ОСОБЕННОСТИ КЛИНИЧЕСКОГО ТЕЧЕНИЯ ПЕРИОДИЧЕСКОЙ БОЛЕЗНИ У ДЕТЕЙ

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ОСОБЕННОСТИ КЛИНИЧЕСКОГО ТЕЧЕНИЯ ПЕРИОДИЧЕСКОЙ БОЛЕЗНИ У ДЕТЕЙ. ЖКМП.-2025.-Т.2.-№2.-С

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Аннотация: Проведен анализ генетических и анамнестических данных, лабораторных и инструментальных исследований, клинических проявлений заболевания у 167 больных с периодическими заболеваниями, а также проведена подробная дифференциальная диагностика с другими острыми инфекционными и хирургическими заболеваниями. В результате были изучены клинические особенности течения заболеваний пародонта у детей и разработан алгоритм ведения пациентов на ранних стадиях заболевания. Таким образом, раннее выявление клинических признаков заболеваний пародонта и нормализация проницаемости сосудов, а также лабораторных показателей позволяет предупредить осложнения в развитии заболевания.

Ключевые слова: *дети, периодическая болезнь, болевой синдром, красный дермографизм, геморрагические высыпания, нарушения функции почек.*

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Annotatsiya: Davriy kasalligi bo‘lgan 167 bemorning genetik va anamnestik ma’lumotlari, laboratoriya va instrumental tekshiruvi, kasallikning klinik ko‘rinishi tahlil qilindi va boshqa o‘tkir yuqumli va jarrohlik kasalliklari bilan batafsil differensial diagnostika o‘tkazildi. Natijada bolalarda davriy kasallikning kechishining klinik xususiyatlarini o‘rganildi va kasallikning dastlabki bosqichlarida bemorlarni boshqarish algoritmini ishlab chiqildi. Shunday qilib, davriy kasallikning klinik belgilarini erta aniqlash va qon tomir o‘tkazuvchanligini, shuningdek, laboratoriya ko‘rsatkichlarini normallashtirish kasallikning rivojlanishidagi asoratlarni oldini olishga imkon beradi.

Kalit so‘zlar: *bolalar, davriy kasallik, og‘riq sindromi, qizil dermografizm, gemorragik toshma, buyrak funktsiyasining buzilishi.*

FEATURES OF THE CLINICAL COURSE OF PERIODIC DISEASE IN CHILDREN

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Abstract: An analysis of genetic and anamnestic data, laboratory and instrumental studies, clinical manifestations of the disease in 167 patients with periodic diseases was carried out, and a detailed differential diagnosis with other acute infectious and surgical diseases was carried out. As a result, the clinical features of the course of periodontal diseases in children were studied and an algorithm for managing patients in the early stages of the disease was developed. Thus, early detection of clinical signs of periodontal diseases and normalization of vascular permeability, as well as laboratory indicators, allows preventing complications in the development of the disease.

Keywords: *children, periodic disease, pain syndrome, red dermographism, hemorrhagic rashes, renal dysfunction.*

Introduction: The close attention of many authors to periodic illness (PI) in children in recent years is associated with the emerging peculiarity of the course of periodic illness (PI) in children and the development of an algorithm for managing patients during an exacerbation. In adults, PI is usually a continuation of the suffering that began in childhood [3, 14, 18]. A characteristic feature of this disease is the imitation of aseptic inflammation with damage to the serous membranes and vascular system of various organs. A large percentage of familial cases of the disease, damage to the kidneys, intestines, liver [1, 4, 6, 18], as well as changes in the joints and muscle tissue in the form of myalgia and arthropathy [6, 16, 17], and the lag in children in physical and sexual development should alert authors studying the problem of BP. Structural changes in tissues can be detected even at the first attacks of the disease [12, 13, 19]. The possibility of developing amyloidosis of internal organs [1, 2, 4, 6] emphasizes the need for early diagnosis of this disease.

