analysed genes *IL-4* (rs 2243250), *TNF-α* (G-308A), *PRSS1* (R122H) and *CFTR* (delF508C) have been studied with polymerase chain reaction (PCR) method. The genotypes distribution among the examined patients and healthy people for the selected genes has been determined. Increasing of the triglycerides level in blood serum is an evidence of the important pathogenetic role of disintegration processes that take place in the pancreas, and of the development of active inflammatory process in the last.

The higher levels of triglycerides were observed in the carriers of NN-genotype by 12.41% and 1.57 times ($p<0.01$) in the carriers of NM-genotype of gene *CFTR*. Authentically higher by 39.61% ($p<0.01$) triglycerides level in the carriers of NM-genotype will be able to cause the formation of pancreatic pseudocysts and abscesses, as a result of enterohepatic circulation disturbance of the free fatty acids. Triglycerides level was increased by 15.33% in patients with GG-genotype and decreased by 6.75% in the carriers of NM-genotype of gene *PRSS1*. The obtained data didn't find credible difference of the influence of the gene PRSS1 polymorphism on blood serum lipidic spectrum of the patients with acute edematous pancreatitis. The triglycerides level was decreased by 3.65% in patients with CC-genotype and increased by 40.88% in the carriers of CT-genotype and decreased by 60.58% in patients with TT-genotype of gene *IL-4* (C-590T). It has to be remarked, that these indices were authentically higher in the owners of C-allel (CC- and CT-genotype) in comparison with TT-genotype carriers by 59.04% and 2.33 times, respectively. The triglycerides level was decreased by 2.19% in patients with GG-genotype and increased by 58.39% in the carriers of GA-genotype of gene *TNF-α* (G-308A).

Thus, the serum triglycerides level is a risk factor for acute pancreatitis development in the examined population from the position of the genes *CFTR* (delF508C), *IL-4* (rs 2243250) and *TNF-α* (G-308A) polymorphism.

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EFFICACY OF EARLY NEEDLE REVISION WITH 5-FLUOROURACIL AND BETAMETHASONE IN FAILING ANF FAILED FILTERING BLEBS

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Successful glaucoma filtering surgery results in the formation of a filtering bleb that has an important predictive implication in assessing the survival of glaucoma surgery [Skuta GL. et al, Wells AP. et al., 2006]. The presence of a diffuse raised bleb with a reduction of intraocular pressure (IOP) is regarded as indicative of adequate drainage and successful glaucoma surgery. Signs of a failed bleb include a flat and injected conjunctiva often with subconjunctival fibrosis sometimes with thin walled cystic spaces. Transconjunctival needle revision is an essential and simple technique in the management of failed or failing filtering bleb to restore the aqueous flow through the preexisting sclerectomy into the subconjunctival space with resultant adequate lowering of the IOP [Lee Y.S., et al., 2016]. Although the time between the trabeculectomy and the needling procedure does not seem to be a determinant of success, Rotchford A.P. and King A.J. (2008) reported better results when performing needling revisions within a three-month period after trabeculectomy in elevated blebs. It is known that 5-fluorouracil (5-FU) is a therapeutic adjunct to prevent fibroblast proliferation within the subconjunctival space and Tenon's capsule [Ewing RH et al., 1990; Durak I et al., 2003].

The aim of the study was to assess the outcomes of needle revision with 5-fluorouracil and betamethasone in failing and failed filtering blebs after trabeculectomy.

