



MODERN ACCES TO DIAGNOSIS AND TREATMENT IN DUODENOGASTRAL REFLUX

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Abstract

This article discusses the current relationship to the diagnostic criteria for duodenogastric reflux. The data of the examination in a planned manner in a hospital setting of patients with various complaints of dyspeptic manifestations are presented. Particular attention is paid to the principles of instrumental diagnosis of patients with this condition. The frequency of occurrence of morpho-functional changes in the gastrointestinal tract was compared and this pathology was assessed.

Keywords: duodenogastric reflux, dyspeptic manifestations, instrumental diagnostics, gastrointestinal tract.

Introduction

Reflux gastritis, also known as chronic chemical-toxin-induced or bile reflux gastritis, or type C gastritis, is a type of chronic gastritis. Reflux gastritis is a dysfunction of the pylorus of the stomach, in which there is a reflux (reflux) of the contents of the duodenum into the stomach.

The formation of DGR causes insufficiency of the sphincter apparatus of the gastrointestinal tract, impaired pyloric gaping, increased intraduodenal pressure, and antroduodenal dysmotility, acting on the retrograde current of duodenal contents.

Pathogenetic significance in the formation of GDR are:

- Damaging effect of pancreatic enzymes, bile acids on the mucosa of the gastrointestinal tract, which leads to the destruction of the mucin barrier of the mucosa of the esophagus, stomach;
- Reverse diffusion of proton ions into the submucosal layer of the gastrointestinal tract;
- Wounds with bile acids of the reflux of the membranes of the epithelium, which are subjected to an increase in sensitivity to pepsin, HP





Damage to the motor-evacuation structure of the gastrointestinal tract causes many structural and morphological diseases associated with GHD.

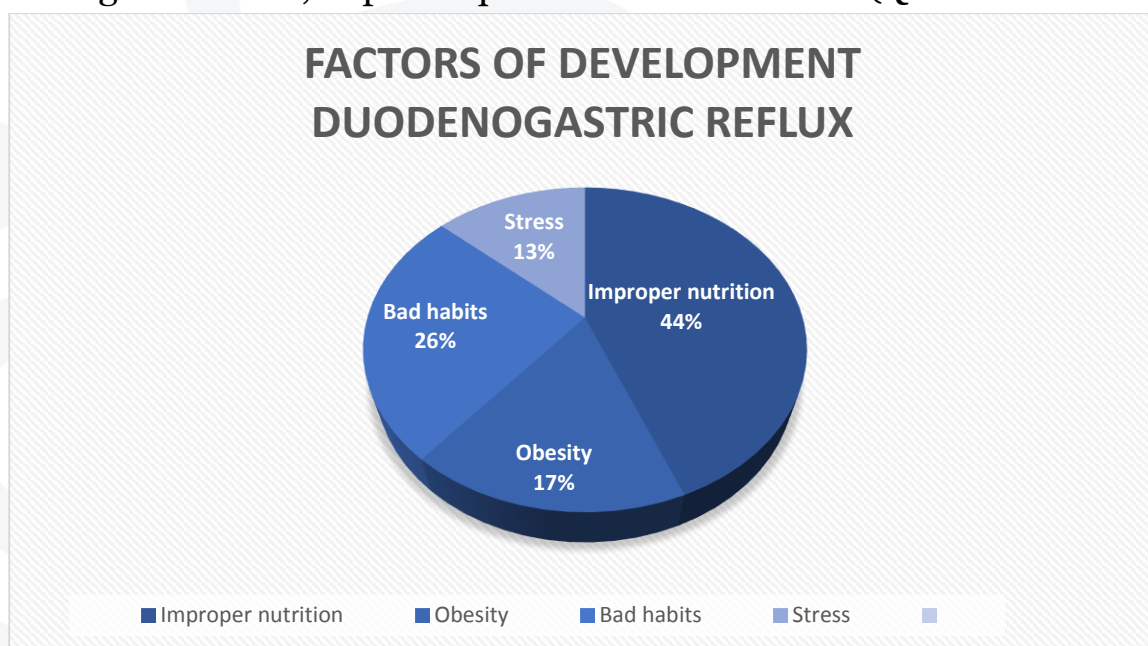
Purpose

The purpose of this review is to clarify the available data on duodenogastric reflux. To consider and study the ways of instrumental diagnostics and treatment of patients with this pathology.

Material and Methods of Research

patients who applied to the city hospital of the Samarkand region were selected for analysis. Recruited patients without organic pathology of the upper gastrointestinal tract with dyspeptic complaints. The patients were divided into two groups. The first group of patients has initial dyspeptic symptoms: complaints of nausea and vomiting (without impurities), belching, pain in the stomach. The second group of patients with characteristic dyspeptic manifestations: the patient is concerned about belching with acidic contents, heartburn, vomiting of bile, and bitterness in the mouth. The following methods are used in the study: collection of complaints, collection of anamnesis (presence of risk factors, infrequent use of alcohol). Instrumental studies, including: esophagogastroduodenoscopy, daily pH monitoring, ultrasound diagnostics, etc.

