Impact Factor: 9.2 ISSN-L: 2544-980X

Tactics of Administration of Patients with Hemorrhagic Syndrome with Chronic Polyposis

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Abstract: The article describes the phenotypic characteristics of 3 patients with various types of gastrointestinal lesions in Crohn's disease, the path to diagnosis verification, and a dynamic assessment of therapeutic tactics. The complexity of the differential diagnosis of inflammatory bowel diseases, despite the use of additional research methods, is determined by the commonality of clinical manifestations. Choosing the correct treatment strategy at any stage of the disease course should be considered an essential component of successful patient management.

Keywords: children, inflammatory bowel diseases, Crohn's disease, ulcerative colitis.

There is an increasing incidence of chronic inflammatory bowel disease (CIBD) in children worldwide. For example, the incidence of Crohn's disease (CD) varies from 1.5 to 11.4 per 100,000 children, but the estimated prevalence of CD is 58 per 100,000 [5, 6]. In childhood, the pathological process of inflammatory bowel diseases is more widespread, prone to a progressive increase in severity, the disease is associated with a more likely development of complications and often requires the prescription of glucocorticosteroids, immunosuppressants and anti-cytokine drugs [2]. In Crohn's disease, the likelihood of complications requiring surgery is also higher in patients with onset of the disease in childhood [1].

Timely and accurate diagnosis and adequate therapy can have a positive impact on the natural course of CIBD. At the same time, in some cases there are no unambiguous diagnostic criteria for inflammatory bowel disease; in particular, the diagnosis of CD is made based on a combination of anamnesis data, clinical picture with typical endoscopic and histological changes [3]. According to the Russian recommendations for the diagnosis and treatment of Crohn’s disease in children (2018), there are criteria for a reliable diagnosis of CD according to Lennard-Jones, including the determination of six key signs of the disease [Lennard-Jones J.E. Classification of inflammatory bowel disease. Scand. J. Gastroenterol. Suppl. – 1989; 170:2-6]. In routine practice, situations may arise that go beyond the scope of clinical recommendations, so the final decision on the management tactics of each patient should be made by the attending physician, who is responsible for his treatment.

In 2017, at the age of 6 years, for the first time there were complaints of traces of blood in the stool, pasty stools up to 3 times a day, pain in the left iliac region. Based on the results of laboratory and instrumental examination, nonspecific ulcerative colitis was verified, total, with a minimum degree of PUCAI activity of 25 b. Positive dynamics of clinical symptoms were obtained during therapy with 5-aminosalicylic acid (5-ASA) per os at a dosage of 50 mg/kg/day. (1.5 g/day) for a year. In 2018, during an endoscopic examination, the phenomena of proctitis were identified. Taking into account the localization of the inflammatory process, the administration regimen of 5-ASA was changed: 0.5 g per os and 1.0 mg per rectum. Within 6 months. therapy, the patient’s condition remained stable, then, due to spontaneous cessation of rectal administration of the drug 5-ASA, the phenomena of hemocolitis

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were noted, stools up to 5 times a day, unformed. The gastroenterologist recalculated the dose of the drug 5-ASA for oral administration (70 mg/kg/day), hemocolitis was relieved. Over the next year of therapy, stools persisted up to 5 times a day, from formed to liquid, 2 times a week. nocturnal bowel movements, weight loss by 5 kg. During an examination in December 2019, a negative result was obtained for determining the immunological markers of CIBD in the blood: ASCA (antibodies to Saccharomyces cerevisiae) and ANCA (antibodies to the cytoplasm of neutrophils); No violations of the cellular and humoral immunity have been established. Endoscopic examination data: the surface of the mucous membrane throughout the entire intestine is granular, smoothness of folds in all sections, absence of vascularity in all sections, with the exception of the dome of the cecum; in the rectum and sigmoid sections of the intestine, inflammatory changes in the mucous membrane are determined along the entire circumference, manifested swelling, a large number of crypts, abscesses, the application of fibrin threads. Irrigography: presence of stricture of the descending colon, smoothness of the folds of the descending and sigmoid colon similar to the “drainpipe” symptom, longitudinal folding of the descending colon.