34 eyes of 34 patients aged 55.7±14.4 years with failing or failed blebs after initial subscleral trabeculectomy were included in study. The glaucoma diagnoses were 21 cases (61,7%) of chronic open-angle glaucoma, 8 cases (23,5%) of chronic angle-closure glaucoma, and 5 cases (14,7%) of exfoliative glaucoma. The Moorfields Bleb Grading System parameters were used for description of bleb before needling including central bleb area, maximal bleb area, bleb height, central bleb vascularity, bleb edge vascularity, and nonbleb vascularity. The preneedling IOP was 34.9 ± 7.4 mm Hg. All patients received needle revision (20 patients (20 eyes) among them - with

5-FU and betamethasone), maximum of four times during first 3 months. A 30-gauge needle was passed 2 to 3 mm from the edge of bleb, underneath the conjunctiva, and parallel to the scleral plane. 5 mg (0.1 ml) 5-FU and 0,1 ml betamethasone (Diprospan) were injected around the newly created bleb. The assessment criteria include: levels of IOP reduction from baseline without/with medication, rate of repeat needling or further surgery within the 1-year follow-up. All patients were followed 1 day, 1 week, 1 month, 3 months, 6 months, 9 months, and 12 months after surgery. The minimal follow-up period after needling was 12 months.

There was no significant difference in IOP between groups in the first 6 months after needling. The mean postneedling IOP was 13.83 ± 4.14 mm Hg, which was significantly different from the preneedling IOP. In 12 months IOP <21 mm Hg without topical hypotensive drops was observed in 70% of patients after needling with 5-FU and betamethasone, and in 42.9% of eyes after needle revision. We performed needling procedures at a mean of 1.83 needlings during 1 year with 5-FU and betamethasone per eye, and 3.21 needlings in group without application 5-FU and betamethasone. The overall success rate of needling procedures with 5-FU and betamethasone was 85%. There was no correlation between the number of 5-FU and betamethasone needle revisions and postneedling IOP reduction. In 12 months repeat filtration surgery was performed in 2 eyes (10%) in 5-FU and betamethasone needling group and in 4 eyes (28.6 %) in needling group without 5-FU and betamethasone application.

So, as conclusion, we can suggest that early needling with 5-FU and betamethasone could significantly prolong the survival time of the filtering bleb in 1-year-follow-up as compared with that without 5-FU and betamethasone application.

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APPROACHES TO RECURRENT META-HERPETIC KERATITIS THERAPEUTIC TREATMENT

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Meta-herpetic corneal disease is considered as a chronic or chronic recurrent superficial post-herpetic corneal inflammation without any detectable HSV-1-activity. Meta-herpetic keratitis is described as a structural damage by the immune and inflammatory mechanisms as a consequence of HSV-1 corneal infection (Liesegang, T.J. 1999). Meta-herpetic erosion, ulcer and bullous keratopathy are the main types of meta-herpetic corneal disease. Stromal keratitis is often presented with eye pain and blurred vision.

The objective of the study is to evaluate the steps in the therapeutic approach to meta-herpetic corneal ulcer. The 6 months of the follow-up results of the case were determined.

Case report: 51-year-old male was admitted with the symptoms of tearing, photophobia, redness and blurred vision in the left eye. He had a history of right recurrent HSV-1 epithelial keratitis in the last 2 years. He had been treated with only topical antiviral medications. The last episode of HSV-1 epithelial keratitis occurred 4 months ago. Visual acuities on admission were 0.01 in the left eye and 1.0 in the right eye. Biomicroscopic examination of the left eye found a centrally located deep corneal ulcer with smooth edges associated with stromal inflammation and descemet folds. Biomicroscopic examination of the right eye and fundus examination of both eyes were normal. The intraocular pressures by Maklakov tonometer were 19 mm and 18 mm Hg respectively. The corneal scraping specimens for bacterial and fungal cultures were negative. The patient was diagnosed with meta-herpetic corneal ulcer in the left eye.

The basic principle of therapy for this disease is rapidly to heal the epithelial defect. Methods to accomplish this include stopping toxic medications use, performing punctal occlusion, instilling tear film supplements, fitting a bandage contact lens, tarsorrhaphy, and in case of significant underlying inflammation, use of topical corticosteroids cautiously while watching carefully for corneal melts.

The treatment tactics includes valacyclovir 500 mg three times a day, fibronectin drops prepared from the patient's serum, vitamin C, vitamins group B, and dexpahtenol. Biomicroscopic