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## Advanced Surgical Treatment for Odontogenic Plugous-Necrotic Phlegmons of the Maxillofacial Region

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**ABSTRACT:** Over the past years, the most widespread form of pyoinflammatory diseases of the maxillofacial region (MFO) has been odontogenic phlegmon. At the same time, many authors note an increase in the number of patients with this pathology, indicating the severity of the course of the disease, an increase in the frequency of atypical forms, including those characterized by a fulminant course, with a large percentage of complications and deaths.

**Key words:** phlegmon, thrombophlebitis, the submandibular, pyoinflammatory.

### Introduction.

Treatment of complicated forms of phlegmon of the maxillofacial region and neck is still a problematic and extremely urgent task. It should be noted the innumerable publications in the world medical literature, numerous, repeated discussions at all kinds of domestic and foreign medical congresses and forums on this topic. Basically, the root cause of this kind of phlegmon is odontogenic infection.

### Main part.

Spilled phlegmon of the bottom of the mouth and neck are of high importance with a degree of danger and critical results. Of the total number of surgical patients, patients with purulent-inflammatory diseases of various locations make up from 35 to 55%, their number from year to year does not show a tendency to decrease. And the number of surgical patients in the maxillofacial hospital with acute inflammatory processes in the maxillofacial region and neck is 68.5–61.3%.

It should be noted an increase in the proportion of patients with progressive severe forms of pyoinflammatory diseases - phlegmons of the floor of the mouth, complicated by sepsis, mediastinitis, thrombosis, cavernous sinus thrombosis, thrombophlebitis, often leading to fatal outcomes. Studies have shown that a progressive purulent infection, which is often the cause of various purulent diseases of the oral cavity, as well as dental diseases, is due to the influence of adverse causes in the oral cavity, frequent manifestations of resistance of pathogenic diseases to antibiotics, and changes in the body's immunological reactivity. Extensive phlegmon of the floor of the mouth and neck are fraught with unfavorable outcomes. To minimize this, high-quality diagnostics and correct surgical treatment are important. The radicality of the surgical intervention depends on the degree of development of the purulent-inflammatory process, as well as on the nature of the microbial agent that caused it (aerobes and anaerobes). The current moment of ontogenesis in purulent-septic surgery is marked by the previously defined principles of treatment of purulent-inflammatory diseases and complications. Thus, extensive phlegmon of the floor of the mouth and neck require high-quality diagnosis and adequate surgical treatment.

**Purpose of the study.** Presentation of the clinical observation of anterior mediastinitis, which ended in recovery after opening the odontogenic putrefactive-necrotic phlegmon of the floor of the oral cavity and deep spaces of the neck with drainage of the anterior mediastinum.

Patient T., born in 1991, turned to the Samarkand branch of the Republican Scientific Center for Emergency Medical Aid (SFRNTSEMP) in serious condition, after examining the surgeons of the admission ward. It was decided to call a maxillofacial surgeon through the air ambulance. At the time of examination, the patient complained of pain and swelling in the floor of the mouth, difficult painful swallowing, restriction of mouth opening. He noted general weakness, malaise, sleep disturbance, an increase in body temperature to 38.5 ° C. According to the patient, he was ill for 4 days. The onset of the disease was associated with hypothermia when a tooth ached. He did not apply to anywhere, he self-medicated. Gradually, the condition worsened, the aforementioned complaints appeared. During hospitalization, the general condition of moderate severity. Skin, respiratory and cardiovascular systems were normal. The face is pale, swelling of the soft tissues of the submandibular regions on the right and left and the submental region. The infiltrate had no distinct boundaries and covered the entire thickness of the bottom of the oral cavity. The skin over it was hyperemic, edematous, sharply painful on palpation, and did not fold into a fold. The mouth is half-open, its opening is limited to 2.5 cm, painful. Swallowing is difficult. The mucous membrane of the sublingual region bulged out in the form of a ridge above the crowns of the teeth, covered with fibrinous plaque. Offensive odor from mouth. Tooth 38 (left lower 3rd molar) is 90% destroyed, tooth percussion is sharply painful. Orthognathic bite. The remaining teeth were affected by caries. A clinical diagnosis was made: "odontogenic putrefactive necrotic phlegmon of the floor of the mouth from the 38th tooth."

