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are linked to increased gut permeability, which can contribute to insulin resistance, a key factor in dyslipidemia and NAFLD development.

The research studied 342 patients with dyslipidemia, 152 of whom had been diagnosed with NAFLD. The prevalence of small intestinal bacterial overgrowth (SIBO) was found to be 45% in patients with dyslipidemia and 53.2% in those with NAFLD. The average zonulin level in patients with NAFLD was 115 ± 2.76 ng/g, which was significantly higher than the normal upper limit of 107 ng/g. Additionally, the study found correlations between zonulin levels, C-reactive protein, and triglycerides, which are markers of cardiometabolic risk. There was also a negative correlation between SIBO and high-density lipoprotein (HDL) levels in patients with dyslipidemia.

The study highlights that zonulin and SIBO may be important targets for prevention and treatment of NAFLD and metabolic disorders.

Key words: non-alcoholic fatty liver disease, dyslipidemias, zonulin, small intestinal bacterial overgrowth, SIBO.

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Kubrak M. A., Zavgorodnii S. M., Danilyk M. B.

EVALUATION OF THE RESULTS OF USING ENDOSCOPIC METHODS AS THE FIRST STAGE OF TREATMENT OF PATIENTS WITH COMPLICATED FORMS OF COLON CANCER

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The use of endoscopic methods for the treatment of patients with complicated forms of large intestine cancer remains a controversial issue. The study aimed to evaluate the results of using endoscopic methods as the first stage of treatment of patients with complicated forms of colon cancer. The study group included 180 (100%) patients with complicated forms of colon cancer. In the comparison group, colonoscopy was performed in 11 (15.49%) patients, and in the main group - in 83 (76.15%) patients, $U=38.0$; $p=0.0019$. Stable haemostasis was achieved in 7 (8.43%) patients of the main group with acute intestinal bleeding; in 31 (37.35%) patients with acute intestinal obstruction, tumour tunnelling was performed, and in 7 (8.43%) patients, a self-expanding metal stent was placed. Another 9 (10.84%) patients achieved the partial restoration of the passage; in 15 (18.07%) patients, the procedure was unsuccessful and in 12 (14.46%), it resulted in complications.

Endoscopic examination of the large intestine has increased the number of postponed surgeries and the proportion of primary radical surgical interventions. It has also reduced the number of surgeries that resulted in colostomy.

Key words: cancer, large intestine, complications, endoscopy, treatment, stenting, tunnelling, surgical treatment.

Connection of the publication to planned research work.

The study was performed within the framework of the research project "Modification of surgical aspects of treatment of patients of different age groups in peacetime and wartime", state registration number 0122U201230.

Introduction.

Malignant neoplasms of the colon remain one of the main pathologies in Ukraine and the world, affecting both men and women over the age of 55 [1].

In Ukraine, there is a negative trend, according to which about 60% of patients are diagnosed with large intestine cancer only after the appearance of clinical signs

of complications: acute intestinal obstruction (AIO), tumour perforation, acute intestinal bleeding (AIB) and others [2].

Numerous global studies have shown that using minimally invasive techniques, in particular endoscopic technologies, is a promising alternative for treating several complications of the large intestine tumour process, which subsequently allows for radical surgical intervention in this category of patients [3-5].

However, several authors and studies also emphasise that preoperative aggressive manipulation of the oncological process results in a greater number of isolated secondary metastases and locoregional lymph node me-

tastases in the long term, which is a negative factor in the treatment of this category of patients [6, 7].

Therefore, it is relevant and important to conduct further studies aimed at assessing the effectiveness of endoscopic methods in the treatment of patients with complicated forms of colorectal cancer.

The aim of the study.

To evaluate the results of using endoscopic methods as the first stage of treatment of patients with complicated forms of malignant colon diseases.

Object and research methods.

A retrospective, prospective cohort study was conducted based on the surgical departments of the City Emergency and Ambulance Hospital of the Zaporizhzhia City Council and the City Hospital No. 7 of the Zaporizhzhia City Council in 2018-2023. The study group included 180 (100%) patients with complicated forms of colon cancer.

