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АКТУАЛЬНІ ПИТАННЯ ПЕДІАТРІЇ, НЕОНАТОЛОГІЇ, ДИТЯЧОЇ ХІРУРГІЇ ТА ЛОР ХВОРОБ

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COMPLEX APPROACH TO DIAGNOSIS AND TREATMENT OF CYCLICAL VOMITING SYNDROME IN CHILDREN

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Cyclic vomiting syndrome (CVS) is a condition with a specific pattern of vomiting with three main features: paroxysmal, stereotypical, and intervening periods of wellness. There is not one single test that confirms CVS; correct diagnosis is made after a doctor study the medical history carefully, performing a thorough physical examination, and conducting tests to exclude other diseases.

Patients present with vomiting episodes that tend to recur in a cyclical pattern, such as every 2 weeks, or every 2 months. The vomiting is paroxysmal, or with sudden onset. Most patients with CVS feel well, until they get a sudden attack of nausea, which usually progresses to vomiting a little later. The nausea and vomiting often start in the evening, and many times can even wake the patient from sleep.

Secondly, the vomiting episodes are stereotypical. Each vomiting "attack" resembles similar episodes they have had previously. Very often, the attacks last between 8 and 24 hours. However, for some patients, attacks can be as brief as 1-2 hours, and for others they can last several days. Episodes often begin with nausea, and progress to vomiting, with some people vomiting several times an hour. During the vomiting episodes, patients often like to be left alone or be in a quiet place. Other symptoms can also occur during the episode, including severe stomach pain, diarrhea, and headache. Patients can become disoriented, irritable and turn pale and clammy during an attack. Some patients vomit to the point of dry heaves or become dehydrated. The episodes often resolve by themselves without any obvious intervention or explanation.

Third, most patients feel completely well in between episodes (intervening wellness). After the episode resolves, the affected patient often returns to feeling "normal" within a few hours, and starts drinking and eating. The period of wellness in between episodes is between 1 and 3 months for most patients. However, some patients will have more frequent episodes (every 1-3 weeks), and others will have episodes that occur rarely (every 6-12 months).

In some patients, CVS may be triggered by either physical or psychological stress. Physical stresses that can trigger episodes include infections such as colds and viruses. Some women may develop CVS or migraines around their menstrual periods. Psychological factors also play a role. Some patients will have episodes triggered by negative (unhappy) stressors, such as tests or term papers. Other patients will have episodes triggered by positive stressors (such as holidays and visits with relatives). However, a large group of patients cannot identify a specific stressful event as a trigger for CVS. While the illness is not caused by stress, stress can make things worse, and CVS is a stressful illness. Therefore, in many patients, treatments to promote relaxation (counseling, yoga, acupuncture) may help. We don´t know about the role of diet in CVS. However, some patients with migraine headaches do benefit from avoiding certain foods such as caffeine, smoked cheeses, chocolate, and legumes.

Treatment for CVS is divided into two major types: abortive therapy and prophylactic therapy. Abortive therapy means giving treatments to stop the episode once it starts, and only giving that treatment during the episode. In contrast, prophylactic therapy means giving a medication every day, whether the child is well or sick, in order to prevent episodes from coming on.

Once a CVS episode starts, it can be very hard to stop. For many patients, the best treatment is supportive, and can, in severe cases, include intravenous fluids and a quiet room in a hospital. Anti-nausea medicines, including ondansetron (Zofran), promethazine (Phenergan), and chlorpromazine (Thorazine) are sometimes used to reduce the feelings of nausea. Prophylactic treatments are medications given on a daily basis to try to prevent episodes from coming on. Studies suggest that in patients with frequent episodes (every 1-2 months), prophylactic treatment can lessen the frequency and severity of episodes.

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TREATMENT OF THE SACRO-COCCYGEAL AREA SPINAL DISRAPHISM IN INFANTS

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Spinal dysraphism encompasses a spectrum of congenital conditions resulting in a defective neural arch through which meninges or neural elements may herniate. These conditions include spina bifida aperta, spina bifida occulta, meningocoele, myelomeningocoele, lipomyelomeningocoele, myeloschisis, and rachischisis - names given variably according to radiological or pathological findings. These variations can be grouped as open if the overlying skin is not intact, pending leakage of cerebrospinal fluid, and occult if the defect is well covered with full thickness skin.

Spinal disraphism in children is a difficult and unsolved problem in pediatric neurosurgery. Pathology of sacro-coccygeal area is 30% - 50% of the total number of spinal disraphism in children.

Objective of the paper is to determine the optimal terms and methods of surgical treatment of spinal disraphism sacro-coccygeal area of infants.