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Out of Hospital Pneumonia in Children Treatment Types

Khalilova Dilobar Salimovna
Bukhara Medical Institute

Abstract: The main focus of this document is on the practical issues of diagnosis and therapy in pediatric patients, and out of hospital pneumonia particular features management of children on an outpatient basis, includes data on the characteristics of EP in children with HIV infection, cerebral palsy, and cystic fibrosis. Book intended for pediatricians, general practitioners, pulmonologists, clinical pharmacologists, resuscitators, as well as teacher's medical universities.

Keywords: children, hospital pneumonia, pulmonology, treatment

Intraduction. Community-acquired pneumonia (home, outpatient) is pneumonia that has developed outside the hospital or in the first 72 hours of hospitalization. In accordance with the International Classification of Diseases, Injuries

And Causes of Death of the 10th revision (ICD-10) and the "Classification of clinical forms of bronchopulmonary diseases in children" [2], the following forms of pneumonia are distinguished: By etiology

- Bacterial (including those caused by atypical bacteria);
- Viral;
- Fungal;
- Parasitic;
- mixed

Downstream:

- ✓ acute - duration up to 6 weeks;
- ✓ Prolonged — duration of more than 6 weeks.
- ✓ By severity:
- ✓ moderate severity;
- ✓ Heavy.

According to the developed complications

- pleural complications - pleurisy;
- pulmonary complications — cavities, abscess;
- pulmonary-pleural complications - pneumothorax, pyopneumothorax;
- infectious and toxic complications — bacterial shock.[4,6,8]

According to WHO, pneumonia is the leading cause of infant mortality worldwide. Among the causes of mortality in children under 5 years of age, it

Accounts for 17.5%, which annually accounts for about 1.1 million

Deaths in the world (this is more than AIDS, malaria and measles

Combined). At the same time, 99% of fatal cases from pneumonia in children under 5 years of age occur in poorly and medium-developed countries of the world [7,3,1]. A global study found that in 2010, mortality due to severe acute lower respiratory tract infections in hospitalized children under the age of 5 in developing countries was almost 4 times higher than in developed countries (2.3% and 0.6%, respectively) [9,8,12].According to the Ministry of Health of the Russian Federation, respiratory diseases in children aged 0-17 years occupy the third place in the structure of causes of death after external causes and malformations[13,15,17]. S. pneumoniae is the most frequent causative agent of VP in children [13, 15, 16].According to a multicenter study in 18 cities of the Russian Federation, among the serotypes of pneumococcal (analysis of 223 strains), the most common cause of VP in children under 5 years of age is serotype 19 (in 33.6% of cases). Serotypes are also important 6 (15,8%), 23 (8,9%) and 14 (7.2%). The remaining pneumococcal serotypes were isolated in less than 5% of cases or were not isolated [15, 19, and 21].

Material and methods: Changes in the general blood test for VP depend on the etiology of the disease for VP caused by S.pneumoniae and other typical bacteria, neutrophilic leukocytosis (more than 15X9 / L) and a significant increase in ESR are characteristic, while the degree of leukocytosis correlates with the risk of lung destruction; for HC1 mycoplasmic, chlamydial and viral etiology there are no characteristic changes, with the exception of chlamydial pneumonia in children of the first months of life, in which high eukocytosis (more than 30x109 / l) can be observed. Bacterioscopy of a Gram-stained sputum smear and sputum

Culture examination is recommended in hospitalized children in all cases of sputum separation. Before sowing, a smear of the delivered material, colored by Gram, is examined in the laboratory. The bacterioscopy method is a mandatory method of rapid diagnosis. Taking into account cytological criteria, it has sensitivity

50-60% and specificity - 80%. Uninformative samples (> 10 squamous epithelial cells and < 25 segmented neutrophils at low resolution - *100) are not subject to bacteriological examination: the test sample is the contents of the oral cavity or

nasopharynx. With the purulent nature of sputum, Gram staining allows for a preliminary etiological diagnosis in 80% of cases.

Results and discussion

The diagnosis can be reliable or probable. Reliable - detection of infiltration of lung tissue on the chest X-ray and the presence of at least 2 of the following criteria:

1. fever above 38 ° C for 3 or more days;
2. cough with sputum;
3. physical symptoms of pneumonia;
4. leukocytes > 15x109/l and/or the number of rod-shaped neutrophils

> 10%.

Probable - the presence of fever, cough and local physical symptoms of pneumonia, but chest X-ray has not been performed. In the first days of the disease, the symptoms of uncomplicated and complicated pneumonia are identical. In most patients, uncomplicated VP is observed, which is characterized by a smooth course: normalization of body temperature usually occurs in the first two days after the onset ABT the disappearance of physical

symptoms — within 7 days, X-ray resolution usually occurs after 2-3 weeks (maximum - up to 6 weeks). Indications for hospitalization are: age up to 6 months of life; severe pneumonia; the presence of severe background diseases — congenital heart disease, chronic lung diseases accompanied by infection (bronchopulmonary dysplasia, cystic fibrosis, bronchiectatic disease, etc.), immunodeficiency, diabetes mellitus; conducting immunosuppressive therapy; lack of conditions for treatment at home or guarantees of implementation of recommendations — socially disadvantaged family, poor social conditions (dormitory, children's home, temporary accommodation, etc.); no response to the initial ABT for 48 hours (persistence of high fever, increase in respiratory failure, appearance of arousal or depression of consciousness). Hospitalized children with VP who do not require intensive therapy should preferably be isolated. In the hospital treatment of children in a pediatrician and or a pulmonologist are carried out, and an anesthesiologist—resuscitator is also in the ICU, if necessary, an examination by a phthisiologist, a thoracic surgeon, a physiotherapist and a physical therapy doctor. All children with severe VP (if the treatment is carried out by a pediatrician) should be consulted by a pulmonologist. Children, who have suffered VP, can be sent for rehabilitation to a specialized local sanatorium. It is optimal to transfer the child to a sanatorium for 10-11 days of inpatient treatment. At the same time, the average duration of stay in rehabilitation treatment should be at least 14 days, during which physiotherapy, physical therapy, reflexology, manual therapy, psychotherapy are carried out, taking into account the prospects for restoration of functions (rehabilitation potential) confirmed by the results of the examination . Routine vaccination is carried out after recovery. The resumption of hardening is possible 2-3 weeks after the normalization of temperature, sports are allowed after 6-12 weeks after recovery (depending on the severity of pneumonia).

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