# **Odessa National Medical University**

Department of Surgery #4 with the course of oncology

LECTURE " Acute surgical pathology of the abdominal cavity. Acute appendicitis. Peritonitis "

The lecture discussed at the methodical conference of department

" " \_ \_\_ 201

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1. Relevance of the topic. Substantiation of the topic.

Acute surgical diseases of the abdominal cavity are a common pathology. This problem is urgent and its relevance is due to the fact that the successes of treatment and saving lives are directly related to timely and correct diagnosis and timely provision of qualified surgical care. About 70% of such patients enter the surgical hospital. Almost 1/3 of urgently hospitalized patients acute surgical pathology is not confirmed: other conditions that occur with false abdominal syndrome (therapeutic, gynecological, urological, infectious other diseases) are diagnosed.

That's why, doctors of any specialty should be familiar with these menacing diseases and know the basics of diagnosing acute diseases of the abdominal organs.

The material that is presented in the lecture is important in the professional training of a specialist:

- students of the medical faculty in the future practical work should be familiar with these issues and be able to diagnose and conduct differential diagnosis of acute diseases of the abdominal cavity; orient in organizational and therapeutic tactics;

- students of the dental faculty should be guided in these issues, due to the fact that the pathology of the mouth and teeth has a direct effect on digestion in patients and the emergence of acute pathology of the abdominal cavity.

2. Objectives of the lecture:

- training

Know:

- the place of acute diseases of the abdominal cavity organs in the morbidity structure;

- general issues of morbidity in Ukraine with acute surgical diseases of the abdominal cavity;

- concepts: diagnosis, diagnosis, differential diagnosis;

- classification of diagnostic methods;

- classification of the "diagnosis" - medical conclusion;

- the structure of the clinical diagnosis;

- basic / general / principles of diagnosis;

- types of pain, as the main manifestation of the syndrome of "acute abdomen";

- clinical characteristics of somatic and visceral pain;

- the basic principles of organizational and medical tactics.

- Educational

The material of the lecture is aimed at the formation in students of logical and clinical professional thinking, the responsibility of the doctor for the condition of the sick person. Are covered in questions of medical ethics and deontology.

**4. Contentsofthelecturematerial**

# General questions

Diagnostics. Differential diagnostics diagnosis.

Terms definition

##### General rules of diagnosis

**TYPES OF BEAMS, AS THE LEADING TISSUE OF DISEASE**

TACTICS ORGANIZATIONAL AND MEDICAL.

LECTURE TEXT: THEORETICAL FOUNDATIONS OF DIAGNOSTICS AND DIFFERENTIAL DIAGNOSTICS OF ACUTE SURGICAL DISEASES OF ORGANS OF ABDOMINAL CAVITY. Acute surgical diseases of the abdominal cavity are a common pathology. This problem is urgent and its urgency is due to the fact that the success of treatment and saving lives of people are in direct connection with the proper diagnosis and timely provision of qualified surgical care. About 70% of such patients enter the surgical hospital. Almost one third of hospitalized patients with acute surgical pathology is not confirmed: other conditions that occur with false abdominal syndrome are diagnosed (therapeutic, gynecological, urological, infectious, etc.).

 From this there are two conclusions:

1. Difficulties in diagnosis can lead to late diagnosis, which means that surgical care will be delayed and may lead not only to complications in the postoperative period, but also threatens the patient with a lethal outcome.

2. If the diagnosis of an acute surgical disease is incorrect, a vaginal laparotomy will be performed, which is also fraught with complications and possible fatal outcome.

Thus, DIAGNOSIS IS THE BASIC CORRECT TREATMENT. An ancient saying of the Greeks reads: "Qui bene diagnoscit bene curat".

This position takes on special significance in the occurrence of sudden acute pain in the abdomen.

An English doctor, Kon, believed that "The severe pain in the abdomen, which suddenly appeared against a background of complete well-being and lasts more than 6 hours, requires more often immediate surgical treatment."

The urgent surgical conditions that occur in the daily practice of a general practitioner and surgeon include:

- traumas of various origin with hemorrhagic or peritoneal syndromes,

- acute appendicitis,

- acute cholecystitis,

-perforative ulcer of the stomach and 12 duodenum,

-perforation of a hollow organ of various origin,

-strangulated hernia,

- acute intestinal obstruction,

- Acute pancreatitis,

-break of pyosalps,

- Mesenteriothrombosis,

-ectopic pregnancy,

acute peritonitis

and other "acute" conditions, which are less common in practice.

In the medical literature and in practical work, with the sudden onset of acute pain in the abdomen, the term - "ACUTE ANIMAL" is often used.

This term should alert the doctor and may indicate the onset or played out catastrophe in the abdominal cavity. CONCEPTS: DIAGNOSIS. DIFFERENTIAL DIAGNOSIS. DIAGNOSTICS.

/ Diagnostics - able to recognize / is the process by which the logic of thinking flows and leads to the solution of the assigned clinical task / patient before the doctor - a clinical problem with all the unknowns.

DIAGNOSIS / broadly understood meaning of the term / is a section of clinical medicine that studies the content, methods and successive stages of the process of recognizing diseases and evaluating the individual's biological and social characteristics, including a purposeful medical examination, interpretation of the results obtained and their generalization form of diagnosis.

All existing methods of diagnosis, which are used in practical work, are subdivided:

- -physical, -biochemical, -instrumental, -laboratory, -machine, -morphological,

- -radio-isotope, -radionuclide, -radiographic, -sexological, -topic, -functional

- -physical, -cytological, -electrophysiological, -endoscopic, -donosological

DIAGNOSIS / Diagnosis - a medical report on the health status of the subject, the existing diseases / or cause of death /, expressed in terms that denote the name of the disease.

DIAGNOSIS, this is a medical report, which is divided by characteristics.

I. By detection time:

- Early. -Retrospective. -Late. -Posthumous.

II. By the method of construction:

a / The diagnosis is direct or by analogy.

b / b / Differential diagnosis - this is the stage of diagnosis, which establishes the difference between this disease and others, similar in clinical manifestations / diagnosis is based on the principle of logical exclusion.

c / Full diagnosis.

g / Diagnosis by observation.

d / Diagnosis by treatment effect.

III. Diagnosis by degree of validity:

1.Diagnosis is preliminary or hypothetical.

2.Diagnosis is final or justified.

3.Diagnoz in doubt.

A fully justified clinical diagnosis should be formulated in the case history within 72 hours of hospitalization of the patient.

  Clinical diagnosis has a structure.

1. The main diagnosis.

La. Competing diagnosis.

   Complications of the main.