All patients were divided into two groups. The comparison group (retrospective) included 71 (39.44%) patients treated for complicated large intestine cancer from 2018 to 2019. The main group (prospective) included 109 (60.56%) patients treated for complicated colon cancer from 2020 to 2023.

The comparison group consisted of 35 (49.29%) women and 36 (50.71%) men, while the main group included 57 (52.29%) women and 52 (47.71%) men, $U=355.0$; $p=0.4893$. The average age in the comparison group was 67.97 ± 12.71 years, while in the main group, 69.78 ± 16.37 years, $U=520.0$; $p=0.7149$.

At the stage of hospitalisation, patients in both groups were examined according to existing protocols for the diagnosis and treatment of complicated forms of colorectal cancer. Instrumental methods included ultrasound examination of the abdominal cavity and retroperitoneal space, X-ray of the chest and abdominal cavity, irrigoscopy, colonoscopy, and computed tomography of the abdominal cavity with intravenous contrast.

The structure of large intestine oncopathology is presented in the **table**.

Among the complications of malignant pathology of the large intestine in both groups, acute obturative obstruction of the large intestine prevailed – 74 (67.89%) patients in the main group and 49 (69.01%) in the comparison group, $U=470.0$; $p=0.8328$. Tumour perforation was detected in 21 (19.27%) patients in the main group and 13 (18.31%) in the comparison group, $U=385.0$; $p=0.6551$. Acute intestinal bleeding was present in 6 (5.50%) and 3 (4.23%) patients, respectively, $U=365.0$; $p=0.5793$. In 3 (2.75%) patients of the main group and

4 (5.63%) of the comparison group, there was a combination of acute intestinal obstruction with tumour perforation ($U=310.0$; $p=0.2802$), and in 5 (4.59%) and 2 (2.82%) patients, respectively, with acute intestinal bleeding ($U=290.0$; $p=0.1081$).

Endoscopic examination of the large intestine was performed using OLYMPUS EVIS EXERA III (190) (USA) and HUGER GVE-2600 (China).

In the comparison group, large intestine endoscopy was performed as a diagnostic examination, while in the main group, it was a therapeutic and diagnostic procedure aimed not only at detecting a tumour but also at eliminating complications of the colon cancer process.

Preparation for colonoscopy included using cleansing enemas without using oral osmotic agents to cleanse the intestines.

During the endoscopic examination, disposable instruments (loops, knives, forceps), disposable dilatation balloons of 6-18 mm in size manufactured by OLYMPUS and STRYKER, self-expanding metal stents manufactured by OLYMPUS and BOSTON SCIENTIFIC, 22 and 25 mm in diameter, 60 and 90 mm in length were used. Coagulation destruction of the tumour was performed using the ERBE VIO 300D device.

All procedures performed with the participation of participants complied with the ethical standards of the institutional research committee of Zaporizhzhya State Medical and Pharmaceutical University, as well as the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. All patients provided written informed consent to participate in the study.

The results were statistically processed using the computer software STATISTICA 13.0, TIBCO Software inc. (Licence JPZ804I382130ARCN10-J) and MICROSOFT EXCEL 2013 (Licence 00331-10000-00001-AA404) using non-parametric analysis methods (Mann-Whitney U test for unrelated groups and Wilcoxon signed rank test for related groups) with an indication of the degree of reliability (data with $p < 0.05$ were considered reliable). The data in the text and tables are presented as $M \pm m$ (arithmetic mean \pm standard deviation), absolute values (n) and their relative proportion (%).

Research results.

In the comparison group, colonoscopies were performed in only 11 (15.49%) patients, whereas in the main group, the number of patients subjected to this study was 83 (76.15%), $U=38.0$; $p=0.0019$.

In the comparison group, all 11 (100%) patients who underwent endoscopic examination of the large intestine had acute obstruction as a complication of the oncological process. None of these patients underwent any manipulations with the oncological process for endoscopic removal of the complication, except for visual diagnosis of the malignant tumour.

In the main group, among 83 (100%) patients examined, 71 (85.54%) were diagnosed with acute intestinal obstruction, 9 (10.84%) with acute intestinal bleeding, and 3 (3.62%) with a combination of these two pathologies.

