VERHALTENSTHERAPEUTISCHE INTERVENTIONEN IM RAHMEN MULTIMODALER SCHMERZTHERAPIE

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Bei chronischen Schmerzpatienten besteht laut aktueller Studienlage nur ein geringer statistischer Zusammenhang zwischen organischer Schädigung und wahrgenommener Schmerzstärke bzw. diesbezüglich erlebter Beeinträchtigung. Ein multimodaler Interventionsansatz hat sich in Anbetracht der Komplexität des Krankheits- und Störungsbildes als gegenwärtiger Behandlungsstandard etabliert.

Chronische Schmerzerkrankungen gehen einher mit mangelnder Befriedigung menschlicher Grundbedürfnisse. Durch fortschreitendes Schmerzleiden entsteht ein Erleben von zunehmendem Kontrollverlust über den eigenen Körper und die Weiterentwicklung individueller Lebensbedingungen. Häufige Folgen von andauernden Leistungseinschränkungen bestehen in Selbstwertzweifeln und psychosozialen Konflikten, insbesondere im Zusammenhang mit Schwierigkeiten bei der Erfüllung gewohnter sozialer Rollen.

Physiologisch fungiert Schmerz, mit einer Überaktivierung des sympathischen Nervensystems, als massiver Stressor für den Gesamtorganismus und hieraus resultierende muskuläre Verspannungszustände münden in eine teufelskreisartige sekundäre Schmerzzunahme. Auf zentralnervöser Ebene spielen im Verlauf der Schmerzchronifizierung neuroplastische Veränderungsprozesse eine bedeutsame Rolle. Durch den ständigen nozizeptiven Input entstehen neuronale Spuren mit vergrößerter Repräsentation des Schmerzgeschehens im somatosensorischen Kortex, eine Schmerzsensibilisierung und ein durch assoziative Lernprozesse zunehmend differenziertes Schmerzgedächtnis. Einerseits existiert eine Wechselwirkung zwischen aktuellem Schmerzerleben, der Schmerzbewertung sowie der Wahrnehmung von Kontrollmöglichkeiten und aufgrund der Entwicklung klassisch konditionierter Schmerzerwartungen beeinflusst der aktuelle Schmerz die zukünftige Schmerzverarbeitung. Andererseits können Verstärkungsprozesse die operante Konditionierung eines bestimmten möglicherweise maladaptiven Schmerzverhaltens bewirken.

Die moderne multimodale Schmerztherapie definiert dementsprechend Schmerz als bio-psychosoziales Phänomen mit Interventionsansätzen auf den Ebenen des Körpers, der Gedanken und Gefühle sowie des beobachtbaren Verhaltens.

USE OF ENDOSURGICAL TECHNIQUES IN THE TREATMENT OF PATIENTS WITH TUMOUR-LIKE OVARIAN FORMATIONS

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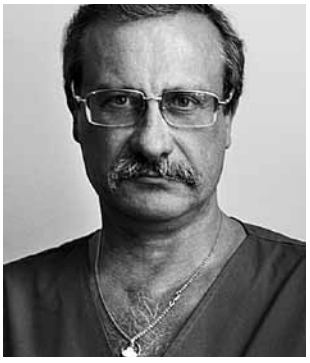

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Ovarian tumours and tumour-like ovarian formations remain one of the most urgent problems in the modern clinical medicine. In the first place, it is caused

by the incidence rate of this pathology and difficulties in the differential diagnostics between malignant and benign ovarian tumours. As D.N. Demidov and B.I Zykin point out in their work (2), ovaries of women of the reproductive age often have functional cysts, follicles and yellow bodies at different development stages.

As a rule, screening examination methods available in the wide clinical practice, e.g. abdominal rectovaginal examination and ultrasound, do not make possible to characterise a pathological process in the ovarian area according to the degree of malignancy.