The operation was performed to open the phlegmon of the bottom of the oral cavity, remove 38 tooth, the wounds were washed in large quantities with antiseptics solutions such as 3% hydrogen peroxide, dekan solution, a counter-opening was created between the incisions, a loose tamponade of

labor was performed, rubber drainage with hypertonic solution and was hospitalized in the department resuscitation SFRNTSEMP. On the 5th day of the illness, the patient in a state of moderate severity was transferred to the department of maxillofacial surgery of the city medical association of the central hospital of Samarkand. 01/04/2021 at 13:55 with a diagnosis of "exacerbation of chronic periodontitis of the 38th tooth, odontogenic putrefactive necrotic phlegmon of the bottom of the oral cavity" after opening the phlegmon.

In the analysis of blood from 04/01/2021 - leukocytosis ( $17 \times 10^9 / l$ ) with stab shift (25%), ESR acceleration up to 34 mm / h.

In the postoperative period, antibacterial therapy (ceftrocion, metrid) was carried out. To improve microcirculation, rheopolyglucin was administered, analgesics and diphenhydramine were administered according to indications. The patient's condition is assessed as corresponding to the severity of the operation. On the plain chest x-ray there is an increase and deformation of the pulmonary pattern due to chronic bronchitis, flattening of the mediastinal pleura on the right.

On January 8, 2021, the patient's condition worsened: hyperemia and edema of the lateral surface of the neck on the left appeared. Anterior mediastinitis on the left was diagnosed and on the same day a consultation was held with the participation of general surgeons, thoracic surgeons, a resuscitator, and it was decided to perform an operation to open the left deep cervical phlegmonous focus with unilateral mediastinotomy according to Razumovsky. The operation was performed under general endotracheal anesthesia with the participation of maxillofacial surgeons, general surgeons, thoracic surgeons and resuscitators. Abundant pus with an ichorous odor was obtained from the deep intermuscular, interfascial space of the neck on the left and from the pretracheal space.

Until January 12, 2021, the patient was in the intensive care unit, where a complex (local, general) treatment was carried out. Antibacterial, substitution and symptomatic treatment was carried out. To correct hypoproteinemia and anemia, single-group plasma transfusion was repeatedly transfused. There were daily, two-fold dressings, medical and sanitation bronchoscopy. Blood count (from 01/11/2021): Hb - 98 g / l, er. -  $4.1 \times 10^{12} / l$ , leukocytes -  $12 \times 10^9 / l$  (eosis - 0%, p / i - 6%, s / i - 84%, lymph. - 7%, mon. - 2%). After stabilization of the state, he was transferred to the department of purulent surgery. Control radiographs showed expansion of the left lung, a decrease in the shadow of the mediastinum. The pleura remained thickened throughout. In the following days of the disease, the clinical picture of the disease went in a good direction. In dynamics, the X-ray picture improved and by 25.01.2021, on the control plain chest X-ray of the left chest organs, the lung straightened, in the upper sections the infiltration decreased both in intensity and in size. In the lower sections, there is a thickening of the pleura and a small amount of fluid on the left.

On the healing of wounds on the neck, in the absence of purulent discharge, the edges of the wounds were brought closer together, and a secondary suture was applied. The volume of discharge from the drainage tubes gradually decreased. 02/07/2021 was discharged in satisfactory condition with a drainage tube under the supervision of a surgeon and maxillofacial surgeon at the place of residence.

**Conclusion.** Despite the medical knowledge of the population on the conduct of extensive dental preventive measures of such forms of phlegmon of the maxillofacial region as putrefactive necrotic phlegmon of the floor of the mouth are found, and these phlegmons need timely diagnosis and surgical treatment in order to prevent various complex complications and death.

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