therefore, less familiar to most clinicians, especially in unusual situations with information deficits and combined pathology.

The purpose of the study was to analyze the clinical features of the tubercular meningitis in a child. A child of 3 years old was admitted on the 5th day of the disease with complains of the fever, weakness, depress of appetite, vomiting, weight loss. The child is unvaccinated because of the mother's refusal. General condition is severe, lethargic, meningeal symptoms were positive, hyperesthesia, photophobia. Leukocytosis, blood neutrophilosis. CSF was clear, pleocytosis 52 cells/mm^3, mostly lymphocytes (82%), normal protein and glucose.

Antibiotics, infusion therapy, dexamethasone and diuretics were prescribed. On the 5th day of treatment convulsions of the right extremities, convergent strabismus, and loss of consciousness were observed. CT scan demonstrated cerebrospinal fluid discirculation, involving the cerebellum, an enlargement of the fourth ventricle and absence of hyperdense brain abnormalities. CSF was clear, pleocytosis 36 cells/mm^3, mostly lymphocytes, normal protein and glucose level was slightly decreased. At that time the doctor received additional information about child's long contact with a relative suffered from tuberculosis. Tubercular meningitis was laboratory confirmed. The child began to receive specific therapy: kanamycin, rifampicin, pyrazinamide, ethambutol, isoniazid and supportive treatment which proved to be ineffective.

Difficulties of early diagnosis were associated with deviant parental behavior, lack of family complete epidemiological information, unusual changes in CSF in combination with a congenital brain malformation that caused the fatal termination of the disease.

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DIAGNOSTIC SIGNIFICANCE OF C-REACTIVE BLOOD PROTEIN FOR VERIFICATION OF ACUTE NON-STREPTOCOCCAL TONSYLLOPHARYNGITIS IN CHILDREN

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Objective of this study was to investigate the diagnostic value of C-reactive protein level for the verification of acute non-streptococcal tonsillopharyngitis in children. The first (I, main) group included 68 children with acute non-streptococcal tonsillopharyngitis, whereas the second (II) group included 34 patients with acute streptococcal tonsillopharyngitis, caused beta-hemolytic streptococcus group A. C-reactive protein (CRP) (mg/1) serum level was determined with a semi-quantitative method using reagents "DAC-SpectroMed S.R.L. "

The results of investigation have shown CRP average level in the first group the admitted to hospital patients was 15.9 ± 1.0 (95% CI 13.8-17.9), in the second control group patients - 14.9 ± 0.63 (95% CI 13.7-16.2) (P> 0.05), respectively. In children who belonged to clinical group I, CRP level more than 16.0 mg / l was in 39.7 ± 5.93% cases, besides more than 50.0 mg / l - in 26.5 ± 5.35% cases. In patients with acute streptococcal tonsillopharyngitis such values of CRP were determined in 41.1 ± 8.44% cases and in 35.3 ± 8.20% of patients (P> 0.05). The investigation of CRP level in the venous blood of children, as a test, allowed to verify the non-streptococcal origine of acute tonsillopharyngitis with a significant sensitivity - 73.5% (95% a confidence interval 63.7-81.8), however, with a low specificity - 35.3% (95% a confidence interval 26.0-45.5), the estimated positive value was 53.2%, the estimated negative value - 57.1%.

Therefore, taking into account the fact that C-reactive protein level in the blood of the examined patients had a high sensitivity (73.5%) for the separation of acute non-streptococcal tonsillopharyngitis, but a low specificity for that (35.3%). This statement allowed to suggest us that it should not be used separately to confirm non-streptococcal or streptococcal etiology of the disease.