Currently, abdominal, thoracic and mixed forms of BP are distinguished. The polymorphism of clinical manifestations of BP gave grounds for the authors to call it Mediterranean fever, benign peritonitis, Armenian disease, unknown infectious disease, etc. [5-8, 11, 18, 20]. Despite the large amount of information on the clinical course of BP, the issues of its etiology and pathogenesis have not been sufficiently developed. It is believed that the cause of changes in many tissue structures in this disease are changes in neutrophilic leukocytes [15, 20, 21].

Methods: This report presents the results of our observations of 167 children with BP. The majority of patients were aged 4-9 years (84 children) and 10-15 years (76), only 7 children were under 3 years old. The patients were of different nationalities: Uzbeks, Tajiks, Russians, etc. There was a slight predominance of boys (92). Most children (65%) had suffered from a number of childhood diseases in the past, among which were often found exudative diathesis (53%), catarrhal tonsillitis more than 3-4 times a year (37%), which served as a provoking factor for the appearance of extraordinary attacks of BP, as well as measles (58%), influenza 1-3 times a year (70%), chickenpox (13%), epidemic mumps (16%). More than half of the patients had foci of chronic infection upon admission to the clinic (chronic tonsillitis in 58%, dental caries in 62%). In 84% of children, the onset of attacks of BP was preceded by a short prodromal period in the form of malaise, lethargy, body pain, dyspeptic disorders, and increased urination (Table 1). The prodrome generally lasted from 40 minutes to 2 hours. In young children, prodrome could be detected only with a thorough clinical examination. At the height of the attack of PE, the skin became pale, moist, and red dermographism was often detected (in 48 patients). Hemorrhagic rashes in the ankle joints could be observed only in 5 patients.

Table 1.Precursors of a PB attack.

Symptoms	Frequency	
	abs.	%
Lethargy	132	79,0
Body pain	78	46,7
Malaise	120	71,7
Pale face	61	36,5
Shadows under the eyes	58	34,7
Drowsiness	30	17,9
Yawning	14	8,4
Yawning	6	4,0
Depression	38	22,8
Irritability	54	32,4
Loss of appetite	141	84,4
Nausea	64	38,3
Increased urination	60	35,9
Dyspeptic symptoms	53	31,8

In the early diagnosis of PB, pediatricians often do not use symptoms such as stereotypical paroxysms and the duration of the disease, which leads to an erroneous diagnosis and, accordingly, to unjustified surgical intervention.

Results: The main clinical syndrome in our observations was abdominal (Table 2), which, however, was somewhat less common (in 94% of patients) than according to other authors [10, 18]. The severity of abdominal syndrome varied: from moderate to severe pain with a clear picture of “acute abdomen”. In 17% of patients, the first manifestations of abdominal syndrome were noted at the age of 1 to 3 years, in 71% - from 4 to 9 years, and only in 12% - after 10 years.

Histological examination of biopsy material from the mucous membranes of the stomach, duodenum and colon in 24 children with BP revealed morphological changes in the tissue with lymphocytic infiltrates, and in some of them, amyloid deposits. Gastroduodenoscopy and colonoscopy revealed superficial or severe gastroduodenitis and colitis. In 18% of children, BP was present in their immediate and close relatives. According to some foreign data, this figure ranges from 6.8 to 60-75%.

According to some foreign data, this figure ranges from 6.8 to 60-75%. In our observations, a burdened heredity for BP was more often manifested in the male line. Cases of BP were established in two or more generations.

Table 2.

Frequency of clinical symptoms in BP in children.

