NOVATEUR PUBLICATIONS
JournalNX- A Multidisciplinary Peer Reviewed Journal
ISSN No: 2581 - 4230
VOLUME 7, ISSUE 3, Mar. -2021

THERAPEUTIC TACTICS FOR VESICOURETERAL REFLUX IN CHILDREN

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ABSTRACT:

Among children and adolescents, vesicoureteral reflux (PMR) occurs in 1% of cases, the proportion of bilateral reflux is up to 50.9% [1]. At the same time, in 50% of cases, the degree of reflux from different sides is different.

Keywords: vesicoureteral reflux, endoscopy, children.

INTRODUCTION:

Among children and adolescents, vesicoureteral reflux (PMR) occurs in 1% of cases, the proportion of bilateral reflux is up to 50.9% [1]. At the same time, in 50% of cases, the degree of reflux from different sides is different. The prevalence of PMR and the consequences of this disease (chronic pyelonephritis, developmental delay, arterial hypertension, chronic renal failure), which inevitably lead to disability, dictate the need to find ways to improve treatment tactics. Among the causes of PMR in boys, the main place is occupied by malformations of the ureteral mouths, while in girls, secondary forms of PMR are predominant, due to urinary tract infection and neurogenic bladder dysfunctions (NDMP). Thus, in the first year of life, the ratio of boys and girls suffering from PMR is 6:1, and as they grow older, this ratio changes exactly the opposite [2].

MAIN PART:

To understand the causes of PMR, it is necessary to have an understanding of the normal structure of the vesicoureteral segment (PMS). Anatomically, the closure function of PMS is carried out due to a certain ratio of the length and width of the intravesical ureter (5:1), the oblique passage of the ureter through the wall of the bladder. The long submucosal tunnel is a passive element of the ureterovesical "valve". The active element of the valve mechanism is represented by the musculoskeletal apparatus of the ureter, which closes the mouth when the detrusor is reduced.

The causes of antiphysiological urine flow include pathological conditions that lead to a violation of the closing function of PMS and high intravesical pressure of urine. The first can include congenital malformations of PMS and the inflammatory process of the superficial and deep layers of the triangles of the bladder (cystitis), which disrupts the detrusor or directly the PMS itself.

PMS abnormalities are the result of improper development of the ureteral outgrowth of the wolf duct at the 5th week of embryogenesis [3, 4]. PMS anomalies can be represented as follows: a wide, constantly gaping shape of the ureteral mouth; the location of the ureteral mouth outside the area of the urogenital triangle (lateroposition); complete absence or shortening of the submucosal part of PMS; violation of the morphological normal structure of PMS (dysplasia).

Loss of the closure function of PMS occurs when the bladder wall or PMS area is inflamed. Most often, secondary PMR is a consequence (complication) of granular, bullous or fibrinous forms of cystitis. Urinary tract infection occurs in 1-2% of boys and 5% of girls. More often, the urinary tract is colonized by opportunistic (intestinal) flora, among which

the main place is occupied by escherichia coli (40-70%) [3].

Normally, PMS is able to withstand intravesical fluid pressure up to 60-80 cm of water column [5]. High hydrostatic pressure is a consequence of intravesical obstruction or functional disorders of the bladder. Intravesical obstruction develops in posterior urethral valves, cicatricial phimosis in boys, sclerosis of the bladder neck (Marion's disease), and meatal stenosis in girls.

NDMP occurs in 20% of children aged 4-7 years. By the age of 14, the number of people suffering from these dysfunctions is reduced to 2% [6]. NDMP manifests itself as irritative or obstructive symptoms. Basic forms NDMP: detrusor hyperactivity, hypotonia and detrusor detrusor-sphincter dyssynergia. In these conditions, PMR is also considered secondary and is a consequence of increased fluid pressure in the bladder. Hyperactivity of the detrusor is characterized by sharp jumps in intravesical pressure and a violation of the accumulative function of the bladder. Hypotension of detrusor is characterized by a decrease in the sensitivity of the bladder wall, its overflow and an increase in the pressure of urine in its lumen above critical numbers.