All patients were in the hospital gastroenterological department under observation. When collecting anamnesis, a special questionnaire was used. (Questionnaire GerdQ)

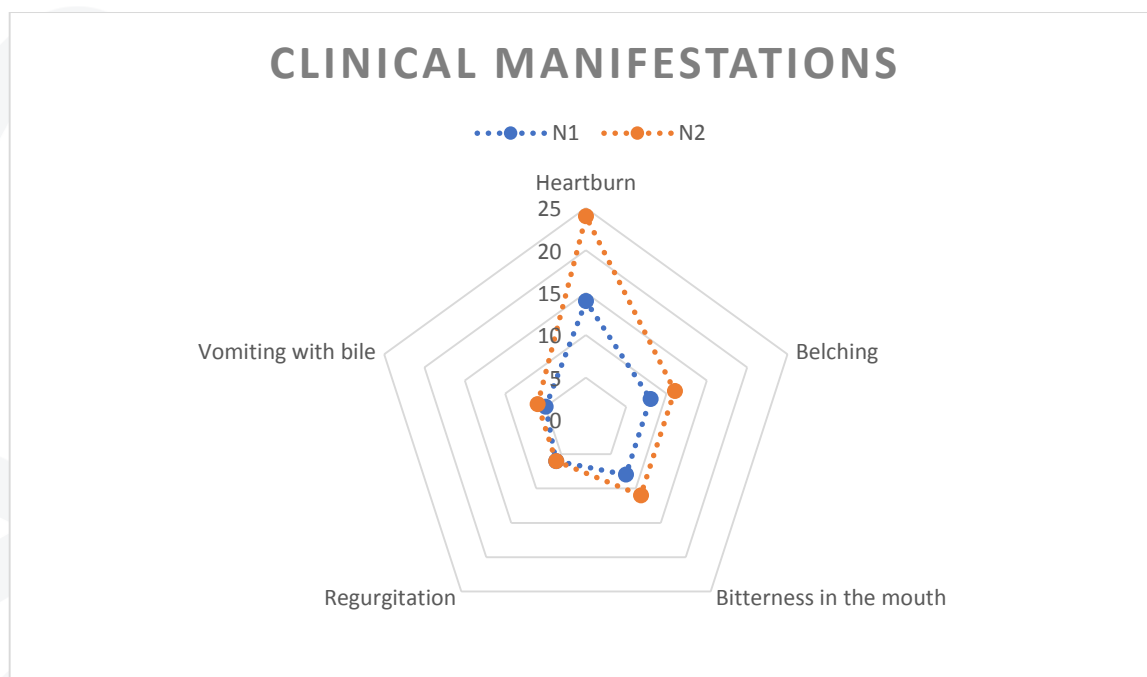




Results

63 patients (38 men and 25 women, mean age 25-48) were examined. The diagnosis was established on the basis of characteristic complaints, anamnesis data and endoscopic examination results. Patients were divided into two groups (N^o1; N^o2). Clinical assessment of GERD symptoms was performed using the GerdQ questionnaire (Questionnaire GerdQ)

Symptoms	Clinical manifestations	
	Scale points in GerdQ	
	Group N ^o 1	Group N ^o 2
Heartburn	8 ± 1	14 ± 1
Belching	4 ± 1	6 ± 1
Bitterness in the mouth	4 ± 1	6 ± 1
Regurgitation	3 ± 1	3 ± 1
Vomiting with bile	2 ± 1	3 ± 1



EGDS can be used on an outpatient basis, as well as in a hospital setting. Endoscopy assessed the contents of the stomach, the nature of the mucous membrane of the gastrointestinal tract and its color, the degree of hyperemia, the presence of erosions, ulcers, the state of sphincters with complications.

During Gastroscopy, the majority of patients in group N1 (79%) have normal gastric mucosa with clear gastric juice, yellowish bile lake (15%) and patients in group N2 with yellowish bile lake (39%), dark green bile lake (31%) and sticky gall patch (17%).



Fig 1 (With EFGDS, we determine the contents in the stomach with clear gastric juice and a yellowish bile lake)

When conducting intragastric pH-metry observed motor activity of the stomach, mild hypoacidity of the antrum of the stomach. With daily pH-metry, the state of intragastric pH and retrograde evacuation of the contents are assessed. Acidity in the body of the stomach and antrum is determined. On the obtained acidograms of patients, GHD was detected in the form of "jagged" alkalization or a rapid increase in pH in the antrum above 4.0, up to 7.0 units, not associated with food intake or saliva intake.

According to the pH-metry of the stomach, in patients of the N^o2 group, high pH values were observed in the antrum of the stomach compared to those of the N^o1 group.

INDICATORS OF INTRAGASTRAL PH IN THE STOMACH OF PATIENTS

Group of patients	In the body of the stomach	In the antrum
N ^o 1	0,8± 0,25	1,6± 0,25
N ^o 2	1,4± 0,25	4,4± 0,25

Ultrasound diagnostics in patients of the N² group revealed sediment in the gallbladder, which is typical for hypomotor dysfunction of the gallbladder. The reverse movement of the contents and fluid from the pyloric sections to the body of the stomach is recorded. There was an expansion of the CBD compared with the norm, which means a violation of the outflow of bile.

Conclusion

1.The study showed the following results: GHD leads to inflammation of the gastrointestinal tract, foveolar hyperplasia, interstitial edema, fibroproliferation and branching of the ridges in the antrum of the stomach.

2. In the study, by comparing two groups of patients, it became more clear that GHD as a pathological reflux complicates the course of many functional and organic diseases of the gastrointestinal tract and is a factor contributing to the occurrence of





changes in the mucous membrane of the stomach and esophagus, and its clinical manifestations do not allow timely diagnosis of GHD and prevent its effects. Therefore, in order to accurately diagnose and treat GHD, it is necessary to develop the most optimal schemes and approaches.

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