2. Concomitant diagnosis.

Complications of attendant.

For the doctor of any specialty the main conditions for successful diagnosis are:

1 - good knowledge of the disease semiology,

2 - observance,

3 - ability to use methods of objective examination.

It goes without saying that it is impossible to give any firm rules or schemes established for the diagnosis due to the multifaceted manifestations of any, even the same disease, in different individuals. You can only outline the way in which they go to establish a diagnosis.

I. Usually, already at the time of collecting anamnesis, there is an assumption about the nature of the disease.

Such a diagnosis is preliminary or suppositive.

For this assumption to turn into confidence, or, on the contrary, it was rejected, check the objective data, which must fully confirm the alleged diagnosis.

In order to be sure of the correctness of the received data, it is necessary to remember the following rules:

1.- every objective symptom should be correctly identified / researched / and evaluated. There should be no doubt about its existence. Example: Ascites - a fluid accumulation in the abdominal cavity. It is characterized by dulling in sloping places, moving blunt sound when the position of the body changes, symptom of "swelling". Research in the supine and standing position gives a sign of the appearance and disappearance of dullness in various areas of the abdomen. Clinical situation. At night, the young woman in the hospital's reception room entered the hospital for 36 years unconscious, with a weak pulse and low blood pressure, a large belly. Skin covers are purple cyanotic color. The ambulance doctor reported that the woman was picked up at the station square. Given the antisocial status of the delivered, the doctor in the resting room decided that the female homeless person was an alcoholic, the big belly was caused by the accumulation of fluid in the abdominal cavity / ascites / in connection with cirrhosis, and the hemodynamic parameters may be the manifestation of bleeding from the varicose veins of the esophagus. In order to establish itself in this concept and have confirmation of ascites. He decided to perform a diagnostic laparocentesis. When laparocentesis, he received 600 ml of clear liquid. Having established himself after the manipulation in his concept, he left the patient under observation. The patient died within 24 hours of increasing cardiovascular insufficiency. Autopsy revealed a pregnancy of 26 weeks. The cause of the lethal outcome was hypothermia and malnutrition.

The erroneous course of the doctor's thinking is clear and does not require comment.

Erroneous results in the study can be obtained if the rules of manual examination are not observed.

Example: Rigidity of the muscles of the anterior abdominal wall can be detected with cold hands. It is necessary to observe the conditions under which the study is performed: palpation when breathing a patient with an open mouth, knees bent by the lower extremities. Failure to comply with these rules can lead to incorrect conclusion and the false strain of the muscles of the anterior abdominal wall by the doctor will be regarded as true.

II. - It is necessary to remember the very relative importance of many symptoms. Symptom is not a disease, but only one of its prolongation. The same sign can be observed in a variety of diseases and lesions of different organs. Therefore, for each disease is not characterized by any particular symptom, and a certain law-their interrelation, depending on those or other producing causes, the nature of which is revealed by us in the process of collecting anamnesis.

- In some processes, there are signs called "absolute" - pathognomonic, inherent only in this pathology "pneumoperitoneum, hemoperitoneum."

- Various pathological conditions can sometimes give objective similar signs. Dullness with percussion of the abdomen in gentle places:

- ascites, - hemoperitoneum, - inflammatory exudate, -infiltrate, - a tumor and a crowded intestinal loop.

This dictates the need for differentiation with the use of additional studies: instrumental, endoscopic, laboratory, ultrasound, etc.

III. It is necessary to find an explanation for the origin of each objective phenomenon that we discover when we examine a patient. As practice shows, if the essence of any symptom in the picture of the disease remains unclear, the conclusions are in most cases incorrect, and the diagnosis is erroneous.

DIFFERENTIAL DIAGNOSIS.

As the patient is examined and the clinical and laboratory information is accumulated, it is necessary to exclude from the number of similar diseases gradually one by one, leaving that which is fully confirmed by the survey data obtained.

This method of establishing the so-called. "Differential diagnosis" / being the stage of diagnosis / is based on the principle of LOGICAL EXCLUSION and is very often used in clinical practice.

Thus, for a correct diagnosis, three conditions are necessary:

 1. All signs of the disease must be true.

2. The essence / pathogenesis of these changes must be correctly understood.

Of all the diseases that give a similar symptomatology, it is necessary to select the one that is best / fuller / confirmed by all survey data (ie. put a differential diagnosis /

NON-COMPLIANCE OF THE LISTED CONDITIONS LEADS TO THE ERROR IN THE DIAGNOSIS, MISUSE-TIKE AND MISUSE.

DIAGNOSIS.

1. Among the so-called subjective symptoms of diseases of the abdominal cavity / acute and chronic / - the pain takes the first and leading place.

It is no accident that the terms "disease" and "sick" are genetically related to the concept of "pain."

We will not analyze modern theories of pain.

2. The pain itself is accompanied by a number of objective signs, which can be detected by direct examination of the patient.

First of all, they include:

- rich mimic reactions / pronounced distortion of the face - the face of Hippocrates,

- motor anxiety of the patient,

- Antalgic poses: "fossilized", compelled position,

- significant changes under the influence of pain in many systems of the human body:

- morphological and chemical changes in blood,

- reactions from the SSS / collapse, bradycardia, tachycardia /,

- changes in respiratory rate,

- disorders of urination,

- digestive disorders / inhibition of secretion /,

- violations of the endocrine system,

- CNS disorders.

In other words, according to Selye's theory, "GENERAL STRESS RESPONSE".

 Therefore, "pain", as a rule, is a phenomenon of a kind of first biological signal of trouble, which should be considered as a powerful source of pathological impulses.

PAINS arising from diseases of the abdominal cavity have a different origin:

They can be associated with unusual in intensity irritants of various receptors, which are embedded in internal organs / mechano-, baro-, thermo-, chemoreceptors. To their irritation leads to inflammation, tension, pressure, tension.

 Excessive irritation of these receptors leads to the formation of so-called "visceral" pain.

A. The mechanism of visceral pain;

Pain irritations emanating from the internal organs are directed to

the brain on large nervous vegetative conductors:

border vein, vagus nerve, celiac nerve, mixed spinal nerves - then through the posterior root to the posterior horns of the spinal cord, spinotalamic pathways to the spectator boograms, the cramps, the reticular formation and the cerebral cortex.

Visceral pain has a clinical characteristic:

1. The localization of pain is fuzzy / diffuse /, but is limited to the topic of the organ.

2. The nature of pain is colicidal, paroxysmal.

3.Boly is long and intense.

 4. Pain accompanied by nausea, vomiting, sweating.

During pain, the abdomen is strained, but between the attacks it becomes mild and there are no signs of irritation of the peritoneum.