In the remaining 26 (23.85%) patients, colonoscopy was not performed due to the existing threatening health condition in 7 (26.92%) patients or the clinical picture of

Table – Structure of malignant diseases of the large intestine in the main and comparison groups, n=180

№	Location of the large intestine tumour	Number of patients in the main group, n (%)	Number of patients in the comparison group, n (%)	p
1.	Cecum	13 (11,93 %)	8 (11,27 %)	0,8643
2.	Ascending colon	12 (11,01 %)	8 (11,27 %)	0,7968
3.	Hepatic flexure	8 (7,34 %)	5 (7,04 %)	0,9110
4.	Transverse colon	4 (3,67 %)	2 (2,82 %)	0,4457
5.	Splenic flexure	2 (1,83 %)	1 (1,41 %)	0,7209
6.	Descending colon	12 (11,01 %)	8 (11,27 %)	0,7968
7.	Sigmoid colon	43 (39,45 %)	30 (42,25 %)	0,5812
8.	Rectosigmoid part of large intestine	13 (11,93 %)	9 (12,68 %)	0,8430

peritonitis against the background of tumour perforation in 19 (73.08%) patients.

According to the results of therapeutic and diagnostic colonoscopy, in 7 (8.43%) of the main group with acute intestinal bleeding, stable haemostasis was achieved by coagulation of the tumour. In 2 (2.41%), there was a slight capillary leakage of blood from the tumour after coagulation.

In 31 (37.35%) patients with acute obstruction of the large intestine, tumour tunnelling was performed by partial balloon dilatation of the large intestine in the area of the oncoprocess and coagulation destruction of the tumour tissue.

A self-expanding metal stent was installed in 7 (8.43%) patients after partial tumour tunnelling and minimal lumen (up to 5 mm).

In another 9 (10.84%) patients, a slight dilatation of the lumen up to 5 mm was achieved with partial restoration of passage (small amounts of gas and liquid stool).

In 15 (18.07%) patients, restoring passage through the large intestine was impossible.

In 12 (14.46%) patients, therapeutic and diagnostic colonoscopy resulted in the development of a complication – perforation of the large intestine in the area of the tumour process, which caused urgent surgical intervention, **fig. 1**.

Thus, according to the results of therapeutic and diagnostic colonoscopy in 47 (63.51%) patients of the main group with acute obstructive intestinal obstruction and 7 (77.78%) – with acute intestinal bleeding, it was possible to completely eliminate the clinical manifestations of complications of the oncological process, **fig. 2**.

After a set of examinations, in the comparison group, 10 (14.08%) patients underwent urgent surgery (up to 2 hours from the time of hospitalisation), 24 (33.80%) patients underwent urgent surgery (up to 6 hours from the time of admission), and another 37 (52.11%) were operated on within 6 hours of hospitalisation after the patient's condition had stabilised.

In the main group, as a result of the first stage of therapeutic and diagnostic endoscopic examination of the large intestine, emergency operations were performed in 8 (7.34%) patients ($U=96.0$; $p=0.0781$), urgent operations in 19 (17.43%) patients ($U=79.0$; $p=0.0394$), and delayed operations in 82 (75.23%) hospitalised patients ($U=79.0$; $p=0.0419$).

The average duration of the preoperative period in the comparison group was 7.80 ± 2.10 hours; in the main group – 26.40 ± 7.30 hours, $U=29.0$; $p=0.0013$. These changes were due to the fact that endoscopic restoration of the large intestine passage allowed patients to undergo a longer preoperative preparation for further one-stage radical surgery.