Detrusor-sphincter dissinergia is a violation of the synchronous operation of the detrusor and the sphincter apparatus, leading to functional infravesical obstruction during miction.

With age there is a trend to reduction of the incidence of primary and secondary increase of the TMR. At the same time, the frequency of regression of primary PMR is inversely related to the degree of PMR. Regression is observed in 80% of cases with grade I and II PMR, and in only 40% of cases with grade III PMR. This is explained by the theory of "maturation" of PMS (Hutch, 1961), which gained its supporters later (Kellerman, 1967; King, 1974). The essence of the theory is that with the development of the child there is a physiological transformation of PMS — the intravesical part of the ureter is lengthened, its diameter decreases relative to the length and the angle of flow into the bladder changes.

The current treatment strategy for PMR includes a set of measures (therapeutic and surgical) aimed at eliminating the cause of reflux and eliminating its consequences. The choice of the method of correction of PMR, of course, is determined by its form.

The essence of conservative therapy should be reduced to the eradication of urinary tract infection and the elimination of functional disorders of the bladder and the prevention of death of the renal parenchyma. According to Yu. F. Isakov, the effectiveness of conservative therapy in the I–III degree of PMR is 60-70%. The main complications (manifestations) PMRS are chronic pyelonephritis (50-70%) and reflux nephropathy (60-70%) [2]. The etiological structure of chronic pyelonephritis (according to A. F. Vozianov et al., 2002) is represented as follows: Escherichia coli-40-60%, proteus-9-16%, Klebsiella-7-20%, Streptococcus-4-10%, L-forms-15%, microbial associations-10-15%, Enterococcus-2-5%, Pseudomonas aeruginosa-2-7%, Enterobacter-5-15%, Staphylococcus-5-14%.

Antimicrobial therapy should be long-term (6-12 months) and applied according to the results of urine culture. The most convenient drugs for children are oral forms. In hospital treatment, intramuscular or intravenous forms are used. After the use of bactericidal drugs (antibiotics), a long course of uroseptic therapy is prescribed. In order to stop the allergic component, desensitizing agents are prescribed.

An important role is played by the use of drugs that improve intracellular metabolism. A mandatory component of conservative therapy is the use of herbal medicines.

A special place in the treatment of urinary tract infections in children should be given to the normalization of intestinal function. Violation of the normal rhythm of emptying the colon leads to compression of the lower third of the ureter, violation of vascularization, stagnation in the pelvic region, infection of the urinary tract (lymphogenic pathway).

NDMP is observed in patients with myelodysplasia and its various manifestations: meningomyelocele, rachisisis, Spina bifida (incomplete closure of the spinal canal) , etc. Treatment of PDMP is an important link in complex therapy. The elimination of functional disorders of the urinary tract is a very difficult task and requires a long time.

A separate place in the treatment of PMR is given to endoscopic methods. Thus, according to a survey conducted by Italian urologists, 80% of parents choose endoscopic treatment as an alternative to open surgery and long-term drug therapy [7].

Priority in the medical use of teflon paste belongs to the otolaryngologist Arnold, who used it for the purpose of correcting the glottis (1962). The introduction of teflon into urological practice took place in 1974, when V. Politano performed a paraurethral injection for urinary incontinence. For the first time, a minimally invasive endoscopic method for correcting PMR was announced by E. Matouschek. In 1981, with a positive result, he performed insuflation of teflon paste to an 8-year-old child in the area of the mouth of the refluxing ureter [8]. Subsequently, O. Donnel together with P. Puri (1984) described the method of endoscopic treatment of PMR [9]. For 25 years, a large number of implantable materials have been tested, starting with teflon and ending with autogenic cell cultures [8-16]. The most complete classification of injectable materials is as follows [17]: auto - and allogeneic: blood, fat, chondrocytes, detrusor cells, human collagen; xenogenic and synthetic: teflon, silicone, dextranomer/hyaluronic acid, calcium hydroxyapatite, bio-glass fiber, polyvinyl alcohol foam, hydroxyethyl methacrylate, bovine collagen, duraspheres (Durasphere B).

