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Gulbakhor Batyrovna Tilyakhodjaeva
Ferghana Medical Institute of Public Health
Senior teacher of the department «Anatomy»,
Ferghana city, Uzbekistan

VARICOSE VEIN DISEASE OF THE LOWER EXTREMITIES AS A TOPICAL PROBLEM IN MEDICAL PRACTICE

Abstract: *The article under discussion reveals the varicose vein disease of the lower extremities which is one of the actual problems in medicine, as there is an increase of morbidity among the population and is characterized by complications that lead to disability. The author of the article consider that mankind, condemned to live under gravity and be upright most of the time, exposed to negative effects of adverse environmental, biological and other factors, is a risk group for venous pathology and therefore the problem should be of continuous interest to preventive medicine.*

Key words: *varicose vein disease, medicine, problem, morbidity, hormonal disturbances, pregnancy, fatigue, swelling, vascular.*

Language: *English*

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Introduction

Discussion

Etiology of the disease:

1.Genetic predisposition.
2. A sedentary lifestyle.
3. Working conditions.
4.Pregnancy.
5.Hormonal disturbances.

Clinical symptoms:

1.Swelling of the lower extremities. 2.Heaviness in the legs.
3.Fatigue.
4.Widening of the veins.
5.Formation of vascular "snakes" and nodules.
6.Formation of lumps under the skin

Diagnosis:

Examination of the patient in upright position. Fixed the venous pattern and anatomical sections, where varicose veins are localized, the nature of varicose veins, the condition of their walls [1, p.6].

On palpation the density of the walls of the nodes and vein trunks, the presence of compactions and areas of painfulness are determined. Cough-push symptom is investigated: in the upright position the index and middle finger of the hand is placed on the vein segment under investigation and the researcher asks the patient to cough. If at this moment the researcher feels a push, it means that above the point of vein clamping the venous valves are incompetent and there is a vertical reflux. When the patient is in the supine position with the leg elevated vertically, the vein collapse must be recorded to detect an unobstructed outflow of blood from the limb. In the same position, palpation along the large and small saphenous veins may reveal openings in the fasciae through which the incompetent perforating veins pass [2, p.15].

The main diagnostic questions such as the presence of vertical and horizontal reflux, the presence and degree of venous hypertension, the state of the valve apparatus of the main and perforating veins, the causes of their dysfunction are nowadays solved with a high degree of reliability by highly informative instrumental methods of examination.

Ultrasound Doppler sonography (USDG) enables to estimate the functional state of the venous system. Doppler ultrasound detects venous blood flow

with a murmur that is synchronized with breathing and resembles the sound of a sea surf: it becomes stronger when you breathe out and it gets progressively quieter with inhalation. Reflux in the saphenous veins can easily be detected by this method [8, p.4].

The most informative current method is ultrasound angioscans with colour flow mapping (triplex scanning).

This method allows to determine reliably the anatomico-morphological changes of the venous bed and choose the adequate method of varicosity treatment, to determine the indications for the operation, the optimal volume of the surgical intervention, the possibility of using some technical means and methods during the operation, to estimate the state of superficial and deep vein walls and valves, their permeability, functional state by Valsalva test (pushing when exhaling), reflux length, state and function of perforating veins.

Classification:

Several classifications are available, including clinical, etiological, anatomical, and pathophysiological features.

Forms of varicose veins:

1) intradermal and segmental varices without pathological veno-venous reflux;

2) segmental varicose veins with reflux through superficial and/or perforating veins;

3) disseminated varicose veins with reflux through superficial and perforating veins;

4) varicosity with reflux through the deep veins.

Based on this classification, the therapeutic and diagnostic tactics of each individual patient can be clearly defined on the basis of this classification, which is of course a great help to the treatment work and enables optimisation and standardisation of the management of such patients.

International Classification of Varicose Acid Disease - CEAP (C - clinic, E - etiology, A - anatomy, P - pathophysiology):

St. 0 No symptoms on examination and palpation, but complaints of heaviness in the legs and tightness of shoes in the evening.

St. 1 Teleangiectasia and/or reticular veins.

St. 2 Varices.

St. 3 Swelling of the lower extremities in the evening.

St. 4 Cutaneous trophic changes (pigmentation, venous eczema, induration).

St. 5 Skin changes progress around the scarring of healed venous ulcers.

St. 6 Skin changes around an open venous ulcer.

Each stage of varicose vein disease is characterised by specific changes in the lower limbs

However, the CEAP classification is considered by most surgeons to be rather cumbersome and not entirely easy to use routinely, particularly in outpatient practice. Its use is more justified in clinical trials and other scientific activities where there is a need to analyse a large data set in a large sample of patients.

Complications:

The most common complications of varicose veins are bleeding, thrombophlebitis and venous ulceration.

Trauma to the affected veins leads to severe bleeding that requires an ambulance to stop the bleeding.

Deep and superficial vein thrombophlebitis is a dangerous complication of varicose veins, which can lead to pulmonary embolism.