SUCH PAINS WILL NOT BE LOCALIZED.

There are three zones of visceral pain.

 1. The epigastrium.

 2. Middle podopumpochnuyu area.

3. Podchidevye.

Pulses emanating from the internal organs in the spinal cord can converge with impulses that are sent along sensitive nerves from the skin.

 On this mechanism there are zones of increased hyperesthesia of the skin / Zakharyin-Geda zone.

Often there are zones of increased tone (according to the same mechanism)

separate abdominal muscles. These viscero-motor reflexes, the clinical manifestation of which is a sign of muscular protection.

This mechanism explains the appearance of the so-called. "Pain points": the anterior and posterior points of Boas, Lanz, Op-hov, Kummel, Gerbst, Sinakevich, Mayo-Robson, and Car.

It is necessary to bear in mind the possibility of viscero-visceral reflexes. In this case, the pain is felt and localized to patients not in the abdominal cavity, but in the heart / Botkin syndrome with LAD, abdominal myocardial infarction syndrome.

B. SOMATIC PAIN.

The mechanism of somatic pain is associated with irritation of the intercostal nerves D5-D12, which innervate the parietal peritoneum. They arise when the sensitive endings of the parietal peritone are irritated by current-sinuses, digestive juices, mechanical irritation / tension, twisting. They occur when the intercostal nerves are damaged outside the peritoneum on their length by hematomas, infiltration, and swelling.

Somatic pains have clinical characteristics:

1.Somaticheskie pain very accurately localized patients.

2.Somaticheskie pain is permanent. The patient lies calmly. Pain is accompanied by a local re-action. When palpation is determined by the rigidity of the muscles of the anterior abdominal wall.

Sensitive somatic innervation extends entirely to the parietal peritoneum, small gland, mesentery of the small and large intestine. In the mesentery, the border between the somatic innervation and the sympathetic passes 3-4 cm from the intestinal wall.

Somatic pains are localized clearly, since the intercostal nerves have a projection field in the cerebral cortex. Somatic pain may be associated with visceral pain.

Assessment of pain as a leading symptom of the disease.

Pain as the leading sign of the disease is assessed by the signs: the nature of pain, the time of its onset, irradiation, localization. On these grounds, a differential diagnosis is also based.

MEDICAL TACTICS.

After the diagnosis is established, the following actions of the doctor are organizational and therapeutic measures, which are determined by the stage of medical care.

1. The tactics of the doctor with a clear diagnosis:

- organizational tactics,

- medical tactics.

The questions of tactics are solved simply: on-site assistance, transportation, hospitalization in the profile department.

2. With a fuzzy diagnosis, one should keep in mind the inadmissibility of prolonging the observation time / no more than 6 hours in a hospital setting.

-Hospitalization in the relevant specialized medical institution for the provision of qualified

   specialized assistance.

IN EVERY DIAGNOSTIC CASE, THE DOCTOR SHOULD BE LOOKING FOR THE FULL AND CONDENSED DIAGNOSIS.

Deviation from these provisions leads to errors in the diagnosis, late diagnosis, late hospitalization, and therefore, incorrect or untimely treatment, the risk of complications and death

*A 47-year-old patient was delivered to the surgical department with an alternative diagnosis of "acute appendicitis: renal colic?". He complained of pain in the right side of the abdomen with irradiation in her lower back, nausea, a single vomiting. The abdomen was painful only with deep palpation in the right iliac region, the muscle tension of the abdominal wall was absent. Positive symptom Pasternatsky. Body temperature is 37.2 degrees. Pulse 78, rhythmic. Leukocytosis is 9.4 g / l. In mocha - erythrocytes up to 30 in the field of vision, in places accumulation of leukocytes. Chromocystoscopy revealed the normal function of the left kidney (indigocarmine appeared in the 4th minute), a sharp weakening of the urinary-division from the right mouth (indigo carmine is excreted weakly sluggishly by a pulsating stream on the 12th minute). On the survey radiograph of the abdomen, shadows of concrements in the projection of the kidneys and ureters have not been revealed. Diagnosis was established-right-sided renal colic, spasmolytic, analgesic, anti-inflammatory therapy was prescribed. On the third day in the right ileal region appeared infiltrate, which on the 5th day, despite antibacterial therapy, reached the size of a large male fist. On the 7th day - a temperature of 38.8o, a chill. Operation: extraembrysis-tire opening of abscess, which contained 100 ml of fetid pus. After 4 months, an operation of appendectomy was performed. It turned out that the appendix was located retro-cecally and almost throughout the entire retroperitoneal space.*

*A retrospective assessment explained the cause of the diagnostic error. The patient entered with an attack of acute appendicitis. The retroperitoneal position of the vermiform appendage excludes signs of irritation of the peritoneum. The inflammatory process spread through retroperitoneal cellulose, reached parauretral tissue and urine, which led to narrowing of the ureteral lumen, urostasis, increased urinary pressure in the renal pelvis, and development of renal colic. Inflammation of the ureter wall caused the appearance of erythrocytes and leukocytes in the urine. Reduction of the excretory function on the right side, finally confirmed the surgeon in the presence of pathology of the mozhevyvodayuschih ways and led to a diagnostic error.*

Movement of the stone along the ureter is not always accompanied by a characteristic pain for the renal colic, and gradually onset obstruction of the ureter does not necessarily lead to a sharp increase in pressure in the upper urinary tract, which is accompanied by pain in the lower back and a symptom of Pasternatsky. Urinary stone, which is stuck in the lower third of the ureter, can cause pain and tenderness when palpation in the inguinal iliac region, which are often regarded as manifestations of appendicitis. Such a diagnostic error entails a vain appendectomy. Only after the removal of the "innocent" vermicular appendage is used the urological examination, which reveals the ureteral obturation by the stone, hydroureter, pyeloectasia, and sometimes - hydronephrosis. The absence of erythrocytes and leukocytes in the urine is explained by the fact that the immobile stone blocks the ureter and blocks the upper urinary tract from the bladder.