The first experience of using antireflux implants alarmed specialists due to the possibility of developing undesirable side effects: the occurrence of necrosis at the injection site, malignancy, migration of material with the formation of granulomas in regional lymph nodes and/or parenchymal organs [18-20]. Modern experimental and clinical studies have proved the inertness and hypo-allergenicity, as well as the safety of currently used biomaterials [12, 13]. Positive results of endoscopic treatment of PMR, according to recent studies, (Chertin, 2003; Kirsch, 2004) reach 70-90%.

Indications for the endoscopic method of correction of PMR are the ineffectiveness of conservative therapy in the period from 6 to 12 months. The absence of an acute phase of inflammation of the bladder is a prerequisite for endocollagenoplasty.

The endoscopic method of PMR correction, due to its simplicity of execution and sufficiently high efficiency, is firmly included in the algorithm of therapeutic tactics. Undoubtedly, an important role should be given to the correct choice of indications for this method. Collagenization of the ureteral mouth is justified in its normal structure, i.e., the absence of a gaping mouth and lateral dystopia. With IV and V degrees of PMR and a decrease in the secretory function of the kidney > 50%, open ureteral reimplantation is indicated.

The method of endoscopic treatment, aimed at lengthening the intramural ureter and reducing the diameter of the mouth, is performed according to the following method. Cystoscopy is performed, during which the clinical and anatomical picture of the bladder is determined: the state of the urogenital triangle,

the shape and location of the ureteral mouths, the presence of paraurethral diverticula and ureterocele, inflammatory changes. Through the working channel of the cystoscope tube, a long injector (diameter 5H) is attached to a syringe with collagen. Collagen is represented by a substance in the form of a gel. The standard volume of collagen in a syringe is 2 ml. The injection of the needle of the injector (length 6 mm) is carried out under the mouth of the ureter — at 6 h of the conditional dial, to the full depth. To prevent complications before collagenoplasty, it is possible to catheterize the mouth with a 5CH ureteral catheter. When the pressure is applied to the plunger of the syringe with collagen, a roller is gradually formed in the area of the needle injection. Depending on the degree of gaping of the mouth and the length of the submucosal ureter, from 1 to 2 ml of the substance is administered. In this case, the mouth of the ureter becomes dotted or slit-shaped, after which the instrument is removed. The bladder is drained for a day by a double-light urethral catheter Foley 8-14Sh, the balloon of which is filled with 5 ml.

The most effective way to correct PMR remains operative-93-97% of cases [21]. More than 80 methods of open surgical treatment of PMR are known-these are various modifications of ureterocystoanastomosis. The principal mechanism of all types of open interventions is the elongation of the intramural ureter in order to create a valve mechanism capable of passing urine in one direction from the ureter to the bladder. The most successful technique is tunnel anastomosis, due to the ability of the tunnel to withstand high hydrostatic pressure inside the bladder (both when the bladder is filled and when urinating), preventing the reflux of urine into the ureter.

Indications for surgical treatment are: reflux megaureter (with grade IV, V PMR), recurrent nature of PMR at lower degrees and the absence of a positive effect from conservative or endoscopic treatment, a combination of reflux with an obstructive component in the PMS zone.

The emergence of new effective drugs in the pharmacological conservative treatment of PMR in children, on the one hand, and the introduction into practical medicine of new surgical methods of treatment, including laparoscopic surgery, robotics, on the other, will certainly change the importance of the usual open methods of PMR correction in the future. But today, open surgical interventions play a key role in the strategy of treating PMR, as they allow eliminating the most complex forms of PMR.

CONCLUSION:

I would like to emphasize that the choice of the method of correction of PMR should be strictly individual and based on an objective analysis of the examination data by the doctor and an assessment of the possibility of using all available methods to eliminate PMR in this particular patient.

