СЕКЦІЯ 11
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.

19 newborns with spinal disraphism sacro-coccygeal area have been operated:16 children aged 1 to 10 days and 3 from 11 to 28 days. Depending on the anatomical variants of spinal disrate sacro-coccygeal areas they were divided into: meningocele (26,32%); myelomeningoradiculocele (15,78%); myelomeningocele (31,58%). The best surgery results were at the age of 7 to 10 days (12 children). The term of surgical operation from 11 until 28 days for 3 children was due to the presence of hernia's coats infection and purulence, which demanded the implementation of preoperative preparation for 5-7 days. The disadvantage of all methods of surgical treatment of spinal disraphism is a danger of iatrogenic damage to neural elements during surgery, depending on the quality of its performance. During the execution of surgical treatment of spinal disraphism you must use radiculolysis with precision microsurgical excision of all cicatricial adhesions, cerebrospinal fluid cysts and other intraradicular formations, a thorough revision of the spinal canal.

Dysfunction of the pelvic organs (urine and anal incontinence) and lower limbs are observed in 63,16 % of children operated for spinal disraphism in the neonatal period which requires further development of methods of their surgical correction at a later age.

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CLINICS AND TREATMENT PECULIARITIES OF BRONCHIOLITIS IN INFANTS

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Acute bronchiolitis is the most common cause for hospitalisation in infancy with 1%–3% of all infants being admitted during their first winter. The disease is caused by a number of common respiratory viruses, with RSV the most commonly identified, and is associated with the characteristic winter peaks in admissions. Lower respiratory infection is the leading cause of global child mortality. Respiratory syncytial virus (RSV) is believed to be the most important viral pathogen causing acute lower respiratory infection in young children. RSV is the most important factor of the death of infants among all virus infections. In the first year of life, 50% of children infected with RSV, and 40% patients developed an infection of the lower respiratory tract. During the first two years of life every child at least once suffers from RSV infection. RSV is responsible for 50-80% of cases of bronchiolitis. In a broad range of respiratory viruses the RSV has a special place due to the diversity and severity of clinical manifestations of the disease in infants it causes. RS infection remains thus far a major medical and social issue causing high prevalence, needs for hospitalizations and mortality in risk groups of children.

The aim of the study was to analyze the clinical and laboratory features and therapeutic tactics of infants suffering from bronchiolitis.

Fifty one children (median age 2,7 months) admitted to the infant infectious department (Regional Pediatric Clinical Hospital, Chernivtsi, Ukraine) with bronchiolitis were enrolled in the study. The examination of infants included: clinical data, complete blood count and analysis of treatment.

The highest morbidity was observed in January-March. Twenty three children (45,2%) hospitalized in severe condition, twenty six infants (50,9%) suffered from moderate bronchiolitis. The clinical picture of infants suffering from bronchiolitis characterized by typical symptoms of bronchioles obstruction, emphysema and early respiratory failure. For most of infants bronchiolitis characterized by subfebrile temperature response. Changes of complete blood count in infants suffer from bronchiolitis characterized by increasing of white cell count (50,6% children), neutrophil count (64,5% infants) and anemic syndrome (64,5%). Initially ten children (19,6%) were hospitalized in the Pediatric Intensive Care Unit, six infants (11,7%) were mechanically ventilated (median 3,5 days), seven patients treated with oxygen (median 1,3 days). Nineteen children (37,3%) had complications of congestive heart failure and treated with diuretics and cardiac glycosides. The average duration of stay in hospital of infants was 9,3 days. Up to 45% of children with RSV bronchiolitis characterized by severe condition, and half of them were hospitalized in the PICU, which increased risk for bacterial co-infection.

Thus, the course of bronchiolitis in infants is characterized by severity, typical signs of damage of the lower parts of the respiratory tract and high probability of bacterial co-infection.

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CLINICAL-PARACLINICAL PECULIARITIES OF TONSILLOPHARYNGITIS OF NON-STREPTOCOCCAL ETIOLOGY IN CHILDREN

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The objective of our study was to investigate clinical-paraclinical peculiarities of tonsillopharyngitis of non-streptococcal etiology in children in order to improve their treatment.

To achieve the purpose of the study two groups of examination were formed. The first (I) clinical group included 66 patients with acute tonsillopharyngitis of non-streptococcal etiology, which was evidenced by a negative result of bacteriological test from the pharyngeal lavage and pharyngeal posterior wall. The second (II) clinical group included 32 children with acute streptococcal tonsillopharyngitis. Streptococcal etiology of the disease was proved by a positive result of culture test from the pharyngeal smear.