Difficult tasks poses to the surgeon differential diagnosis of acute appendicitis in women. Synthopia of the lower abdominal organs, especially in the pelvic position of the appendix, brings together a clinical picture of acute appendicitis with signs of acute inflammation of the uterine appendages, a twisted cyst, or a malnutrition or inflammation of the ovary. Very often, operating with the previous diagnosis "acute appendicitis", the surgeon identifies an ectopic pregnancy, which is accompanied by intra-abdominal bleeding. Errors are allowed and gynecologists. Often accepting a woman with complaints of pain in the abdomen and frequent urge to defecate, revealing a bimanual examination of soreness with a shift of the uterus and a fluctuating cylindrical formation in the pelvis, the gynecologist begins an emergency operation for pelvic peritonitis, pyosalpings, and reveals the empyema of the appendix, located deep in the small pelvis. The puncture of the posterior vaginal vault can provide valuable diagnostic information and clarify the correct pre-operative diagnosis if Douglas pocket of the peritoneum is not obliterated by fissures and if during puncture it is possible to extract blood or pus. With obliteration of the uterine-rectum pocket, the puncture is "dry" and uninformative. When obtaining purulent exudate confirmed pelveoperiton, but it is impossible to reliably determine its source on the basis of a macroscopic evaluation of pus. Ultrasound diagnosis does not solve the problem. Pipe abortion and ovarian apoplexy with a slight bleeding do not give an echo. The pyosalpingscan not be distinguished from the empyema of the vermiform bud. The cyst or ovarian tumor is clearly different in the ultrasound study. However, the detection of a tumor does not mean that it is precisely the cause of an acute disease. The most informative method of preoperative differential diagnosis is laparoscopy. In the absence of laparoscopy, diagnostic problems are solved with the help of laparotomy.

Appendicular infiltration is a frequent complication of acute appendicitis. In a patient with an appendicular infiltrate in the right ileal region, a dense, painful formation is palpable. If the doctor observes the appearance and growth of this formation, which appeared on the 3rd-4th day of abdominal pain and which is accompanied by an expressed febrile condition, there is no doubt that appendicular infiltration occurs. There are, however, situations where the patient "misses" the first days of the illness, without giving value to the pain in the right side of the abdomen, and the infiltration either increases very slowly, or "freezes" without abscessing or dissolving. Then the patient gets with a palpable tumor in the right side of the abdomen, and the doctor has problems with different diagnosis of appendicular infiltration and cancer of the blind or ascending colon. If the patient falls in the planned order, these problems are solved by X-ray contrast colonic irrigation, colonoscopy (with biopsy indications), laparoscopy. Sometimes the final diagnosis is determined only after a diagnostic laparotomy, during which there are also ambiguous situations.

We observed a patient who got with the symptoms of intestinal obstruction on the second day of the disease. There was swelling of the abdomen, non-removal of stool and gases. When examining and auscultation a typical symptom of Valya, the noise of splashing in the abdomen. In the right iliac region, a dense, painless, proximal, measurable mobile tumor of the size of a male fist is restricted. The patient, a man with reduced intelligence, did not notice this tumor. At a roentgenoscopy of a stomach or belly have revealed horizontal levels (bowls of Kloyber) in a thin gut. An emergency operation with a preliminary diagnosis of "cancer of the cecum, acute intestinal obstruction". During the laparotomy, a macroscopic evaluation confirmed the diagnosis of cecal cancer and performed a right-sided homictectomy. The patient recovered. At a histological study, the inflammatory nature of the "tumor", which was formed around the appendix, was verified.

 If the correct diagnosis were made prior to surgery, it would be possible to confine ourselves to a much less pic-like operation-shunting Ileotransversoanastomosis followed by antibacterial and anti-inflammatory therapy of the appendicular infiltrate, after resorption, which could be performed by an up-penectomy.

The following case history illustrates the possibility of a different plan error.

 A 59-year-old patient got with complaints of abdominal pain, which lasts for 7-8 days. In the right ileal region, a painful tumor the size of a child's cool-chokis palpated. Appendicular infiltration was diagnosed. Antibiotics are prescribed. On the 5th-6th day of treatment, the pain and soreness in palpation disappeared, the infiltration decreased. At the subsequent observation, infiltrate sizes remained unchanged. Suspected cancer of the cecum. Colonoscopy with biopsy confirmed the diagnosis. The patient was operated on. Right-sided hemicolectomy was performed. Recovery.

Subjective and objective improvement after antibiotic therapy is explained by a decrease in perifocal inflammation, which led to a decrease in the size of the tumor and the elimination of pain and soreness.

With high subhepatic location of the cecum, acute appendicitis has to be differentiated with acute cholecystitis. The leakage of exudate in the right iliac region leads to the fact that acute symptoms of acute appendicitis hide acute pancreatitis. Diarrhea is often a sign of acute enterocolitis. However, with severe forms of phlegmonous appendicitis spreading phlegmon to the wall of the cecum can lead to diarrhea. This is very dangerous, because, taking diarrhea as the basis for the diagnostic concept, the doctor begins treatment of enterocolitis and violates the optimal timing of surgery for acute appendicitis. Such a mistake can be fatal: diarrhea, which complicates the course of acute appendicitis, indicates a severe form of inflammation of the appendix and delay in surgery sharply worsens the prognosis.

Strangulated hernia. It would seem, what diagnostic problems can be connected with the strangulated gry-zhe! Disease with clearly defined manifestations, which are accessible by visual and palpatory evaluation. I start-diagnu "" strangulated hernia "" defines the patient himself. However, there are problems, and mistakes in diagnosing the injured hernia threaten with gross tactical errors, sometimes with tragic consequences.

Often the urgent surgeon has to differentiate the strangulated femoral hernia with the pathology of the lymph nodes located in the Scarpian triangle. Dense painful formation, which is located at the groin below the ligamentous ligament, may be infringed by a hernia, banal lymphadenitis, metastasis of a malignant tumor into lymph nodes. I will give some examples.

The 67-year-old patient complained of pain in the left groin, where a painful education was felt for 2 days. Objectively: the skin of the inguinal area is slightly hyperimirovan, a painful formation with a diameter of about 4 cm is sensed under the ligamentous ligament. The skin of the interdigital spaces of the left foot is inflamed, there is sloughing and wetting, which are characteristic for fungal attack. With the diagnosis of "abscessed inguinal lymphadenitis," the patient was taken to a purulent operating room. After cutting the skin, infiltrated fiber and superficial fascia, it was found that the cause of inflammation is not lymphadenitis, but the strangulated femoral head with hernia. The patient was transferred to a "clean" operating room. In the process of operation, there was pristetochnoe (Richter's) infringement with gangrene of the ileum wall. Gut resection. Recovery.

In this case, the diagnostic error did not lead to a tactical error, because by mistake the diagnosed abscessed lymphadenitis also required an emergency operation.

Often admit a mistake of another plan. The patient is urgently operated with a presumptive diagnosis of "strangulated femoral or inguinal hernia," but there is an adenoflegmon or abscess. In this case, the diagnostic error does not lead to tragic consequences. They are prevented by a timely operation, which clarifies the diagnosis and corrects the therapeutic tactics.