Phlegmatic thrombosis of lower limb veins is a severe course, resulting from total thrombosis of the entire venous system of a limb. There are two types of phlegmazia: white and blue.

White phlegmazia occurs when there is a preserved outflow of venous blood from the limb through the visceral veins of the pelvis. In some clinical manifestations it is similar to arterial embolism: severe ischemic pain due to powerful arterial spasm, pale skin, no pulsation in the peripheral vessels, but unlike arterial embolism, the limb is swollen, moist and warm [5, p.6].

Blue phlegmazia is due to a complete blockage of venous outflow from the limb. The limb turns dark blue which is covered with frictions and severely edematous and intoxicated. The process rapidly spreads to the perineum. This is the only type of venous insufficiency which leads to gangrene and requires amputation.

A thrombus placed in the superficial veins, most frequently in saphenous vein thrombophlebitis, can cause an embolism, if it reaches the middle third of the thigh. Clinically this can be seen by the level of inflammatory changes in the form of thickening, soreness and hyperaemia along the vein. This is where the thrombus attaches to the walls of vein. The diagnosis is clarified by an ultrasound duplex scan.

The most dangerous part of the thrombus is the flotation apex. If the apex of the flotation thrombus is located in the middle third of the thigh, an emergency admission and ligation of the great saphenous vein at the junction with the femoral vein - crossectomy - is necessary [10, p.76].

Treatment:

Treatment measures of any nature should be aimed at restoring or improving blood flow, prevention of CVI complications, improvement of quality of life of patients.

The basic principles of conservative treatment depend on the degree of CVI: at grade 0, elastic compression (therapeutic knitted fabric of grade 1-2) is used, grade 1 - elastic compression (therapeutic knitted fabric of grade 1-2) with occasional courses of monopharmacotherapy, grade 2 - elastic compression (therapeutic knitted fabric of grade 2 with repeated courses of monopharmacotherapy). Therapies, 3rd

and 4th degree - elastic compression (therapeutic knitted fabric, class 2-3) with continuous combined treatment with pharmacology, local treatment and physiotherapy.

Drug therapy is used at the beginning of the disease.

Medical therapy:

1. Venotoniruyuschie tablets, capsules, drops to restore elasticity of veins, improve tissue trophism and blood microcirculation: Detralex, venoruton, ascorutin, endotelon, glivenol, tribenol, vasobral, eskusan, anavenol;
2. Venotonics in the form of ointments and creams: Troxevasin, Lyoton 1000 gel, Essaven, Venitan;
3. Anticoagulants: heparin, hirudin, phenyndione, aspirin.
4. Antiaggregants: persantin, thrombonil;
5. When venous ulcers develop, prescribe anginine, prectal, pentoxifylline.

- Sclerotherapy of main vein tributaries with sclerosants of different concentrations depending on vein diameter.
- Miniphlebectomy
- Sclerosurgical techniques.

Surgical treatment is based on a combined phlebectomy - elimination of vertical and horizontal reflux by removing varicose veins using a special probe (stretching).

By removing the varicose veins with a stylet (styping) and endoscopic vein dissection (transection and ligation) of the perforating veins.

Prevention of CVI and its complications:

Prevention of CVI and its complications begins with the prevention of varicose veins in the lower extremities. The risk factors are described above and allow for primary prevention by identifying risk groups.

A healthy lifestyle since childhood: a proper diet, eating foods free of preservatives and nitrates, avoiding genetically modified foods in the diet.

Eat plenty of fruit and vegetables rich in vitamins C and E. Avoid excessive weight and constantly monitor the balance of caloric intake and expenditure.

Timely detection and treatment of concomitant diseases (collagenosis, diabetes mellitus, hypertension, dyshormonal disorders, etc.), rational contraception.

Elastic compression is nowadays considered as the earliest prophylaxis, especially in risk groups. The rational choice of compression and the wide range of elastic stockings permit their use without disturbing aesthetics and fashion. Modern advances in civilization, such as long plane journeys with limited mobility and prolonged driving, especially with automatic transmission, which causes one leg to be switched off, may be risk factors for thrombotic complications.

The shape of the feet should be monitored, flat feet should be detected as early as possible and corrected by special physical exercises (weight transfer from heel to toe and back without emphasis on the heel, circular movements of the feet).

Wear rational shoes (3-4 cm heel, supinators for transverse flatfoot, and in risk groups also for longitudinal flatfoot, with a wide toe). Ensure correct walking - heel to toe on the outside of the foot. Avoid flat-soled shoes and high heels. Rational exercise is an important component of the lifestyle. All kinds of dynamic exercise: walking, jogging, swimming are important components not only for primary prevention, but also for the prevention of complications. Exercise should be alternated with rest, keeping them in an elevated position at pelvic level if possible.

Conclusion

In conclusion it should be noted that mankind, condemned to live under gravity and be upright most of the time, exposed to negative effects of adverse environmental, biological and other factors, is a risk group for venous pathology and therefore the problem should be of continuous interest to preventive medicine.

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