

COURSE AND DIAGNOSIS OF ACUTE PANCREATITIS IN CHILDREN`

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Abstract.

Relevance. Acute pancreatitis is one of the most severe diseases of the digestive system and if not diagnosed in time, complications may develop. **The aim of the study.** To determine the diagnostic criteria for acute pancreatitis. **Materials and methods of the study.** An examination of 25 children aged 9 to 15 years with acute pancreatitis was conducted. All patients underwent a general blood, urine and feces analysis, a biochemical blood test, as well as an ultrasound examination of the pancreas and liver. **Research results and discussion.** According to the survey results, 100% of patients experienced the onset of pain within the first 1.5-2 hours, and patients accurately indicated the location of the pain. Of these, 59% of patients experienced severe, stabbing pain in the epigastric region, and 33% experienced pain in the left side. After 2-3 hours, the pain radiated to the lower back and spine, and 6.3% to the left shoulder. Patients often experience nausea, vomiting, dry mouth, constipation, flatulence, increased sweating, and weakness. Positive symptoms of Shchetkin-Blumberg, Kerte, Kacha, Mayo-Robson were noted during palpation. **Conclusions.** Mondoran's triad is an accurate universal method for diagnosing acute pancreatitis in children. The clinical picture characteristic of the early stage of acute pancreatitis is as follows: acute, constant stabbing pain in the epigastric region, often radiating to the abdominal region and accompanied by dyspeptic disorders. The disease can be confirmed by palpation (Shchetkin-Blumberg, Kerte, Kacha, Mayo-Robson symptoms).

Key words: acute pancreatitis, pancreas, patients, clinical course, girdle pain, diagnostics.

Relevance. Today, acute pancreatitis is one of the most severe diseases in the pathology of the digestive system, and if acute pancreatitis is not diagnosed in a timely manner, it can lead to the development of edema [1,6,7,9,10,13]. There are 4 degrees of acute pancreatitis: 1) mild acute pancreatitis, in which inflammation, diffuse edema, and necrosis and insufficiency are observed; 2) moderate acute pancreatitis, in which transient organ failure (less than 48 hours) or the presence of pseudocysts, infiltrates, abscesses; 3) severe acute pancreatitis, in which pancreatic necrosis or peripancreatic necrosis or persistent organ failure occurs. 4) critical acute pancreatitis, with the development of infected pancreatic necrosis or peripancreatic necrosis and persistent organ failure. According to the revised Atlanta classification, there are a number of criteria for assessing acute pancreatitis, and the diagnosis is made if 2 out of 3 are present: a) typical clinical picture (triple sign) according to UTT: enlarged pancreas, decreased echogenicity, indistinct contours, free fluid in the abdominal cavity; c) an increase in the concentration of amylase and lipase by 3 times or more than the norm [4,5,11]. The basis for the diagnosis of acute pancreatitis is the triple sign: severe pain in the epigastric region or girdle-like pain, pain that does not decrease after antispasmodic drugs, pain in the heart region, radiating behind the sternum, nausea, lack of relief after vomiting, and tension in the upper abdomen. Dry mouth, thirst, the patient's tongue is covered with a white coating. These symptoms are caused by the intake of fatty, fried and large amounts of food and diseases of the biliary tract [2,3,8,12].

The aim of the study. to determine the diagnostic criteria for acute pancreatitis.

The aim of the study. A questionnaire was administered to 25 children aged 9 to 15 years, hospitalized in the Samarkand city hospital with acute pancreatitis. 10 (40%) were boys, 15 (60%)

were girls, the average age of the patients was 12 years. All patients underwent a general blood, urine and feces test, biochemical blood test, ultrasound examination of the pancreas and liver.

Results and discussion of the study. According to the results of the questionnaire, the onset of pain in 100% of patients was observed within the first 1.5-2 hours, and the patients accurately indicated the location of the pain. Of these, 59% of patients had severe, stabbing pain in the epigastric area, and 33% had pain on the left side. After 2-3 hours, the pain was referred to the lower back and spine, and in 6.3% to the left shoulder. 84% of patients had severe pain in the abdomen, and these patients turned to medical personnel on the 2-4th day of the disease. 62% of patients took painkillers at home («no-shpa», «baralgin»), but the pain did not disappear completely, the pain decreased within 1.5-2 hours, and then severe pain started again. When we pay attention to the causes of acute pancreatitis, it was found that 35% of patients had an excessive intake of fatty, fried foods in their diet. 24% of patients had biliary dyskinesia, cholecystitis, and the remaining 31% had a genetic predisposition to the development of this disease. The clinical presentation of the disease varied, but often nausea, vomiting were observed, and patients did not feel relief afterwards. Symptoms of dry mouth, constipation, flatulence, profuse sweating, and weakness were observed in all patients. Symptoms such as diarrhea, increased blood pressure, fainting, headache were rarely observed in patients. Most of the patients admitted to the department did not seek emergency medical care. Biliary dyskinesia and cholecystitis were also detected in the patients. When palpating the patients, the following signs were revealed: positive Shchetykin-Blumberg symptom, 95% of patients also had a positive Kerte symptom (muscle tension in the projection of the pancreas and pain 5 cm above the navel), 58% of patients had a positive Kach symptom (pain when palpating the transverse tumor of the 8-11th thoracic vertebra), 50% of patients Mayo-Robson's symptom was positive (pain on palpation in the left costo-spinal angle) and Mondor's triad (pain, vomiting, flatulence) was observed in 45% of patients.

When analyzing the anamnesis of patients with a diagnosis of acute pancreatitis, it was found that this disease occurs equally in boys and girls. The main causes of the development of acute pancreatitis are excessive and excessive intake of fatty, fried foods, biliary dyskinesia, cholecystitis, and hereditary predisposition. The clinical course of the disease in patients varied. In children, the pain often began in the epigastric region or under the left rib. The pain was severe, stabbing, and spread to the entire abdomen within 2-3 hours. In some cases, the pain spread to the lumbar region, left shoulder, and often had a girdle-like character. In most cases, dyspeptic changes were observed: nausea, flatulence, constipation, profuse sweating, dry mouth, and thirst. The patients were helped to diagnose «acute pancreatitis» by the symptoms of Shchetkin-Blumberg, Mayo-Robson, Kerte, Kach, and Mondor's triad. These symptoms are used to confirm the diagnosis.

Conclusion. Thus, despite the high incidence of acute pancreatitis in children today, the diagnosis is not sufficient. The Mondor's triad is an accurate universal method for diagnosing acute pancreatitis. The clinical picture characteristic of the early stage of acute pancreatitis is: acute, constant stabbing pain in the epigastric region, often radiating to the left hypochondrium, to the abdominal surface, and accompanied by dyspeptic disorders: nausea, feeling of heaviness after vomiting, flatulence, diarrhea. The disease can be confirmed by additional palpation methods (Shchetkin-Blumberg, Kerte, Kach, and Mayo-Robson symptoms).

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