The article presents data of treatment of 30 children who had undergone forced extensive resection of the small intestine. 30 children with developmental disabilities were the small intestine: multiple small bowel atresia - 6 (20%), small bowel atresia with ischemic lesions - 7 (23.3%), isolated small bowel volvulus due to malrotation syndrome - 7 (23.3%). The remaining 10 children included in this group: idiopathic volvulus of the small intestine - 2 (6.7%), intussusception - 2 (6.7%), strangulation intestinal obstruction including repeated resection - 6 (20%).

For the purpose of verification of congenital abnormalities or acquired pathology and dynamic control of the disease using the following methods of investigation of patients: clinical and laboratory data, clinical, biochemical parameters. Instrumental - fibrogastroduodenoscopy, beam: survey radiography chest and abdomen, barium passage through the intestines, and irrigoscopy, irrigography, ultrasound, echocardiography, neurosonography test goiter.

Character surgery in infants depended on the type of pathology and the presence of complications. Children (n = 6) with multiple small bowel atresia are operation was resection of the small intestine sites with atresia and imposing enteroanastomosis end to end the traditional method (3 cases), 2 cases when the difference and outlet diameters resulting intestine anastomosis imposed on the proposed our procedure, in one case imposed Y-shaped anastomosis enterostomies. In neonates (n = 7) with small bowel atresia complicated by bowel necrosis in 3 cases resection unsustainable portion of the small intestine with the imposition of the Y-shaped anastomosis with ileostomy in one case imposed enteroanastmosis end to end, in 3 cases superimposed enterostomies. In isolated small bowel volvulus after detorsion of 7 children from 2 performed extensive resection of the small intestine with the imposition of the Y-shaped anastomosis in 4 patients enterostomies imposed in 2 cases, when there is doubt the viability of the border of the small intestine used the technique of programmed relaparotomy.
Thus, the timing of reconstructive operations were determined by us, first of all, the nature and level of pathology overlay enterostomy, relief of the inflammatory process in the abdomen, loss of correction capabilities through the stoma, and the dynamics of body weight of the patient. Besides this condition should be considered disabled intestine, ie preservation of its motor activity. In the case of the Y-shaped overlay enteroanastomosis (n = 6) enteritis we closed by the end of the month after the anastomosis. To this period restored passage intestinal chyme, with minimal loss through enteritis, the kids had a productive chair. Terminal enterostomy (n = 7) was closed in the period from 2 to 4 weeks and approached individually in each case taking into account the circumstances that previously outlined.

Some difficulties arise in selecting the options and closing overlay entero-enteroanastomosis after resection of the small intestine, where the length of the remaining segment of the terminal ileum is not more than 5-7 cm or hypoplasia with "deaf" suturing the terminal ileum, and the more time passes before reconstructive surgery, the more pronounced its atrophy.

At the same time it must be remembered that the preservation ileocecal flap and the right half of the colon plays an important role in the prevention of the effects of extensive resection of the small intestine.

Inclusion in the digestive process as much as possible the functional surface of the colon significantly reduces the period of adaptation to the growing organism and leads to an earlier period of stabilization processes "short bowel syndrome."

In 2 cases when closing enterostome we imposed (at a length of 6 cm stump) entero-enteroanastomosis end to end, in 2 cases enterocekoanastomosis end-to-side, in 3 cases enteroastsendoanastomosis end-to-side by our method with an antireflux component. Developed individual approaches and methods of surgical interventions at all stages of the treatment of infants with severe malformations of the small intestine allowed to carry out adequate correction of obstructive processes, and
perform reconstructive surgery, taking into account characteristics of the
growing organism, thereby minimizing the consequence of extensive resection
of the small intestine.

Two patients six and twelve years cause extensive resection of the small
intestine was isolated idiopathic volvulus of the small intestine. For these cases
of idiopathic volvulus we assigned due to the fact that during the operation we
did not install any anatomical and morphological causes of the volvulus.

In two cases, extensive resection of the small intestine was carried out with
intussusception that occurred against the background of diffuse polyposis of the
intestine. In one case juvenile polyposis accompanied by recurrent small bowel
intussusception and re-resection of the small intestine. When the first surgical
intervention was involved in intussusceptum resected portion of the small
intestine are not viable to 70 cm, and in one repeat intervention portion carrying
polyps from 1.5 to 2.5 cm for a 40 cm
In another case of small bowel intussusception with bowel necrosis occurred in a
child with gamartromal polyposis (Peutz-Jeghers syndrome), which also ran
extensive resection of the small intestine. In both cases, were formed
enteroanastomosis end to end.

In 6 patients, the cause of extensive resection of the small intestine was
strangulation adhesive ileus. And in 4 patients were repeated small bowel
resection. These children have had prior resection of the small bowel
intussusception in about three cases and in one case over lymphangioma. In the
future, these children appeared adhesive intestinal obstruction, which led to
necrosis of the area of the small intestine. Resection of the central portion of the
small intestine was performed in four patients, distal - 2 patients.

In all cases imposed enteric anastomosis end to end. Our research nearest postoperative period showed that patients who were
produced significant volume radical surgery for malformations and intestinal
diseases in the near term, in some cases, are not completely healthy. This period
is a period of adaptation of the functional state of the bowel and restore homeostasis in all organs and systems, which can last from 6 months to 2 years.

During this period, patients, in some cases, to restore the function of the alimentary canal and the metabolic state in need of correction of nutritional status and drug rehabilitation. Targeted nutrition correction this category of children was conducted based diets creation of specialized products for enteral feeding containing easily digestible complete protein digested fats enriched with vitamin-mineral complex. With traditional diets based on natural products administered enzyme preparations (panzinorm forte) in the age dosages. Used for the correction of dysbiosis multiprobiotic "Symbiter" which eliminates disbiosis varying degrees. It effectively normalizes bowel dysfunction has antidiarrheal properties. To correct the violations of hematological parameters (anemia) was administered erythropoietin and iron preparations per os, and correction of functional diarrhea was appointed antidiarrheal drugs.