

## **A new method of the treatment of purulent-destructive pulmonary diseases in patients with diabetes mellitus**

**Okhunov Alisher Oripovich**

*Tashkent Medical Academy, Uzbekistan.*

The main aim of our research was to create the maximum restriction of the purulent-necrotic process in the lung, obstruction of the draining bronchus while maintaining its sanitation, sealing the transthoracic drainage and creating a controlled unlocked cavity.

After a transtracheal endobronchial and transthoracic installation under X-ray control of the drains, the destructed cavity was thoroughly washed with 0.18% sodium hypochlorite solution. The transthoracic drainage obturator was connected to an active aspiration system with a vacuum of 20-30 mm H<sub>2</sub>O. An endobronchial obturator catheter was connected to a container with an ozonized 0.9% sodium chloride solution up to 500 ml per day in combination with a 0.18% sodium hypochlorite solution, in a daily volume of up to 1000 ml. The washing of the cavity was carried out in a flow-drop mode at a rate of 3-4 ml / hour.

After a decrease of a purulent discharge and the release of necrotic sequestration, usually had occurred by 2-3 days, washing with an ozonized 0.9% sodium chloride solution was stopped. A water-soluble ointment-based dioxidine-proteolytic composition began to be injected into the cavity, consisting of a water-soluble ointment of laevomecolum (25 g), 1% solution of dioxidine (10 ml) and trypsin (100 mg). For this, every 6 hours, the patient changed body position to an "anti-drainage" towards to the transthoracic obturator. The latter was left open, a portion of the dioxidine-proteolytic composition was injected into the endobronchial obstruction catheter closely, until its excess flowed away through the transthoracic drainage, that was indicating the filling of the cavity, after which the transthoracic drainage was blocked. After 60-90 minutes, the transthoracic drainage was connected to active aspiration by 20-30 mm H<sub>2</sub>O level, and the endobronchial drainage was blocked, which contributed to the subsidence of the cavity.

X-ray inspection was performed every two days. When a thin-walled cavity was formed, which usually

occurred by 5–7 days of the dioxidine-proteolytic composition injection, the transthoracic drainage was removed. Every day, 1-2 times a day, the patient was given "an anti-drainage" position of the body, 0.5-1.0 ml of 10% lidocaine solution was injected into the abscess cavity and after 0.5 minutes 0.5-1.0 ml of Lugol's solution was injected there, too. After an exposure, the catheter was connected to an active aspiration of 20-30 mm H<sub>2</sub>O for 10-15 minutes.

This stage was carried out until the cavity was completely scarred, usually by 8-12 days.

Thus, the development and application of original methods of transthoracic drainage and differentiated sanitation of a purulent-necrotic lesion in the lung with acute purulent-destructive diseases made it possible to reduce the duration of rehabilitation by  $12.7 \pm 0.5$  days, increase the frequency of complete and clinical recovery by 12% , reduce the frequency of chronicity by 5.5% and mortality by 6.5%.