Dangerous is an erroneous diagnosis, which objects to the need for emergency surgery. Such errors include the diagnosis of metastasis in inguinal lymph nodes in a patient with strangulated hernia.

A 71-year-old patient operated in the past for a cancer of the lower ampulla of the rectum. He complained of pain in his right groin, where he felt the sickness of the size of a cherry. He considers himself sick for 3 days. The surgeon excluded the diagnosis of the strangulated hernia and hospitalized the patient with the assumption of metastasis of rectal cancer into the inguinal lymph node. The decision was made - after traditional studies to subject the patient to lymphadenectomy with a histological examination of the drug. The next day the patient's condition worsened. The pain in the groin increased, the reddening of the skin and the infiltration of the subcutaneous tissue appeared. This was regarded as a consequence of the disintegration of tumor metastasis with perifocal inflammation. Have decided to appoint or nominate antibacterial preparations. The next day - a sharp deterioration: different pains in the abdomen, a protective strain of the muscles of the abdominal press, signs of irritation of the peritoneum. Urgent laparotomy: in the abdominal cavity - intestinal contents, turbid exudate, fibrinous plaque on the intestines. On the antiserum surface of the sub-intestine, a site of necrosis 2.5x2.0 cm with perforation in the center. Resection of the destructed portion of the intestine. Incision in the right inguinal region. Scattered edemas, subcutaneous tissue and fascia. The infiltrated peritoneum of the hernial sac, protruding from under the ligamentous ligament is removed. Bassini plastic surgery. The patient died of peritonitis. Signs of the progression of cancer in the section have not been identified.

Thus, the diagnostic error played a fatal role. Uncertified and unpeeled Richter infringement resulted in necrosis and perforation of the constricted wall, hernitis, emptying of the intestine into the abdominal cavity, peritonitis with fatal outcome. What does the sad experience of such observations teach us? - Differential diagnosis of strangulated femoral hernia and pathology of lymph nodes can not be performed on the basis of clinical assessments alone. Therefore, urgent surgical revision in doubtful cases is an obligatory and decisive method.

Tumors of the abdominal cavity often metastasize to the navel. Metastasis of the cancer in the navel is a dense, moderately painful knot, "diving" into the abdominal cavity. Most often in the navel metastasize cancer of the stomach and ovarian cancer. Sometimes stomach cancer metastasizes into the ovary (Crookedberg's metastasis) and into the navel. According to the visual and palpation signs, the metastasis of the cancer in the navel is similar to the umbilical hernia, which contains a rigidly restrained strand of a large omentum. Necrosis of hernia contents is complicated by hernia, which is manifested by hyperemia and edema of the tissues of the umbilical region. Similar edema and hyperemia is possible with the disintegration or infection of a metastatic tumor node. Errors in differential diagnosis are allowed often. Yes, the metastasis of cancer in the navel is taken for an impaired umbilical hernia, urgently operate and make the correct diagnosis only when the section "protrusion" at the cut is a typical picture of a malignant tumor. Such an error is safe. It only helps in diagnosing a common form of a malignant tumor that has been asymptomatic. It is much more dangerous to take an injured hernia for the metastasis of cancer in the navel and to abandon the urgent operation. In order to avoid the possibility of unjustified errors, it is necessary to take as a rule - the doubt in the diagnosis is an indication for an urgent operation. Only an operation can confirm or reject the assumption of infringement of the umbilical hernia. It is clear that we are talking only about those variants of infringement, where solid education in the umbilical region is clinically difficult to distinguish from metastasis of a malignant tumor. Large, strained elastic bulges with signs of intestinal obstruction do not cause diagmonic doubts and do not constitute diagnostic alternatives to cancer metastases in the navel.

Differential diagnostics of strangulated hernia and intestinal obstruction is actual. Patients with strangulated hernia are often referred to a surgical hospital with a diagnosis of "intestinal obstruction". The fact is that this is not an erroneous diagnosis, since the strangulated hernia in most cases (if the gut is infringed!) Is accompanied by the phenomena of obstruction, which turn out to be the leading signs of the disease.

A sick 63 years old, a full woman, got on the third day with abdominal pain, nausea, repeated vomiting. The abdomen is swollen, a clear symptom of Valya in the left ileal region, a noise of splashing in the abdomen. Radiographically, the horizontal levels and the Clauber cups are determined. With the diagnosis of "acute intestinal insufficiency", the patient underwent surgery. Middle laparotomy. Large intestine and aboral 70 cm ileum in a collapsed state. The loop of the sub-intestine, fixed in the inguinal canal. The intestine is easily removed from the inguinal canal. No signs of necrosis. The operation was completed by gernioplasty according to Girard.

It is difficult to say whether the diagnostic error is a consequence of the obesity of the patient and the objective difficulty of revealing the hernial protrusion, or it has occurred because of insufficiently thorough medical research. Anyway, the correct diagnosis of the strangulated inguinal hernia would allow performing an operation with significantly less traumatic access - a cut in the inguinal region. A thorough audit of inguinal areas, which is aimed at finding possible protrusion of a hernia, necessary in all patients with acute surgical abdominal pathology.

We observed patients who were diagnosed with "erysipelas of the umbilical region", "phlegmon of the inguinal region". Bright hyperemia with characteristic, clearly delineated "flame tongues", swelling, tissue infiltration, high body temperature, chills - all these signs seem to confirm the correctness of the primary diagnosis. However, anatomical evidence, survey results and palpation allowed the majority of patients to identify an impaired inguinal, femoral or navel hernia, complicated by herniitis and inflammation of surrounding tissues. During the urgent operation, they had a small hernial protrusion with infringement of the necrotic omentum, less often - parietal (Richter) infringement of the gut with gangrene of the wall.

Acute intestinal obstruction is characterized by a clear syndrome, which has characteristic subjective and objective symptoms. Patients complain of abdominal pain, nausea, vomiting, and the absence of stool and gases. Objectively observed bloating, high tympanitis over the anterior abdominal wall, the noise of splashing, and with the X-ray study - horizontal levels and bowls of Kloyber in the intestine.

The main issue of differential diagnosis is the determination of the mechanical or dynamic origin of obstruction. From the decision of this question depends the choice of an adequate - surgical or conservative - method of treatment. Objective difficulties are due to the fact that the listed clinical and radiographic signs of obstruction are found both in the mechanical and in the dynamic version.

