% due to the synergy of COVID-19[5] consequences (systemic inflammation) and wartime factors (military

trauma, dehydration, prolonged evacuation immobilization). Several groups of safety criteria are identified that minimize the risk of PE during palliative intervention:

1. Patient condition • D-dimer level: If the indicator rises rapidly, intervention is extremely dangerous. • Mobility index: Complete immobility for more than 3 days is a critical risk. • Caprini score status: If the score is >8 , the risk of PE becomes critical (over 11%). • Coagulogram: Absence of signs of DIC syndrome and pronounced hypercoagulation. [6]

2. Course of the operation • Volume of aggression: Transition from total adhesiolysis to selective dissection of adhesions only in the area of obstruction. • Duration of intervention: "The 90-minute rule" (limiting the duration of intervention to 1.5–2 hours).

3. Preventive criteria (preoperative) • Preoperative preparation: Administration of low molecular weight heparins (LMWH) 12 hours before surgery. • Mechanical prophylaxis: Mandatory elastic compression of the legs (stockings or bandages) directly on the table and after surgery. • Adequate hydration: Avoiding patient dehydration, which "thickens" the blood.

4. Preventive criteria (operative) • Minimally invasive approach: Use of laparoscopy (if the adhesive process allows), which reduces the time spent in bed after surgery.

Conclusions: The modern strategy of surgical palliativity in adhesive disease in the conditions of 2020–2026 is based on recognizing the critical increase in VTE risk (by 40–60%) due to the cumulative impact of COVID-19 consequences and specific wartime factors. The main safety criterion is the transition to the concept of "surgical minimalism," which involves selective adhesiolysis only in the zone of obstruction and strict adherence to the "90-minute rule." Monitoring the dynamics of D-dimer and the mobility index is prognostically significant, where a Caprini score of over 8 serves as an indicator of marginal risk. The safety of the intervention is guaranteed only under the condition of multimodal prevention, which combines pharmacological anticoagulation, mechanical compression, and the active implementation of minimally invasive technologies to ensure early postoperative activation of the patient. Improvement of diagnostic algorithms taking these factors into account allows for the minimization of fatal thromboembolic complications, despite the high complexity of the palliative patient group.

References:

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