ACUTE PANCREATITIS IN CHILDHOOD

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ANNOTATION

Acute pancreatitis in children among diseases of the digestive system is one of the most severe diseases. For the diagnosis of the disease, the triad is important: severe pain in the epigastric region or lower back pain, pain that does not decrease after taking antispasmodic drugs, irradiation of pain to the retrosternal region, nausea, vomiting, lack of relief after vomiting and tension in the upper abdomen. Clinical signs characteristic of the disease: acute, persistent pain and dyspeptic disorders are observed in the epigastric region. The disease can also be confirmed by determining the signs of Shchetkin-Blumberg, Kerte, Kach, Mayo-Robson.

KEY WORDS: acute pancreatitis, patients, diagnosis clinical course, lumbar pain.

INTRODUCTION

In recent years, acute pancreatitis has become one of the most serious diseases in the pathology of the digestive organs, and if the disease is not diagnosed in time, it can lead to development into a tumor [1-10,13-19]. There are 4 degrees of acute pancreatitis:

1) a mild level of acute pancreatitis, in which inflammation, diffuse swelling is observed, and there is no necrosis and insufficiency;

2) moderate severity of acute pancreatitis, with transient organ failure (less than 48 hours) or pseudocysts, infiltrates, abscesses;

3) severe degree of acute pancreatitis, in which pancreonecrosis or peripancreonecrosis or persisted organ.

4) critical stage of acute pancreatitis, with the development of infected pancreonecrosis or peripancreonecrosis and persistent organ failure.

There are a number of criteria for assessing acute pancreatitis according to the revised Atlanta classification, and the diagnosis is made if 2 of 3 are present:

a) a typical clinical picture (triple sign);

b) according to UTT: enlarged pancreas, decreased echogenicity, unclear contours, free fluid in the abdominal cavity;

c) the concentrations of amylase and lipase increase 3 times or more compared to the norm [11,12].

The diagnosis of acute pancreatitis is based on three signs: severe pain in the epigastrium or lumbar pain, pain that does not decrease after antispasmodic drugs, pain radiating in the area of the heart, 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 [21-26].

THE PURPOSE OF THE STUDY

Determine diagnostic criteria for acute pancreatitis in children.

MATERIALS AND METHODS OF RESEARCH

We examined 25 children aged 9 to 15 years, hospitalized in the Samarkand city hospital with acute pancreatitis. There were 10 boys (40%), 15 girls (60%), the average age of the patients was 12 years.

RESEARCH RESULTS AND DISCUSSION

All examined patients experienced pain in the first 1.5-2 hours, and the patients clearly indicated the location of the pain. 59% of patients experienced severe, stabbing pain in the epigastric region, and 33% had pain on the left side. After 2-3 hours, the pain radiated to the back and spine, and in 6.3% - to the left shoulder. 84% of patients had severe abdominal pain, and these patients contacted medical personnel on the 2-4th day of illness. 62% of patients took painkillers at home (“no-shpa”, “baralgin”), but the pain did not completely disappear, the pain decreased within 1.5-2 hours, and then severe pain began 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% were found to have 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 Shchyotkin-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 (transverse 8-11 thoracic vertebra) pain on palpation of the tumor), 50% of patients had a positive Mayo-Robson symptom (pain on palpation of the left costo-spinal angle) and 45% of patients had Mondor's triad (pain, vomiting, flatulence).

Analyzing the anamnesis of patients diagnosed with acute pancreatitis, it was found that boys and girls have the same incidence of this disease. The main reason for the

development of acute pancreatitis is a large and excessive intake of fatty, fried foods, biliary dyskinesia, cholecystitis, and genetic predisposition. The clinical course of the disease in patients was different. In children, the pain often started in the epigastric area or under the left rib. The pain is strong, wedge-shaped, spread to the entire abdomen within 2-3 hours. In some cases, the pain spread to the lower back, to the left shoulder, and was often lumbar. In most cases, dyspeptic changes were observed: nausea, flatulence, constipation, profuse sweating, dry mouth and thirst. Shchyotkin-Blumberg, Mayo-Robson, Kerte, Kach's symptoms, Mondor triad helped to diagnose "acute pancreatitis" in patients. These symptoms are used to confirm the diagnosis.

CONCLUSION

Currently, despite the high incidence of acute pancreatitis in children, diagnosis is insufficient. Mondoran's triad is an accurate universal method for diagnosing acute pancreatitis. The clinical picture, characteristic of the early stage of development of acute pancreatitis, is a sharp constant wedge-shaped pain in the epigastric region, often the pain spreads to the left rib, to the surface of the abdomen and is accompanied by dyspeptic disorders: nausea, vomiting, lack of relief after vomiting, flatulence, diarrhea. The disease can be confirmed using additional palpation methods (Shchetkin-Blumberg, Kerte, Kach, Mayo-Robson symptoms).

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