Клінічна диференційна діагностика інтермітуючого та персистуючого АР є досить складною і ґрунтується на таких ознаках: при інтермітуючому АР закладення носа є непостійним, виділення часто водянисті, гіпосмія непостійна, завжди є чхання, нерідко є кон'юнктивальні симптоми, рідко бронхіальна астма та хронічний синусит. Для персистуючого АР вищеописані ознаки нерідко протилежні. Важливо оцінити ступінь тяжкості АР у дітей дошкільного віку для обґрунтування обсягу лікування.

У комплексному лікуванні АР у дітей дошкільного віку необхідно застосовувати іригацію слизової оболонки порожнини носа зволожуючими засобами на основі фізіологічного розчину (Хьюмер), топічні глюкокортикостероїдні препарати протизапальної дії – мометазон фуроат (Флікс) та H_1-антигістамінні препарати другого покоління – левоцетиризин (Алерзин) відповідно до інструкцій, які мають патогенетичну дію. Ендоназальні кромони (кромоглікат натрію) менш ефективні порівняно з ендоназальними глюкокортикоїдами. Антилейкотрієнові засоби (монтелукаст натрію) часто застосовуються у дітей, хворих на АР у поєднанні з коморбідними алергічними хворобами. Застосування системних глюкокортикоїдних препаратів у дітей обмежене, необхідна консультація дитячого алерголога.

Таким чином, ефективність лікування дітей дошкільного віку, хворих на АР, забезпечується спільною працею дитячих оториноларингологів та дитячих алергологів. Запрпонований алгоритм діагностики АР забезпечує оптимальну ефективну терапію.

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ASTHMA AND COVID-19 IN THE PRACTICE OF A FAMILY DOCTOR

People with moderate to severe asthma may be at higher risk of getting very sick from COVID-19. COVID-19 can affect your nose, throat, lungs (respiratory tract); cause an asthma attack; and possibly lead to pneumonia and acute respiratory disease. **Objectives of the study -** tactics of management patients with asthma during the covid-19 pandemic.

Materials and methods. Test access to the following full-text and abstract databases was used: base package EBSCO; the world's largest abstract database and scientometric platform Scopus; Google Scholar search; MEDLINE; EBSCO eBooks Clinical Collection; abstract scientometric database of scientific publications of the Web of Knowledge project of Thomson Reuters - Web of Science Core Collection WoS (CC); (SCIE (Science Citation Index Expanded); SSCI (Social Science Citation Index); AHCI (Artand Humanities Citation Index).

Results and discussion. How to prepare for COVID-19: make sure that you have at least a 30-day supply of your medicines; take everyday precautions like washing your hands, avoiding close contact, and staying at least 6 feet (about 2 arm lengths) from other people; wear masks in public settings and when around people who don't live in your household; when out in public, keep away from others and avoid crowds; wash your hands often with soap and water for at least 20 seconds or use hand sanitizer that contains at least 60 % alcohol; avoid cruise travel and non-essential air travel; during a COVID-19 spread (outbreak) in your community, stay home as much as possible to reduce your risk of being exposed; if someone in your home is sick, have them stay away from the rest of the household to reduce the risk of spreading the virus in your home.

Follow the recommendations below to reduce your chance of an asthma attack while disinfecting to prevent COVID-19. If you have asthma - ask an adult without asthma to clean and disinfect surfaces and objects for you. Stay in another room when cleaners or disinfectants are being used and right after their use. Use only cleaning products you must use. Some surfaces and objects that are seldom touched may need to be cleaned only with soap and water. Make a list of the urgent care or health facilities near you that provide nebulizer/asthma treatments. Keep it close to your phone. If you have an asthma attack, move away from the trigger such as the disinfectant or the area that was disinfected. Follow your Asthma Action Plan. Call 911 for medical emergencies.

Pollen exposure weakens the immunity against certain seasonal respiratory viruses by diminishing the antiviral interferon response. Here we investigate whether the same applies to the pandemic severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which is sensitive to antiviral interferons, if infection waves coincide with high airborne pollen concentrations. Our original hypothesis was that more airborne pollen would lead to increases in infection rates. To examine this, we performed a cross-sectional and longitudinal data analysis on SARS-CoV-2 infection, airborne pollen, and meteorological factors. Our dataset is the most comprehensive, largest possible worldwide from 130 stations, across 31 countries and five continents. To explicitly investigate the effects of social contact, we additionally considered population density of each study area, as well as lockdown effects, in all possible combinations: without any lockdown, with mixed lockdown−no lockdown regime, and under complete lockdown. We found that airborne pollen, sometimes in synergy with humidity and temperature, explained, on average, 44% of the infection rate variability. Infection rates increased after higher pollen concentrations most frequently during the four previous days. Without lockdown, an increase of pollen abundance by 100 pollen/m3 resulted in a 4 % average increase of infection rates. Lockdown halved infection rates under similar pollen concentrations.

As there can be no preventive measures against airborne pollen exposure, we suggest wide dissemination of pollen−virus coexposure dire effect information to encourage high-risk individuals to wear particle filter masks during high springtime pollen concentrations.

Coexposure to airborne pollen enhances susceptibility to respiratory viral infections, regardless of the allergy status. We hypothesized this could be also true for SARS-CoV-2 infections. To investigate this, we tested for relationships between SARS-CoV-2 infection rates and pollen concentrations, along with humidity, temperature, population density, and lockdown effects [4]. Our unique dataset derives from 130 sites in 31 countries and across five continents. We found that pollen, sometimes in synergy with humidity and temperature, explained, on average, 44% of the infection rate variability (Figure 4). Lockdown halved infection rates under similar pollen concentrations. As we cannot completely avoid pollen exposure, we suggest wide dissemination of pollen−virus coexposure information to encourage high-risk individuals to wear particle filter masks during high springtime pollen concentrations.

Conclusions. In the near future, as a result of prognostic linear analysis, an increase in the incidence of BA is expected in the world, due to the constant presence of risk factors that provoke, including the SARS-COV-2 virus, the development of the disease, as well as due to the rapid growth of allergic population. GINA emphasizes the poor adherence to the algorithm of the proposed strategy of anti-inflammatory therapy and not esthisas a modifying risk factor for exacerbations in COVID-19. Significant for the control of inflammation in asthma actions of corticosteroid sare mediated at the molecular level through genomic dextra genomic mechanisms.