year. The following methods of examination were used to determine functional state of the hepatobiliary system organs: instrumental (ultrasound examination of the abdominal organs), laboratory (biochemical, immune-enzymatic) and statistical. A comprehensive examination found that the majority of patients (26 – 70,3%) suffering from rosacea had changes in the hepatobiliary system organs (chronic cholecystitis and hepatitis), which were manifested by changes detected by the ultrasound examination of the liver and gallbladder, and changes in the content of cholesterol in the blood serum, lipid spectrum, activity of transaminase and alkali phosphatase. Considering the changes detected in the functional state of the hepatobiliary system organs and in order to improve the effect of rosacea treatment, a comprehensive therapy of 18 patients (the main group) was supplied with hepatoprotector containing silymarin. The rest 19 patients (the group of comparison) received standard therapy for dermatosis. According to clinical observations patients with rosacea from the main group who received a hepatoprotector containing silymarin in addition to the comprehensive treatment presented much earlier decrease of hyperemia and swelling (on an average 6-9 days earlier) and infiltration signs of dermatosis disappeared on an average 10-14 days earlier than in the patients from comparison group. When the treatment was over, the state of clinical recovery was registered among 13 (72.2%) patients with rosacea in the main group, considerable improvement – in 5 (27.8%) patients; and in the group of comparison among 10 (52,6%) and 9 (47,4%) individuals respectively. Thus, addition of a hepatoprotector containing silymarin to a comprehensive treatment of patients with rosacea and functional changes of the hepatobiliary system organs available promotes effect of treatment for such patients.

Semianiv I.O.

MANAGEMENT OF DIABETES MELLITUS-TUBERCULOSIS

Department of Phthisiology and Pulmonology
Bukovinian State Medical University

The association between diabetes mellitus (DM) and tuberculosis (TB) has been known for many years but studies in the last 10-15 years have highlighted that DM (both type 1 and type 2) increases the risk of active TB and that patients with dual disease have worse TB treatment outcomes compared with those who have just TB alone. The rapidly growing epidemic of DM in low and middle income countries therefore threatens TB control efforts and might derail progress made towards achieving the Sustainable Development Goal of ending TB by 2030. Likewise TB may provoke hyperglycaemia and result in overt DM in susceptible persons.

Our study is based on the analysis of treatment of 30 patients with comorbid TB / diabetes pathology who were hospitalized during 2020-2021.

The management of DM during TB treatment is aimed at improving TB treatment outcomes and reducing DM-related morbidity and mortality. The key activities are optimizing glycaemic control (through dietary instructions and medication) and implementing measures to reduce the risk of cardiovascular disease. Metformin is the first choice oral glucose-lowering drug for TB patients. Sulphonylurea derivates can be used as add-ons or in patients who cannot use metformin although drug-drug interactions with rifampicin limit their use. Insulin is effective in patients with severe hyperglycaemia but has several disadvantages limiting its use in TB patients in programmatic settings. Cardiovascular risk assessment should be considered in TB-DM patients through counselling and prescription of anti-hypertensive, lipid-lowering and anti-platelet treatment with the aim of lowering early and long-term cardiovascular morbidity and mortality. Aspirin and statins should be considered early on in patients who have a previous history of cardiovascular disease.

Monitoring of glucose control during TB treatment is best done by measurement of FBG. HbA1c can be used but is generally not repeated within 2-3 months after starting DM treatment. The frequency of monitoring depends on DM severity. In mild cases (for example, HbA1c < 8% at baseline), blood glucose or HbA1c measurement can be repeated after 3 months. In more severe cases (for example, HbA1c > 10%), FBG measurements should be done more frequently, for example every one – two weeks until reasonable control is achieved. If FBG cannot be done because patients have come to the clinic in a non-fasting state, then post-prandial blood glucose

measurements can be done with the aim of reaching glucose levels < 11.1 mmol/l (< 200 mg/dl). Use of insulin ideally requires self-monitoring of blood glucose.

The documented experience of treating DM in TB patients is mostly limited to three types of drugs: metformin; sulphonylurea derivates (SUs) and insulin. These three types of drugs are also the most widely available. Newer drugs for treating DM, such as incretin-based therapies (glucagon-like peptide 1 receptor agonists and dipeptidyl peptidase 4 inhibitors) and sodium glucose transporter 2 inhibitors, are generally not available in resource-limited countries.

The standard treatment regimens recommended for drug-susceptible and drug-resistant tuberculosis (TB) remain unchanged with or without diabetes mellitus (DM) as there is no strong evidence currently to support an alternative approach. Dosages should be given daily throughout both the initial and continuation phases. When the person with DM is diagnosed with TB, either through bidirectional screening in the TB clinic or through bidirectional screening in the DM clinic, the treatment should always be administered, supervised and monitored in a TB clinic where the drugs are available and where health care workers are trained in the management of the disease and patient-centred care.

Since DM is associated with an increased risk of drug-resistant TB and worse TB treatment outcomes, patients need to be carefully assessed for drug resistance at the beginning of treatment and carefully monitored for failure during treatment and for relapse after treatment has been completed.

Sorokhan V.D.

THE USAGE OF AUSAK AND REO-WATER SOLUTION IN THE COMPLEX TREATMENT OF PATIENTS WITH ACUTE SHIGELLOSIS

Department of infectious diseases and epidemiology
Bukovinian state medical university, Chernivtsi

Clinical and laboratory studies were performed in 5 patients with shigellosis. All patients had gastroenterocolitis syndrome (acute onset, fever, nausea, vomiting, abdominal pain, mainly in the left lower quadrant, frequent scanty stools with mucus. The course of the disease was moderate.

The effectiveness of AUSAK (containing a live culture of saccharomyces boulardii (5 billion CFU), as well as vitamin B2) was studied in 5 patients. A one sachet of AUSAC was administered PO QD for 5 days. To restore the signs of dehydration supplemented solution (ReO-water) was given orally in addition to the basic treatment: detoxification and rehydration with parenteral ("Trisil", reosorbilact) administration of saline solutions, nifuroxazide, enterosorbents, enzyme preparations.

As a result of clinical monitoring, it was found that in patients treated with AUSAK in combination with a solution of ReO-water, the disappearance of symptoms of intoxication and normalization of bowel movements occurred earlier (on average 1.5 days) compared with the control group.

Sydorchuk A.S.

IVERMECTIN FOR PREVENTION AND TREATMENT OF COVID-19: PROS & CONS (BRIEF REVIEW)

Department of infectious diseases and epidemiology
Bukovinian state medical university, Chernivtsi

For a discovering of ivermectin and arthemisin in 2015 Nobel Prize in physiology and medicine was awarded. C47H72O14(H2B1b) is chemical formula of this prospective drug, which since 1997 was approved for a treatment of onchocerciasis and strongyloidiasis mainly. This substance can be used in human only per os and can connect on 93% with serum proteins and metabolize in the liver. Ivermectin is active because can amplify a formation of neuro mediators which inhibit gamma amino butyric acid that led to the blockage of neuromuscular transmission, paralysis and death of parasite.