The symptom of Val is strong, which is often accompanied by an unusually loud rumbling, "snarling" peri-steel, which is characteristic of mechanical obstruction. Visible through the anterior abdominal wall, the "bulging" loop of the intestine, contracting and relaxing, carries serpentine movements, trying to overcome the stenosis and push through it intestinal contents. The causes of stenosis are diverse. The narrowing of the intestine (up to complete obturation) can be caused by a tumor, scar scar, spikes, intussusception, a large gallstone, an ascaris ball, a caloric "blockage". Val's symptom, without specifying the nosological nature of the narrowing, usually indicates a mechanical genesis of the obstruction and determines the indications for an emergency operation. This is its differential diagnostic value. However, if the presence of Val's symptom is a significant sign of the mechanical genesis of obstruction, the absence of pre-stenotic peristalsis does not reject a mechanical obstruction and does not take indications for laparotomy. Val's symptom may be absent in later periods of impassability, when neglect of the disease leads to depletion of bowel motility, or obstructive peritonitis paralyzes peristalsis. Thus, Val's symptom can not be considered an absolutely reliable differential diagnostic feature, which distinguishes between mechanical and physical impassability from dynamic obstruction.

Of particular importance are X-rays contrast study of the colon (irrigoscopy) and colonoscopy. If a mechanical obstruction is localized in the large intestine, these studies resolve the diagnostic problem. With the help of irrigoscopy, colonoscopy reveals tumors of the large intestine, polyps, invagination, cicatricial deformities, coprostasis, sygmoidal curvature, megadolicholone. But if the level of the mechanical barrier is outside the colon, the diagnosis is beyond the capabilities of these methods. They allow the removal of a mechanical obstruction only at the level of the large intestine.

The informative nature of the observation of the orthograde passage taken by the x-ray contrast medium (barium sulfate, iodolipol) is also limited. The fact is that in cases of mechanical obstruction the stopping level ("stop") of the contrast mass usually corresponds to the level of the mechanical obstacle. At the same time, in the conditions of dynamic obstruction, when there is no mechanical obstruction, the X-ray contrast preparation stops at an undefined level due to the absence of peristaltic waves, which ensure its progressive movement in the aboral direction. This can lead to a false-positive diagnosis of mechanical obstruction with subsequent vain laparotomy.

The most informative method of differential diagnosis is laparoscopy, the possibility of which is much greater. The possibilities of laparoscopy are compared with the diagnostic informativeness of la-parotomy, which determines not only the mechanism of obstruction, but also its nosological affiliation. With mechanical obstruction laparoscopy determines the level and cause of the obstruction, thus contributing to the selection of the optimal variant of the operation. It is common knowledge that mechanical obstruction determines absolute indications for an urgent operation, and with dynamic obstruction the operation is usually not shown. But there are no rules without exceptions! There is a form of dynamic intestinal obstruction, in which indications for non-terminal surgery are as categorical as in the case of mechanical obstruction. This is the dynamic insensitivity caused by peritonitis. Dynamic intestinal obstruction accompanies fibrinous purulent peritonitis, which aggravates acute appendicitis, perforated ulcer, acute inflammation of the uterine appendages, bile ducted peritonitis, characteristic for fermentative cholecystitis, hemorrhagicpancreatogenic peritonitis in destructive pancreatitis. The endoscopic picture of all these diseases is quite typical, and laparoscopy could be a decisive procedure in the differential diagnosis of intestinal obstruction if the dangers of laparoscopy did not limit its use in conditions of intestinal obstruction. The risk of damage to the thinned wall of the swollen bowel is exceptionally high, so in doubtful cases, the explorative laparotomy is used more often than laparoscopy.

We discussed the diagnostic possibilities that confirm or do not confirm, or less often, the mechanical genesis of the obstruction and conclude that in doubtful cases, the last act of diagnosis is laparotomy. However, if the auditory abdominal cavity reveals that the impassability is dynamic, the operation significantly complicates the forecast. Therefore, the decision on diagnostic paw rotomyshould be preceded by an action that is aimed at finding and identifying possible extraperitoneal causes of dynamic intestinal obstruction.

A frequent cause of dynamic intestinal obstruction is the pathology of the urinary tract, which is manifested by episodes of renal colic.

A 35-year-old patient was delivered with a diagnosis of "acute intestinal obstruction" on the third day of the disease, which is manifested by girdling pains in the abdomen, nausea, swelling, and the absence of gases. urine. "A severe last attack of renal colic lasted 5-6 days, after the attack, which was stopped by spasmolyticsand anesthetics, left dull pain in the left half of the animal." Three days ago the pain intensified, and he every day but took platyfilin, baralgin, no-shpa. General condition of medium severity: pulse 86, rhythmic, abdomen sharply raised, high tympanitis above the abdominal wall, splash of the shoulder, visceral, palpatory and auscultatory, the peristalsis is not determined .The symptom of Pasternak is doubtful The ampulla of the rectum is empty and the pronounced me- thorism in the small and large intestines is determined on the roentgenogram of the abdomen.Chromocystoscopy: on the right side indigo carmine enters the fourth minute by a good stream. On the left side after 15 minutes the dye does not appear. Diagnosis: mo-chechen disease, left-sided renal colic, dynamic intestinal obstruction. Anesthetic, vagomimetic drugs, enemas managed to cope with the dynamic impassability of the intestine. After the elimination of meteorism on the intravenous excretory urogram, the following was found: stone, obturating the juxtavezic section of the left ureter, ureteroectasia and pyeloectasia. The stone was removed operatively. Recovery.

In this case, the diagnostic efforts were successful, and the patient escaped the vain laparotomy, which could be used according to the indications substantiated by the diagnosis of the direction. Unfortunately, there are other sad observations related to the dramatic consequences of diagnostic errors.

The 67-year-old who suffered from urolithiasis was taken with severe pain in the left side, nausea, vomiting, bloating. In the past he suffered pyelolithomy on the left side. Condition after receipt of moderate severity. The abdomen is upset. The noise of splashing is determined. On the roentgenogram - horizontal levels in the small intestine. In the left hypochondrium a dense formation is felt, which protrudes 5-6 centimeters below the costal arch. In the analysis of urine urate, 5-10 erythrocytes in the field of view. The palpation in the hypochondrium is qualified as hydronephrosis, and swelling, splashing sound and horizontal levels are qualified as manifestations of dynamic intestinal obstruction. It was decided to prepare a patient for urological examination and surgery for urolithiasis. On the second day during the siphon enema, we started sharp pains in the abdomen. Cold sweat, tachycardia, falling blood pressure, muscle tension and signs of irritation of the peritoneum along the entire abdomen left no doubt that an intra-abdominal catastrophe occurred. Emergency laparotomy. In the abdominal cavity, a turbid liquid introduced as an enema, with admixtures of feces. The formation, which was qualified as hydronephrosis, turned out to be a large tumor of the left, spleen flexure of the colon. In the area stretched by gas and filled with rare feces of the resulting loop of the colon - a perforation with a diameter of about three centimeters. Obstructive resection of the colon according to the type of operation of Hartmann. Severe postoperative course. The patient was discharged on the 50th day after the operation.