For this reason, when having indistinct palpatory data and ambiguous results of echographic examinations, many authors, e.g. G.M. Savelieva (3), L.V. Adamyan et.al. (1), A.N. Strizhakov, A.I. Davydov (1991), Saksetall (1985), Bouttevilleetall (1087), are of the opinion that it is possible to use laparoscopic techniques to determine the character of ovarian tumours and surgical treatment more accurately.

In "Dr Paramonov's Clinic" we observed and treated 67 women with various tumour-like ovarian processes (class IX of the World Health Organisation Histological Classification of Ovarian Tumours, 1973) (4). The patients were between 21 and 34 years old. The average age was 26.5±2.1.

Ovarian pathology was diagnosed by means of a traditional scheme which included taking of medical history, general clinical and gynaecological examination and a series of additional procedures. In order to eliminate metastatic ovarian cancer, we examined the condition of the gastrointestinal tract by means of fibro-gastroduodenoscopy or stomach fluoroscopy, rectoromanoscopy and colonoscopy. To determine the content of the tumour marker CA^{125} in the blood serum, we used a monoclonal antibody method. During our work we used reagents and equipment by Olimpus (Japan) and SorinBiomedica (Italy). None of the examined women had any pathological changes of the gastrointestinal tract or any significant increase of the CA^{125} content.

The medical history showed that before hospitalisation 28 (41.8%) women received combined therapy in regard to ovarian inflammatory disease and 25 (37.3%) women received combined oral contraceptive pill in the course of 2–3 menstrual cycles. 14 (20.9%) patients did not receive any conservative treatment due to the fact that the tumour diameter was larger than 6 cm or because there was a strong tendency to a cyst with a twisted pedicle.

All the patients underwent a dynamic examination of small pelvis organs. We used real-time equipment SiemensSonolineVeraPro (Germany), 3.5 MHz convex and linear sensors and a 6.5 MHz intra-vaginal convex sensor. Operative laparoscopy was performed under combined endotracheal anaesthesia using standard techniques with three protocols. We used equipment by "Cabotmedical", "AutoSutricalInstruments", «Johnson & Johnson» (USA) and "Endmedium" (Kazan). Pneumoperitoneum was created by CO_2.

During laparoscopic surgery, we took a sample of the abdominal cavity contents for a further bacteriological and virologic analysis for the presence of predominantly sexually transmitted pathologic agents.

When detecting a tumour-like formation in the ovarian area, the cyst was removed without pouring the contents into the abdominal cavity, if possible.

For this purpose, the tumour-like formation was enucleated from the surrounding tissues and placed into a special rubber tank (airtight reservoirs from glove rubber). Only after this we performed a cyst aspiration with the smallest amount of the contents getting into the abdominal cavity. Monopolar and bipolar coagulation were used for the mobilisation of the formation and hemostasis.

When the ovarian pathology was combined with a significant adhesive process (in 14 –20.9% – patients), we performed adhesiostomy, fimbryolysis, uterine tubes patency recovery (salpingostomy, salpingoneostomy), usually by means of sharp dissection using monopolar electrocoagulation.

Postoperative regimen management was very active. In the first hours after recovery, patients received general massage, respiratory exercises, physical therapy. 3–4 hours after the surgery the patients were transferred from the resuscitation department to the general hospital ward. Narcotic analgesics were only given to the patients once and were combined with antihistamines. There were no drinking limitations for the patients. The food intake was optional and took place in accordance to the patient's state.

According to our data, the average duration of surgery was 44±6 minutes, the blood loss in all the cases was very low and did not exceed 50ml. The use of laparoscopic surgery made it possible to reduce the patients' stay in the hospital, which lasted 4.3±0.4 days on average.

The size of the extracted formations varied between 3 and 11 cm in diameter and was 4.8±0.6 cm on average.