Considering the absence of clinical-endoscopic remission during therapy with optimal doses of the drug 5-ASA, the formation of dynamic narrowing of the lumen of the colon, the main diagnosis should be considered Crohn's disease of the colon, inflammatory form, continuous recurrent course, clinical-endoscopic exacerbation, minimal degree of activity, PCDAI 5 points. Stricture of the descending colon. In accordance with Russian recommendations for the diagnosis and treatment of Crohn's disease in children, systemic glucocorticosteroids are prescribed to induce remission of the disease; while reducing the dose of prednisolone, a thiopurine drug (azathioprine) is recommended to maintain remission. Observation in dynamics.

Inflammatory bowel diseases are characterized by the presence of inflammatory-destructive processes in the intestines and a chronic relapsing course. The etiology of inflammatory bowel diseases, including CD, has not been established: the disease develops as a result of a combination of several factors, including genetic predisposition, defects in innate and acquired immunity, intestinal microflora and the adverse effects of various environmental factors. Approximately 100 single nucleotide polymorphisms have been described that are associated with CD and are likely to predispose to changes in the innate immune response, autophagy, microbial recognition mechanisms, endoplasmic reticulocyte stress, epithelial barrier function, and the adaptive immune response. The key immune defect that precedes the development of CIBD is impaired recognition of bacterial molecular markers (patterns) by dendritic cells, which leads to hyperactivation of pro-inflammatory signaling pathways [6]. In the pathogenesis of CIBD development, the role of a decrease in the diversity of intestinal microflora due to a decrease in the proportion of anaerobic bacteria, mainly Bacteroidetes and Firmicutes, is discussed. Triggering factors for the manifestation of the disease include exposure to tobacco smoke, nervous stress, vitamin D deficiency, a diet low in dietary fiber and high in animal protein, and intestinal infections. The result of the mutual influence of these risk factors is the activation of Th1 and Th17 cells, overexpression of proinflammatory cytokines, primarily tumor necrosis factor alpha, interleukins 13 and 23, and cell adhesion molecules. A cascade of humoral and cellular reactions leads to transmural inflammation of the intestinal wall with the formation of sarcoid granulomas characteristic of CD (but not ulcerative colitis), consisting of epithelioid histiocytes without foci of necrosis and giant cells.

Differential diagnosis of ulcerative colitis and CD can be difficult in the presence of such common symptoms as pain in the lower abdomen, diarrhea, tenesmus, fever, and weight loss. The addition of extraintestinal manifestations of diseases further complicates diagnosis. According to O.S. Shifrin [4], with nonspecific ulcerative colitis and Crohn's disease there is not a single clinical, radiological, endoscopic or other sign that is clearly pathognomonic for any of these diseases. In CD, any parts of the gastrointestinal tract can be affected, and the lesions are progressive. At the time of diagnosis, complications (strictures, fistulas) are found in only 10-20% of patients, while within 10 years such complications develop in more than 90% of patients. Within 10 years, surgery due to complications and/or failure of conservative therapy is performed in half of patients with CD, and 35-60% develop disease relapse within 10 years after surgery [8].

Due to the progressive nature of the disease, patients with CD are prescribed lifelong therapy and regular monitoring of disease activity is carried out, including not only instrumental research methods, but also laboratory analysis of inflammatory markers.

The clinical cases described in the article demonstrate various variants of the course of Crohn's disease, certain difficulties at the diagnostic stage, the need to evaluate the effectiveness of therapy and make timely decisions to intensify treatment in each specific case.

Conclusion. The complexity of the differential diagnosis of inflammatory bowel diseases, despite the use of additional research methods, is determined by a certain commonality of clinical manifestations. The choice of the correct treatment tactics at any stage of the disease course should be considered as an essential component of successful patient management.

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