Symptoms	Frequency	
	abs.	%
Abdominal pain	157	94,0
Abdominal muscle tension (defence muscu laire)	160	95,8
Chest pain	37	20,9
Joint pain	25	13,7
Fever	167	100
Nausea	120	71,8
Vomition	88	52,6
Enlarged liver	70	41,8
Enlarged spleen	66	39,1
Pain when urinating	32	19,1
Anemia	42	29,1
Increased ESR	167	100
Neutrophilic leukocytosis	150	89,8
Eosinophilia	48	28,7
Hyperproteinemia	114	68,0

No specific causes contributing to the occurrence of attacks of the disease were identified. In our observations, crises of BP in children occurred from 1-3 times a week to 5-6 times a year. Moreover, each patient had periods of increasing and decreasing frequency of crises depending on the season. Attacks of the disease lasted from 1 to 5-8 hours (in 78%), and sometimes up to 2 days (in 22%). In 97.7% of cases, they occurred against the background of high temperature (38.5-40.50C), only 2.3% of patients had subfebrile temperature. Comparatively rare (in 6.5% of children) was thoracic syndrome, the interictal period of which was more defined and prolonged (25-35 days or more). Some children (5.5%) of younger age had a musculoskeletal syndrome of unclear localization, which for a long time gave rise to erroneous diagnosis of rheumatism, rheumatoid arthritis, etc.

All patients at the height of the attack had shortness of breath, retraction of the compliant parts of the chest, and some children had dry, widespread wheezing. In parallel with the improvement of the general condition of the children, changes in the respiratory organs also disappeared. During the attack, changes in the cardiovascular system were also determined, which were mainly functional in nature (tachycardia, muffled heart sounds, systolic murmur at the apex of the heart). Increased blood pressure was found in 8 patients. In 32% of patients, some changes in the kidneys were detected. In 10% of children, they developed almost simultaneously with the main manifestations of PI, in the rest (22%) - after 4-6 months or more. Clinical and laboratory signs of renal dysfunction included erythrocyturia (in 11% of patients), leukocyturia (in 7.8%), proteinuria (in 9%), cylindruria (in 5.3%) and azotemia. The latter was quite persistent and, as a rule, persisted even after the attack. The degree of azotemia did not always correspond to the severity of the pathological process.

Persistent proteinuria in combination with minimal hematuria and leukocyturia was determined in 17% of children. In some children, daily protein extraction reached 2.5-3.0 g. These patients mainly suffered from amyloidosis of internal organs. Nephrotic syndrome in some children developed in parallel with changes in urine alkalization, mainly after 3-5 years. In 12 children, manifestations of amyloidosis of internal organs were noted in the final stage of the disease. With the development of complete nephrotic syndrome, these 12 children developed chronic renal failure, some of them simultaneously had liver failure, eclampsia and neuroses.

Hyperproteinemia (68%) and dysproteinemia due to hyper-α2-globulinemia were often detected. In the presence of hepatorenal syndrome, hypoalbuminemia (up to 36-40%) and hypo-μ-globulinemia were determined. However, in 22% of patients, hyper-μ-globulinemia was accompanied by an increase in cholesterol levels. These changes were especially pronounced at the height of the PB crisis and persisted in the interictal period. Complementary activity, phagocytosis, and properdin levels [8] were sharply reduced. Increased activity of acid and alkaline phosphatases in neutrophils and high activity of acid phosphatase in lymphocytes [8,9], detected in most patients, to some extent indicated increased allergization of the body.

Indirect confirmation of this was an increase in vascular permeability (fluorescent method) in a number of children, especially at the height of the attack (3-5 times higher than normal). As a rule, the normalization of vascular permeability and enzyme activity in leukocytes lagged behind clinical remission. Based on our long-term observations [9, 12, 13], we can assume that strict periodicity of attacks is not

necessary, but there are cases with a more or less defined sequence of paroxysms, mainly in younger children. The rhythm of attacks of the disease in our observations varied even in the same patient depending on the influence of external and internal factors [12, 13].

Conclusion: Thus, the peculiarity of the clinical course of periodic disease in children is the generalized lesion of almost all organs and systems, the clinical symptoms of which depend on the predominant dysfunction of one or another organ. Changes in the activity of blood leukocyte enzymes to some extent indicate an increasing allergization of the child's body, activation of the function of certain groups of blood lymphocytes. Indirect confirmation of this is an increase in vascular permeability in a number of children, especially at the height of an attack of the disease. As a rule, early detection of the clinical features of periodic disease and normalization of vascular permeability as well as laboratory parameters allows avoiding complications in the course of the disease.

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