ON THE CLASSIFICATION OF MALLORY-WEISS SYNDROME.

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Annotatsiya. Maqolada Mellori–Veys sindromining tasnifi va klinik ahamiyati yoritilgan. Klinik tajriba va zamonaviy ilmiy manbalar tahlili asosida sindromning morfologik, patogenetik va klinik mezonlarga ko‘ra tasnifi ko‘rib chiqilgan. Endoskopik belgilar, qon ketish darajasi va klinik oqibatlar asosida turkumlashning afzalliklari tahlil qilinadi. Taklif etilayotgan tasnif erta tashxis qo‘yish, davolash strategiyasini tanlash va bemor prognozini yaxshilashda muhim ahamiyat kasb etadi.

Kalit so‘zlar: Mellori–Veys sindromi, tasnif, oshqozon-ichak qon ketishi, endoskopik belgilar, patogenez, klinik ahamiyat

Аннотация. В статье рассматривается классификация синдрома Маллори–Вейсса и её клиническое значение. На основе анализа клинического опыта и современных научных данных представлена систематизация синдрома по морфологическим, патогенетическим и клиническим критериям. Особое внимание уделено эндоскопическим признакам, степени кровотечения и клиническим исходам. Предлагаемая классификация способствует более ранней диагностике, выбору адекватной лечебной тактики и улучшению прогноза для пациентов.

Ключевые слова: синдром Маллори–Вейсса, классификация, желудочно-кишечное кровотечение, эндоскопические признаки, патогенез, клиническое значение.

Abstract. The article addresses the classification of Mallory–Weiss syndrome and its clinical significance. Based on clinical experience and analysis of current scientific literature, the syndrome is classified according to morphological, pathogenetic, and clinical criteria. Special emphasis is placed on endoscopic findings, the degree of bleeding, and clinical outcomes. The proposed classification facilitates early diagnosis, the selection of appropriate treatment strategies, and improved patient prognosis.

Keywords: Mallory–Weiss syndrome, classification, gastrointestinal bleeding, endoscopic findings, pathogenesis, clinical significance.

Relevance of the Topic:

ISSN 3030-3907

Mallory-Weiss syndrome (Mallory-Weiss tear) is an acute condition characterized by longitudinal mucosal tears in the cardiac part of the stomach and distal esophagus, accompanied by upper gastrointestinal bleeding. Despite having a relatively favorable prognosis with timely diagnosis and treatment, this syndrome remains a significant cause of upper gastrointestinal bleeding. In some cases, there is either overestimation or underestimation of the severity of the condition, leading to unjustifiably aggressive or, conversely, insufficient treatment tactics.Currently, improving the proportionality of diagnostic and therapeutic approaches remains an urgent task — that is, ensuring an adequate and well-grounded scope of diagnostic measures and selecting optimal therapeutic interventions in accordance with the patient's clinical characteristics and the severity of bleeding. This will help reduce the frequency of rebleeding, minimize the risk of complications, and improve the efficiency of medical resource use.

Thus, studying the issues of optimizing the diagnosis and treatment of Mallory-Weiss syndrome, aimed at individualizing and rationalizing medical care, is a relevant and socially significant area of modern gastroenterology and endoscopy.

The aim of the study: to improve the treatment results of patients with Mallory-Weiss syndrome by systematizing the clinical signs of the disease and a differentiated approach to the choice of treatment method.

Materials and methods: The results of examination and treatment of 112 patients with Mallory-Weiss syndrome , who were hospitalized in the emergency surgery department of the multidisciplinary clinic of the Tashkent Medical Academy for the period from 2012 to 2024, were analyzed. All patients were divided into two clinical groups - control and main. The control group included 64 patients who underwent traditional treatment approaches. In the main group, 48 patients underwent an improved set of treatment measures.

Results obtained . In the control group, conservative measures were taken upon admission of patients to the hospital after endoscopic examination (general and local hemostatic therapy, infusion program, antiulcer drugs, endoscopic methods of hemostasis - electrocoagulation, injection, installation of a Blackmore tube). If conservative therapy was ineffective and there was active bleeding, surgical treatment was performed: gastrotomy and suturing of the crack in the mucous membrane of the cardioesophageal junction. Primary hemostasis was achieved in 50 (78.1%) patients, repeated endoscopic interventions had to be resorted to in 10 (15.6%) cases, in 4 (6.3%) cases hemostasis was achieved by open surgery.