It should also be noted that the use of diagnostic colonoscopy at the first stage also changed the structure of surgical interventions due to an increase in the number of primary radical operations: in the comparison group, such interventions were performed in 48 (67.61%) patients,

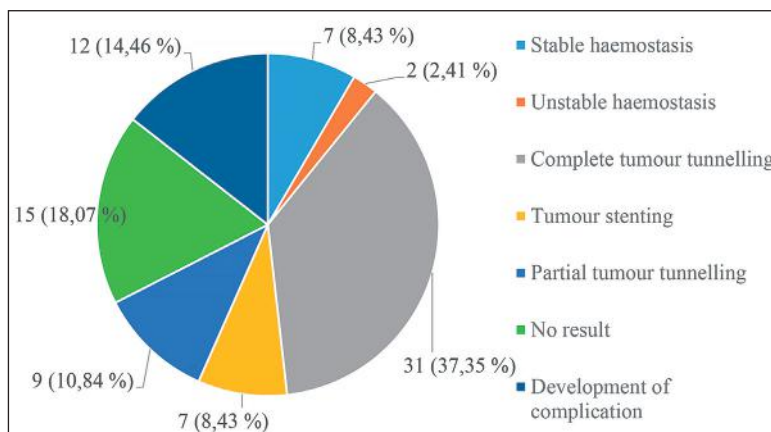


Figure 1 – Structure of therapeutic and diagnostic endoscopy of the large intestine in patients of the main group with complicated forms of colon cancer (n=83).

in the main group – in 97 (88.99%) patients, $U=81.0$; $p=0.0478$.

Palliative surgeries were performed in 18 (25.35%) and 7 (6.42%) cancer patients, respectively ($U=19.0$; $p=0.0006$), and symptomatic surgeries in 5 (7.04%) patients in the comparison group and 5 (4.59%) in the main group ($U=210.5$; $p=0.6084$).

Another important positive aspect of therapeutic and diagnostic colonoscopy is the fact that by preparing patients for primary radical surgery, it was possible to significantly reduce the number of interventions that ended in colostomy: 42 (59.15%) patients in the comparison group and 23 (21.10%) in the main group ($U=28.5$; $p=0.0081$), as well as to perform surgical intervention using laparoscopic techniques in 24 (22.02%) patients in the main group, while in the comparison group such operations were not performed in any of the patients.

Discussion of the research results.

In the structure of urgent diseases of a general surgical hospital, complicated forms of large intestine cancer occupy one of the leading places, with a significant proportion of operations performed for acute obstructive intestinal obstruction [8].

Modern endoscopic techniques make it possible not only to diagnose the oncological pathology of the large intestine but also to perform primary radical treatment of the patient – submucosal resection of the tumour [9].

In the case of complicated forms of large intestine cancer, it is not possible to radically remove the oncological process, but it is possible to eliminate the complica-

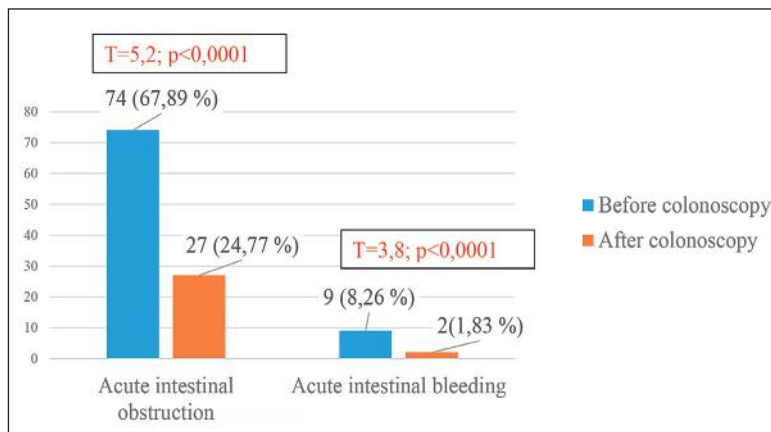


Figure 2 – Presence of clinical signs of complications in patients of the main group before and after therapeutic and diagnostic colonoscopy (n=109).

tions of the malignant disease and prepare the patient for primary radical surgery in the future [10].

This possibility of colonoscopy is especially relevant in cases of obstructive tumour obstruction of the large intestine because, in 25.0-70.0% of cases, it is possible to restore the passage through the intestine and eliminate the clinical manifestations of AIO, which allows for postponing the operation [11, 12].