Thus, in a patient with a clinic of acute intestinal obstruction, two variants of errors in differential diagnosis with renal pathology are possible: the diagnosis of mechanical obstruction in a patient with renal colic threatens in vain laparotomy, and diagnosis of nephrolithiasis in a patient with mechanical obstruction, which entails a delay in life -necessary operation.

A special place among the signs of dynamic intestinal obstruction is myocardial infarction. This threatening, prognostically difficult disease often affects people who did not suffer from ischemic heart disease in the past and considered themselves to be practically healthy. Flaring "like a bolt from the blue", the catastrophe catches the patient suddenly, the pain in the epigastric region, characteristic of the gastrealgic form of the infarction, is generated by erroneous diagnostic predictions. And the joined phenomena of reflex intestinal paresis and ha-stroparez sometimes deceive even experienced doctors.

A well-known physician, a healthy man of 58 years, became acutely ill when he was fishing on a warm summer day. At first he regarded the nausea that appeared as a result of overheating and fatigue, but severe pains in the stomach and vomiting made him lie down on the shore. His condition deteriorated sharply, he was covered with a sticky cold sweat, there was a short loss of consciousness. When the ambulance arrived from the city in 1.5 hours, the patient was in a collapse, the abdomen was sharply swollen, the palpation of the abdominal wall was painful. With the diagnosis of "intestinal obstruction" he was taken to a surgical clinic where, on the basis of clinical and radiological data, the diagnosis was confirmed and the preoperative preparation was started. But an electrocardiogram performed in the framework of mandatory pre-operative examinations revealed a focus of ischemia. The consultation of experienced doctors without doubt settled on the diagnosis of "myocardial infarction, dynamic intestinal obstruction" and canceled the operation that was being prepared. The infarction was confirmed by the clinic and repeated electrocardiograms. Manifestations of dynamic intestinal impassability were resolved. Two months later, when there was subjective and objective improvement in the patient's condition, a second heart attack occurred and the patient died.

It can be reiterated that the decision to abort surgery for bowel obstruction was taken after a lengthy discussion, without confidence in the reliability of the diagnostic concept adopted. It would be simpler to act according to the canons of urgent surgery, in accordance with which, in case of doubt, it is necessary to operate. If the patient were operated on, there would be an imminent death, which, reliably, would come quickly after the operation, and the doctors would have reason to see a causal relationship between their erroneous decision and the patient's death. On the other hand, the decision that we adopted and became the right decision was not a priori unconditional. It could be wrong. The patient had a myocardial infarction with the phenomena of secondary intestinal obstruction. Everything could be the other way around. Primary there could be an intra-abdominal catastrophe (mechanical intestinal obstruction, acute pancreatitis, even a perforated ulcer), and the myocardial ischemia revealed on the electrocardiogram could be the result of a reflex spasm of the coronary vessels that reacted to the pain syndrome. And then the refusal of an urgent operation would be a mistake.

Patients who have myocardial infarction with phenomena of dynamic intestinal obstruction are often found, and acute diseases of the abdominal organs occur under the clinical mask of myocardial infarction. There are no recipes that would guarantee us from diagnostic errors. To reduce the reliability of errors, the inclusion of an electrocardiogram in the number of mandatory preoperative examinations in a patient with acute surgical pathology of the abdominal cavity.

Extra abdominal causes of dynamic intestinal obstruction, which are located in the chest, are not limited to myocardial infarction. We observed patients whose intestinal obstruction was provoked by lower-grade pneumonia or pleurisy.

Once an ambulance was delivered to a sick artist 47 years old with a diagnosis of "intestinal impassability". He complained of violent pains in the abdomen and shortness of breath, the inability to take a deep breath, the nausea, the non-circulation of gases for two days. The chair was three days old. After clarifying the anamnestic details, it became clear that three weeks ago he was "as if" a cold, but after three or four days of treatment with "home remedies" he went to work, where he felt weak, sweating, malaise, and increased fatigue. Three days ago the condition worsened, there were pains in the right hypochondrium, hindered breathing. Very quickly joined the bloating, the gases ceased to flow. After hospitalization in the hospital, the clinical picture of the intestinal obstruction did not cause doubts: a dome-shaped swollen abdomen, a high tympanitis, an inflated unperistant loop of the intestines contouring through the abdominal wall, a splash noise during tapping of the abdominal wall. The right half of the thorax clearly lagged behind in the act of breathing, with percussion on the right side below the angle of the scapula, femoral stupidity was defined, and during the auscultation breathing noises were not listened. On the roentgenogram of the abdomen, wide multiple horizontal levels and the Clauber bowl confirmed the diagnosis of intestinal obstruction, and the blackening of the right hemithorax below the level of the VI rib on the scapular line confirmed the diagnosis of exudative pleurisy established according to the physical data. The anamnesis and objective attributes represented arguments for two alternative concepts. 1). The patient has a mechanical intestinal impassability, possibly caused by an obturatingtumor of the colon, which metastasized into the lungs and pleura and caused the phenomenon of carcinomatous pleurisy. In this case, the disease that preceded during three weeks of obstruction should be regarded as a clinical manifestation of metastases in the lungs and pleura. 2). The patient suffered pneumonia, which was complicated by pleurisy with the phenomena of reflex dynamic intestinal obstruction. The first diagnostic concept determines the indications for urgent surgery, which is aimed at eliminating obstruction. The second concept directed therapeutic measures to eliminate pleurisy - the source of pathological impulses that support intestinal paresis. Based on the second concept, a pleural puncture was performed, 1 l of transparent exudate was aspirated, antibacterial, anti-inflammatory therapy and stimulation of intestinal peristalsis were prescribed. With pleurisy managed to cope, manifestations of dynamic intestinal obstruction resolved. The patient recovered.

One could give examples when the concept of mechanical obstruction, which is caused by a tumor, was correct. Our observation can be an illustration of the objective difficulties of differential diagnosis of mechanical intestinal obstruction of tumor genesis and dynamic intestinal obstruction, which is caused by pleurisy or basal pneumonia.