The histological verification of the extracted formation showed that 18 (26.8%) women had follicular cysts, 13 (19.4%) — multiple follicular cysts (polycystic ovaries), 23 (34.3%) — corpus luteum cysts, 6 (8.9%) — surface epithelial inclusion cysts (germinal inclusion cysts) and 7 (10.4%) — paraovarial cysts.

The patients were advised to have sexual abstinence until their next period and use condoms in the course of at least 3 months after the surgery.

There were no complications during the surgery or in the postsurgical period. We agree with the opinion of L.V. Adamyan et. al. that, when treating patients

with ovarian tumours, operational laparoscopy might have the following complications: the possibility of pouring out the formation contents into the abdominal cavity and the possibility of the process dissemination which is characterised by the absence of guarantee of the complete capsule removal and the impossibility of the precise histological analysis of the removed tissues due to coagulation or tissue vaporisation.

However, taking into account the insignificant frequency of ovarian tumour malignization — 1.8 out of 100 (Andlf E. AstedB., 1986) — we think that it is possible to use laparoscopy for the treatment of tumour-like ovarian processes after the preliminary elimination of the malignant character of the formation (the principle of the oncological alertness).

For this purpose, we dynamically determined the tumour marker CA^{125} by means of the ultrasound and examined the condition of the gastrointestinal tract. It is necessary to emphasize that an atrophic form of the chronic gastritis A+B (5) detected during the fibrogastroduodenoscopy is one of the increased risk factors for the ovarian cancer.

Furthermore, we think it is advisable to treat patients with tumour-like processes with monophasic birth control pills in the course of three months according to the method of Granberg et. al. (1989). And only in case this treatment is inefficient, it is necessary to perform an endoscopic surgery. The exception is made in the case of women with tumour-like formations, the diameter of which is more than 6 cm due to the fact that this category of patients has a high risk of acute complications in the course of the ovarian tumour, e.g. twisted pedicle or rupture of the cyst capsule.

Therapeutic laparoscopy is particularly advisable for women who plan a pregnancy in the nearest future or have various types of tuboperitoneal infertility, because the surgery makes it possible to both modify the condition of the fallopian tubes and reduce the frequency of the postsurgical adhesion — the main infertility factor — to the minimum.

DIE DIAGNOSTIK UND BEHANDLUNG ANALER INSUFFIZIENZ BEI KINDER

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Einleitung

Analatresie und Atresie des Rektums machen über 80% aller anorektaler Mißbildungen bei Kindern aus (Korol E.F, 2005; Lenushkin A.I. 1999; Rintala R. 1994)) Anale Inkontinenz gehört zu den schwierigsten Pathologien im Kindesalter. Die Stuhlinkontinenz führt zu schweren seelischen Leiden beim Kind und Eltern. (Fomenko O.J 2007; Sulajmanov A.C. 1984; Nicastro A. 2006) Trotz vielen Forschungsarbeiten und trotz der Entwicklung neuer plastischen Rekonstruktionstechniken, ist das Ergebniss in 15% bis 60% der Fälle nicht zufriedenstellend. (Dultsev J.V. 1993; Evans D. 2005) Die Erfolgsrate chirurgischer Behandlung bei Analatresie hängt vom Stadium, Form der Atresie, Kindesalter und der Art der Rekonstruktion ab. In den letzten Jahren hat man sich viel bemüht um die Ergebnisse der operativen Behandlung der angeborenen kolorektalen Mißbildungen und insbesondere der Analatresie zu verbessern. Nichtdestotrotz bleibt die Frage der Erfolgsrate Rekonstruktioneingriffe bei Analatresie offen.

In der Proktologie wendet man immer häufiger die Operation nach Feierman bei der Neubildung des analen Sphinkters an, außerdem führt man die Sphinkteroplastik aus der Fascia lata nach Vredin, aus M.gluteus maximus nach Aminov usw durch. In diesem Zusammenhang bleibt eine qualitative Verbesserung der Behandlung bei Kinder mit Stuhlinkontinenz wichtig.