Seo S. Y. and co-authors and Sarani B. and co-authors indicate that the use of endoscopic methods of tumour destruction and large intestine stenting allowed more than 65.0% of patients to restore intestinal passage and subsequently perform primary radical intervention without colostomy, which had a positive effect on the perioperative results of treatment of this category of patients and improved the quality of life of patients compared to the group of patients with colostomy [13, 14].

In their analysis, Sengupta N. and colleagues indicate that endoscopic treatment is the method of choice for treating acute intestinal bleeding due to tumour genesis, followed by delayed surgical treatment [15].

Our study also indicates that diagnostic endoscopy can eliminate complications in 67.47% of patients in the study group (AIO and AIB), thus reducing the number of emergency operations and interventions with stoma creation, and enabling laparoscopic surgery in this category of patients.

Conclusions.

1. Endoscopic examination of the large intestine in patients with complicated forms of colon cancer is a mandatory method at the first stage of the treatment and diagnostic complex, which in 47 (63.51%) patients with acute intestinal obstruction and 7 (77.78%) patients with acute intestinal bleeding allowed to eliminate clin-

ical manifestations of complications of the oncological process.

2. The use of therapeutic and diagnostic colonoscopy increased the number of postponed operations – from 37 (52.11%) in the comparison group to 82 (75.23%) in the main group ($U=79.0$; $p=0.0419$) while reducing the number of emergency and urgent surgical interventions.

3. Due to the use of diagnostic colonoscopy at the first stage, the proportion of primary radical surgical interventions also increased: in 48 (67.61%) patients in the comparison group and 97 (88.99%) in the main group, $U=81.0$; $p=0.0478$.

4. Due to the use of endoscopic methods in the treatment of patients with complicated forms of colon cancer, it was possible to significantly reduce the number of operations that ended with colostomy: 42 (59.15%) patients in the comparison group and 23 (21.10%) in the main group ($U=28.5$; $p=0.0081$), as well as to perform surgical intervention using laparoscopic techniques in 24 (22.02%) patients in the main group, while in the comparison group such operations were not performed in any of the patients.

Prospects for further research.

The use of endoscopic methods in the treatment and diagnostic complex will allow patients with complicated forms of colon cancer to increase the proportion of patients who will be able to undergo a one-stage radical surgical intervention using both classical and laparoscopic techniques and improve the quality of life of this category of patients by reducing the proportion of patients with colostomy.

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ОЦІНКА РЕЗУЛЬТАТІВ ВИКОРИСТАННЯ ЕНДОСКОПІЧНИХ МЕТОДІВ ЯК ПЕРШОГО ЕТАПУ ЛІКУВАННЯ ХВОРИХ З УСКЛАДНЕНИМИ ФОРМАМИ РАКУ ОБОДОВОЇ КИШКИ

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Дискутабельним залишається питання щодо використання ендоскопічних методів лікування хворих з ускладненими формами раку товстої кишки. Метою дослідження було провести оцінку результатів використання ендоскопічних методів в якості першого етапу лікування пацієнтів з ускладненими формами злоякісних захворювань ободової кишки. В групу дослідження ввійшло 180 (100%) хворих з ускладненими формами раку ободової кишки. У групі порівняння колоноскопія проведена у 11 (15,49%) хворих, в основній групі – у 83 (76,15%) обстежених, $U=38,0$; $p=0,0019$. У 7 (8,43%) обстежених основної групи з ГКК вдалося досягти стійкого гемостазу, у 31 (37,35%) хворого з ГКН виконано тунелізацію пухлини, у 7 (8,43%) – встановлено саморозширюючий металевий стент. Це у 9 (10,84%) пацієнтів досягнуто часткового відновлення пасажу, у 15 (18,07%) хворих процедура була безуспішна та у 12 (14,46%) - завершилася розвитком ускладнення.

Ендоскопічне дослідження товстої кишки збільшило кількість відтермінованих операцій та частку первинно-радикальних оперативних втручань, а також дало змогу зменшити кількість операцій, що завершувалися виведенням колостоми.

Ключові слова: рак, товста кишка, ускладнення, ендоскопія, лікування, стентування, тунелізація, хірургічне лікування.