The difficult task is to establish the cause of intestinal obstruction in patients with acute impairment of cerebral circulation. Ischemic or hemorrhagic stroke, as a rule, is accompanied by paresis of the intestine, which leads to coprostasis. Long-term coprostasis ends with obturation of the terminal sections of the colon with dense masses, which turn into coprolites, causing a mechanical obstruction to the passage of intestinal contents. At the end of the acute period of cerebral circulatory disorders, peristalsis is restored, and intestinal obstruction, which began as a dynamic obstruction, acquires clinical signs of a mechanical one. Appears visual, and sometimes auditory, "snarling" peristalsis (a symptom of Val), on the radiograph of the abdomen determine the horizontal levels and cups of Kloyber, there are signs of an emergency operation. Since the aboral part of the stool is usually stuck in the lower ampullary department of the rectum, diagnostic and tactical problems are solved during the finger examination per rectum. Destruction of coproliths with the help of a finger followed by an enema eliminates coprostasis and relieves the patient of obstruction. However, in the early days of acute cerebrovascular accident, when coprolites are not yet formed, manifestations of dynamic obstruction are very dangerous, and surgeons sometimes use laparotomy, which drastically worsens the prognosis of the underlying disease. Unfortunately, there are mistakes of a contradictory nature. Knowing that acute disturbance of cerebral circulation is accompanied by dynamic disorders of peristalsis, a surgeon a priori any obstruction in a patient with a stroke qualifies as dynamic and is mistaken in those cases when the patient develops mechanical obstruction due to a stenosingtumor, infringement of a hernia , rub-zovoy soldering or curl of the intestine. And then the patient dies not from a stroke, but from an intra-abdominal catastrophe.

What needs to be done to reduce the reliability of errors? - It must be remembered that an acute disorder of cerebral circulation causes a violation of intestinal motility, threatens with dynamic non-permeability and coprostasis. Therefore, one should not use carelessly laparotomy, not trying to restore peristalsis and eliminate coprostasis. On the other hand, every case of intestinal obstruction in a patient with a stroke should not be qualified as a dynamic intestinal obstruction and categorically reject an urgent operation. It is necessary to carry out a set of measures that are aimed at differential diagnosis of the cause of obstruction. This complex includes finger examination per rectum, irrigoscopy of the large intestine, X-ray examination of the passage of barium taken per os, therapeutic measures that are aimed at stimulating the intestines and clarifying the diagnosis of ex juvantibus (the introduction of parasympatomimetics, enema, parainal blockade) . The qualitative implementation of this complex does not guarantee against errors, but reduces their number.

Differential diagnosis of dynamic and mechanical obstruction is topical, mainly in relation to obstructive obstruction, which usually proceeds milder than strangulation. Strangulation, as a rule, from the very beginning shows itself a rigid, sudden pain in the abdomen, caused by acute ischemia of the organ. Therefore, during the strangulation variant of the impassability of associations with dynamic disorders of passage, intestinal contents do not arise, and differential-diagnostic efforts are directed to acute abdominal diseases accompanied by a pain syndrome - perforated ulcer, de-structural pancreatitis, and a twisted ovarian cyst. It should be pointed out that if differential diagnosis of the cause of intestinal obstruction is decisive in the choice of therapeutic tactics (conservative or surgical), then differential diagnosis with acute surgical abdominal pathology only clarifies the noso-logical affiliation of the disease, which, like strangulation obstruction, dictates the indications to an urgent operation. Clarification of the diagnosis in this case influences the choice of optimal operative access, and sometimes affects the composition of the operating team, in which, with a strong suspicion of the pathology of the female genitals, gynecologists are included. We repeatedly operated on patients who, under the mask of a twisted ovarian cyst, concealed the turn of the sigmoid colon or the striation of the ileum by cicatricial cramping. Swollen with gas, an elasticly strained bowel loop is often perceived as a twisted ovarian cyst. The operation in these cases begins the gynecologist, and the surgeon finishes. The preoperative diagnostic error does not bring about such great troubles, since corrections are made during an emergency operation. It is only necessary to remember that a well-developed, gynaecological

Sudden acute pain in the abdomen, which occurs during strangulation intestinal obstruction, characteristic for perforating ulcers and for acute destructive pancreatitis. The widely known textbook differential-diagnostic features that distinguish these nosoforms. The absence of hepatic dullness and the presence of gas under the diaphragm are characteristic features for patients with a perforated ulcer. High values ​​of blood and urine amylase, effusion in the left costal-diaphragmatic sinus are noted during pancreatitis, isolated wide horizontal level and Kloyber's bowl of hampered loop, indicate strangulation obstruction. All this is - yes, these signs contribute to the refinement of differential diagnosis. But a patient with a perforated ulcer may not have gas under the diaphragm, acute pancreatitis may occur with comparative indices of amylase and diastasis, and a horizontal level in the intestinal loop can be observed even during a dynamic obstruction. Therefore, erroneous preoperative diagnoses are inevitable. But in connection with the fact that any of the diagnoses that indicates acute surgical pathology of the abdominal organs dictate the need for rapid surgery, diagnostic errors do not entail tactical miscalculations and are corrected during the operation.

We discussed some variants of differential diagnosis of acute surgical diseases of the stomach. This is just a small part of the possible alternatives that have to be compared, weighed and evaluated by the urgent surgeon in practical work. Similarity of clinical manifestations of various diseases creates objective prerequisites for diagnostic errors. To reduce the number of errors, it is necessary to expand the indications to the use of a "catheter". Qualitative changes in the diagnosis of acute surgical diseases of the abdomen can be achieved only with the provision of urgent surgical hospitals with endoscopic equipment and endoscopic personnel who are on duty around the clock, which will allow performing diagnostic laparoscopy at any time of the day.

5. Materials for activating students during the presentation of the lecture.

The material of the lecture in the process of reading is associated with questions of medical ethics and deontology.

6. General material and methodical support of the lecture:

The lecture uses tables !, diagrams, drawings, slides, codograms, slidescope, overhead projector, darkened audience, school board.

7. Materials for self-study of students:

A) from the topic of the lecture, / question, literature, problem.

Control questions:

- What difficulties can be assumed in the diagnosis and differential diagnosis of acute diseases of the abdominal cavity;

- Give the definition of "Diagnosis", "Differential diagnosis", "Diagnosis";

- What are the signs of "Diagnosis" ?;

- What are the components of the clinical diagnosis ?;

- What are the rules for diagnosing ?;

- How are diagnostic methods divided into clinical practice ?;

- What are the two types of pain you are aware of ?;

Give a clinical description of visceral pain;

- Give a clinical description of somatic pain;

- What are the main types of doctor's tactics?

Bibliography:

1. Kuzin M.I. Surgical diseases. G .: Medicine, 1995.- P. 331-369.

B) from the topic of the next lecture / literature, list of main issues.

The next lecture is not connected with the above.

8. The literature used by the lecturer to prepare the lecture.

Literature:

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