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Features of Surgical Treatment of Rotary Chest Deformation In Young Children

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ANNOTATION: This article analyzes the results of diagnosis and minimally invasive treatment methods of thoracic gyrus deformity in children. Modern examination methods and surgical correction of this disease in children are covered in detail by comparing them.
KEY WORDS: chest, thoracoplasty, vortex deformation.

The characteristics of the surgical treatment of the gyrus deformity of the chest in young children show a change in many ways. One of the most common practices is the rapid replacement or debridement of existing nipples to accelerate breast transformation. Also, if the condition is very severe, surgery to control the chest is possible. This will be important for all of us, as the breast is very important for lifelong health.

Torrential deformation of the chest is one of the diseases in which the change of the chest and the deformation of the chest occur. The first of these practices, in many cases, is the rapid replacement of the nipples due to the baby's mouth. In addition, transformational physiotherapy and rehabilitation treatments are also practiced. If not treated in time, surgery is possible to control the breast. All practices may involve some degree of risk, so it is important to be modest. It is important to communicate with specialists from a wide range of Uzbekistan so that this process does not depend on the appearance and duration of the appearance.

In all cases, in the case of thoracic torsion, other medical conditions (for example, breast bandages) are indicated to accelerate the management of the majority of the breasts. In this case, there are changes in the breasts before the term. Practices can include many types of physiotherapy (eg, massage, ibrotherapy of general muscles) or exercise therapy (eg, hydrotherapy, bandage therapy) or the use of products that affect the culm (orthopedic) of the internal content, and finally, internal chemical lamps. The results of operations require substitution to speed up time management. It is important to consult a medical professional for further questions.

Torrential deformation of the chest is a disease in which the shape or cage of the breasts is deformed. In this case, medical procedures are indicated to accelerate the dreams of the breasts and to correct deformations in the cage. These include breast augmentation surgeries, physical therapy and rehabilitation treatments, bras, and barrier bandages. The results of operations require substitution to speed up time management. It is important to consult a medical professional for further questions.

Funnel chest deformity is a curvature of the sternum and anterior ribs of varying shape and depth, leading to a decrease in the volume of the chest, compression and displacement of the mediastinal organs, causing functional disorders of the cardiovascular and respiratory systems, manifested by cosmetic defects of varying severity. The chest in patients with VDHA changes shape, volume and size, which is manifested by a decrease in the sterno-vertebral distance and flattening of the chest itself. In some cases, congenital shortening of the sternophrenic ligament occurs. These changes lead to a decrease in the mobility of the chest and a decrease in the excursion of the diaphragm. Persistent paradoxical breathing may develop (retraction of the sternum and ribs during inspiration), which is most clearly manifested during screaming and crying [5,6,12]. During the neonatal period and in the first year of life, the disease can only manifest itself as paradoxical and less commonly stridor breathing. According to some authors, in almost half of the cases, retraction increases as the child grows. Children lag behind in weight and physical development, and the protruding edges of the costal arches and the transverse groove that forms above them, the “Harrison’s pseudo-sulcus,” begin to attract attention. Lifting to the edges of the costal arches, the rectus abdominis muscles are pushed forward, creating the impression of its enlargement. The ventilatory-respiratory function of the lungs

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suffers due to impaired drainage of the bronchial tree, and frequent bronchitis and pneumonia are observed. Significant changes are observed in the cardiovascular system: complaints of fatigue, shortness of breath during fast walking and running, stabbing pain in the heart area, increased heart rate. It is generally accepted that the treatment of pectus excavatum is only surgical, and no conservative methods can correct this defect.

According to the literature and our observations, indications for surgical treatment depend on a number of factors. 1) The age of the patient. There is no consensus regarding the age at which surgical treatment should be performed. At the same time, most authors indicate that the older the age, the worse the results of the intervention. In our opinion, the best age for radical surgery is 2-5 years. Due to the high elasticity of the sternum and ribs, the operation is technically easier to perform, which guarantees normal development of the chest.

Contraindications for surgical intervention may include severe congenital heart defects, Marfan syndrome, acute inflammatory diseases. To date, a total of more than 50 different methods of surgery for VDHA have been proposed, which can be classified into 4 groups: with the use of external traction of the sternum, the use of internal metal fixators, with using bone grafts, without the use of any fixatives. Dr. Paul W.

Sanger was right: “if there are too many methods for treating the same disease, none of them is satisfactory.” One of the most common types of thoracoplasty for VDHA is the technique proposed by Ravich M.M. in 1949. It consists of mobilizing the parietal pleura over the entire area of deformation, after which the deformed areas of the costal cartilages are transected subperichondrially and removed. Ribs 2 and 3 intersect in an oblique direction.

After elevation of the sternum, its posterior cortical plate is crossed along the upper border of the deformity and a wedge-shaped spacer from the resected rib is inserted into the resulting cleft. Osteotomized fragments of the 2nd and 3rd ribs are positioned so that their medial part lies above the lateral, and fixation is carried out with nylon sutures. The severed pectoral muscles are sutured to the sternum. In 1968, N.I. Kondrashin proposed changing thoracoplasty according to M. Ravich in the direction of reducing the volume of rib resection and refused to completely isolate the sternum to insert a wedge along its posterior surface. The following surgical technique was used. After mobilizing the skin and pectoral muscles, the domes of the diaphragm are mobilized on both sides, they are separated from the costal arches to the parietal pleura. Transverse segments of 3-7 ribs are excised directly at the sternum on both sides, the width of the excised segments is 2 cm. Then an anterior wedge-shaped sternotomy is performed at the level of the transition of the handle into the body of the sternum, followed by suturing it in the corrected position with three Mylar sutures. 3-7 ribs are resected wedge-wise at the border of the cartilaginous and bone parts and sutured with lavsan sutures in the corrected position.

The muscles and skin are sutured in layers. Sutures are placed on the skin wound after the tubular retrosternal drainage is removed through an independent skin incision. Thoracoplasty using the Bairov method is performed in young children. The patient is positioned on the back, a flat cushion is placed under the shoulder blades. At the edge of the depression, 4 small longitudinal skin incisions (3-4 cm) are made in such a way that from each wound the rib above and below can be treated. Having slightly shifted the skin wound to the apex of the curvature of the rib and bluntly dissected the muscles above it, trying not to damage the pleura and blood vessels, resect the necessary segment of the rib, which is calculated on the contourogram, without affecting the growth zone (the place of transition of the bone part into the cartilaginous part) and immediately the ends of the resected ribs are sutured lavsan threads. After this (4-5 cm), an incision is made in the skin and subcutaneous tissue above the base of the xiphoid process, which, unlike the traditional method, is not cut off from the sternum.

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