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CLINICAL AND ANAMNESTIC FEATURES OF THE COURSE OF SEVERE PNEUMONIA IN EARLY AGE CHILDREN WITH CONGENITAL ANOMALIES OF CLEFT LIP AND PALATE

Akmalova Nasiba Alisherovna

Tashkent Pediatric Medical Institute

Scientific supervisor: Associate Professor of Medical Sciences ***Aliyev A.L.***

Annotation: *In this study, clinical and anamnestic features of the course of severe pneumonia in early age children with congenital anomalies of the cleft lip and palate were observed with analysing of life history and current condition of the children. Research methods are analysis, clinical observations, x-ray studies. Clinical and anamnestic features of the course of severe pneumonia in early age children with congenital anomalies of the cleft lip and palate were determined. It was revealed that the severity of the condition of examined children was due to a burdened maternal history, premorbid background, artificial feeding and prematurity factor itself and such conditions of the microflora of the gastrointestinal tract.*

Key words: *pneumonia, congenital anomalies of cleft lip and palate, young children, clinic, X- ray studies.*

Relevance: Acute pneumonia in young children remains a significant cause of morbidity and mortality, despite the introduction of potent broad-spectrum antimicrobial agents, comprehensive supportive treatment regimens, and preventive measures (4). An unfavorable background for pneumonic dysbiosis is a cause of recurrent pneumonia in children, prolonged disease duration, and a tendency toward exacerbations, relapses, and complications (2).

Patients with congenital anomalies of the maxillofacial tissues and organs occupy a special place. Of particular interest is the assessment of the clinical course of acute pneumonia in these premature infants. However, despite this, there are few studies or literature data with theoretical or practical significance regarding the treatment of this group of patients. Treatment is associated with particular difficulties

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and requires the involvement of highly qualified specialists, consistency, and a comprehensive approach.

Since ancient times, external factors have been thought to play a certain role in the origin of congenital anomalies such as cleft lip and palate (CLP), as well as maternal illnesses during pregnancy (infectious diseases, uterine pathology, spontaneous or induced miscarriages), psychological trauma, malnutrition, and other factors (1).

CLP represents a severe developmental defect that leads to serious consequences. From birth, there are pronounced dysfunctions of the lip and palate. Sucking and swallowing are impaired, and later on, chewing functions are also affected, which in turn leads to developmental delays in the child and, in some cases, death within the first weeks of life. In CLP, nutrition, swallowing, and breathing are severely disrupted. This can lead to aspiration of oral cavity contents and various complications involving the respiratory tract and lungs (1;3).

The above facts highlight the need to study the clinical and anamnestic features of acute pneumonia in the context of CLP in young children.

Research Objective: To analyze the clinical and anamnestic features of the course of acute pneumonia in young children with congenital cleft lip and palate anomalies.

Materials and Methods: A total of 45 archived medical records of children with severe acute pneumonia and congenital cleft lip and palate anomalies (CLP) were analyzed, along with 18 premature infants weighing between 1500g and 1800g and aged from 3 to 11 days.

Results and Discussion: The age of the mothers ranged from 19 to 49 years: 5% were under 20, 23% were 20–25 years old, 51% were 26–30, and 17% were 30–35. About 28% of the children were born from a first pregnancy. The outcome of previous pregnancies was unfavorable (miscarriage, stillbirth, or premature birth) in 3% of cases. Fetal protein-energy deficiency was noted in 17%. Gynecological diseases were present in 11% of the mothers.

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Chronic infections and conditions such as pyelonephritis, glomerulonephritis, rheumatism, diabetes mellitus, obesity, and acute/chronic bronchitis were observed in 24.6% of women. Acute respiratory viral infections (ARVI) with high fever in the first half of pregnancy were reported by 16.2% of women, and 6% in the second half. The pregnancies were often complicated: early toxicosis occurred in 32.6% of cases; gestosis of varying severity in 27%; the threat of miscarriage in 18%; chronic intrauterine hypoxia in 8%; and infectious diseases in 20%. Labor was timely in 67.1% and premature or delayed in 33%. The most frequent complications were premature rupture of membranes (12%) and anhydrous intervals of 6 to 12 hours (11%). Abnormal labor activity was observed in 4% of women, requiring labor stimulation in 2% of cases. At birth, 7% of newborns had an Apgar score of 7–8, 25% had 4–5, and 5% had 3–4 points.

The study of the clinical course showed that the majority of children (12) had a normal body temperature throughout the illness, 4 had subfebrile temperatures, and only 4 cases were accompanied by high fever (up to 39°C). All premature infants with CLP showed clinical signs of pneumonia accompanied by respiratory distress syndrome, cyanosis (2 cases), acrocyanosis (6 cases), weakened breathing in the lungs, and abdominal distention (13 cases) either at admission or within 2–3 days. Intestinal syndrome developed at the onset of the illness or within 2–3 days after admission and remained a leading feature during the entire acute phase. The diagnosis of pneumonia was radiologically confirmed: in 14 children, focal shadows were found on chest X-rays, and in three children, even confluent lesions were observed.

Conclusion: The findings indicate that the severity of the children's condition was due to a complicated maternal history, premorbid background, artificial feeding, and the very fact of prematurity. Children with low birth weight and various forms of immunodeficiency have intestinal flora that becomes pathogenic, triggering inflammatory processes in both the intestines and lungs. The effectiveness of therapy depends on an individualized approach, considering the etiology of the disease, the course and stage of the pathological process, the child’s age, and the severity of extrapulmonary organ involvement.

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