REFERENCES:

1) Yatsyk P.K., Zvara V. Vesicoureteral reflux in children. M., 1990. pp. 41-44.
2) Kokolina V.F., Rumyantseva A.G. Practical guide to children's diseases. Nephrology of childhood. Moscow: Medpraktika-M, 2005. Vol. VI. p. 234, 240, 252.
3) Lopatkin N.A., Pugachev A.G. Vesicoureteral reflux. M., 1990. p. 5, 119.
4) Campbell M. Clinical Pediatric Urology. 1951; 164.
5) Isakov Yu.F. Surgical diseases in children. M., 1998. p. 327.
6) Vishnevsky E. L. Hyperactive bladder in children/Current issues of diagnosis and treatment of urological diseases in adults and children. Tyumen, 2005. S. 324.
7) Capozza N., Lais A., Matarazzo E. et al. Treatment of vesico-ureteric reflux: a new

algoritm based on parental preference//BJU international. 2003; 92: 285–288.

8) Matouschek E. Treatment of vesicoureteral reflux by transurethral teflon injection//Urologe A. 1981; 20: 263-264.
9) Puri P., O'donnell B. Correction of experimentally produced vesicoureteric reflux in the piglet by intravesical injection of Teflon//Br. Med. J. 1984; 289: 5-7.
10) Semenova A.A. Chepurov A.G. Endoscopic correction of vesico-mochetocnikov reflux by injection of Teflon paste//Urology and nephrology. 1993. No. 2. S. 7-10.
11) Puri P., Chertin B., Dass L. Treatment of vesicoureteral reflux by endoscopic injection of dextranomer/hyaluronic acid copolymer: preliminary results//The Journal of Urology. 2003; 170: 1541–1544.
12) McPherson J.M., Wallace D.G., Piez K.A. Development and biochemical characterization of injectable collagen//J. Dermatol. Surg. Oncol. 1988; 14 (1): 13.
13) Alkan M., Talim B., Ciftci A. O., Senocak M.E., Caglar M., Buyukpamukcu N. Histological response to injected gluteraldehyde cross-linked bovine collagen based implant in a rat model//BMC Urology. 2006; 6: 3.
14) Paradysz A., Fryczkowski M., Krauze-Balwinska Z., Gajewski D. Comparison of effectiveness of endoscopic injection of autologous blood and conservative therapy in the treatment of bilateral primary vesicoureteral reflux//Wiad. Lek. 2002; 55 (7-8): 404-410.
15) Kireeva N.B., Khafizova A.L., Parshikov V.V., Zaugarov M.Yu., Aleynik D.J. Endoscopic correction of vesicoureteral reflux in children using autologous or allofibroblasts//Nizhny Novgorod Medical Journal. 2003. No. 3-4. Pp. 8-12.
16) Babanin I.L., Kazanskaya I.V., Konoplev V.D. Efficiency of endoscopic treatment of vesicoureteral reflux in children using bioimplants: proceedings of the X Russian Congress of Urologists. M., 2002. pp. 698-699.
17) Ander A.H. Endoscopic treatment of vesicoureteral reflux. Abstract Book from 8th Mediterranean video-endoscopic urology and European society of urological technology. 2006; 13–14.
18) Larsson E., Stenberg L. et al. Injectable dextranomer-based implant: histopathology, volume changes and DNA-analysis//Scandinavian Journal of urology and Nephrology. 1999; 33 (6) 355–361.
19) Mittleman R.E., Marraccini J.V. Pulmonary Teflon granulomas following periurethral Teflon injection for urinary incontinence//Arch. Pathol. Lab. Med. 1983, 107: 611–612.
20) Aaronson I.A., Rames R.A., Greene W.B., Walsh L.G., Hasal U.A., Garen P. D. Endoscopic treatment of reflux: migration of Teflon to the lungs and brain//Eur. Urol. 1993, 23: 394–399.
21) Lopatkin N.A., Pugachev A.G., Apolikhin O.I. / / Urology. M., 2002. P. 118.
22) Shamsiev A.M., Daniyarov E.S., Babanin I.L., Shamsiev J.A., Ibragimov, S.S. the Effectiveness of surgical treatment of obstructive uropathy in children, Pediatric surgery, 4, 2012.
23) Shamsiev J.A., Daniyarov E.S., Ibragimov, S.S., Atakhanov M.M. The Choice of treatment of vesicoureteral reflux in children scientific notes of Orel state University: Natural, technical and medical Sciences 2014. Volume 2, Number 7. Pages 100-101.