ISSN 3030-3907

The conducted analysis of the reasons for unsatisfactory treatment results in the control group showed that the main reason was the low efficiency of the primary hemostasis methods used, in particular endoscopic methods, and the lack of a differentiated approach depending on the intensity of bleeding. It should be noted that another negative aspect was the discomfort experienced when using the Blackmore tube due to the inflation of the esophageal balloon.

Taking into account the above, we modified the Blackmore tube , which consisted of reducing the size of the esophageal balloon and giving it a spherical shape, which made it possible to reduce the phenomena of discomfort in patients.

We have systematized the classification of Mallory-Weiss syndrome by the localization of the lesion; by the extent, number and length of ruptures; and the intensity of bleeding.

I. By localization of the lesion

EF type (esophageal fissure) - The lower third of the esophagus

KEF type (kardioesophageal fissure) - Cardioesophageal junction

KESF type (cardioesophageal - stomach fissure) - cardioesophageal junction with extension to the gastric mucosa

HF type (hernial fissure) - a crack inside a hernia of the esophageal opening of the diaphragm (HOD).

II . By the number of breaks

Unit

Multiple

III . By the length of the gap

Small - up to 1.0 cm

Average - from 1.0 to 2.0 cm

Large - more than 2.0 cm

IV . By the depth of the defect

Stage 1 - rupture of the mucous membrane.

Stage 2 - rupture of the mucous membrane and submucosal layer.

Stage 3 - rupture involving the circular muscle layer.

Stage 4 - rupture of all layers of the esophagus.

V. By the intensity of bleeding

1st degree - ongoing bleeding

1a - jet, profuse arterial bleeding, the source is not visible due to the impossibility of cleaning the esophagus from blood

1b - jet, arterial bleeding, the possibility of esophageal sanitation makes it possible to determine the source of bleeding

1b - venous bleeding, no blood clots

ISSN 3030-3907

1g - the crack is covered with fresh blood clots, there is blood seepage under them

2nd degree - stopped bleeding

2a - visible thrombosed vessel in the area of rupture

2 b - fixed clot in the rupture area without bleeding

2 in - the rupture is covered with fibrin

3 - rupture without signs of bleeding, granulation of the crack.

The choice of hemostasis method is primarily determined by the intensity of bleeding and the type of crack location.

For bleeding of 1a, 1b degree, regardless of the type of location (EF , KEF , KESF and HF types) **the bleeding area** is clipped or electrocoagulated. If endohemostasis is impossible , temporary hemostasis is achieved by installing a modified Blackmore tube for 24-48 hours, followed by an attempt to clip the bleeding area. If endoscopic hemostasis is ineffective, open surgery is performed. However, if the source is located inside the GERD (HF type) (with a hernia size of 5.0 cm or more in length and 3.0 cm or more in width), it is necessary to install a nasogastric tube for gastric lavage with subsequent endoscopic clipping of the crack, since in such cases the installation of a Blackmore tube does not provide a hemostatic effect due to the gastric balloon slipping out of the GERD. With the KESF type, retrograde clipping of a gastric fissure after stopping bleeding using a Blackmore tube .

At grade 1b, due to the high risk of recurrent bleeding, injection of the crack edges with electrocoagulation is performed.

In case of grade 1 bleeding, the edges of the crack are injected with a 33% ethanol solution (up to 20 ml) in order to prevent recurrence of bleeding.

At stage 2a, due to the high risk of relapse, clipping or electrocoagulation of the thrombosed vessel is performed using an endoscopic mosquito clamp.

For bleeding of grades 2b, 2c and 3, conservative treatment is carried out.

Conclusion:

A differentiated approach to the choice of hemostasis method allowed to increase the effectiveness of primary hemostasis from 78.1% to 91.7%, reduce the frequency of repeated endoscopic interventions from 15.6% to 6.3% and reduce the need for open surgical interventions from 6.3% to 2.1%.

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ISSN 3030-3907