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CLINIC, DIAGNOSIS AND TREATMENT OF DUODENAL ULCER IN CHILDREN

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ANNOTATION

The problem of duodenal ulcer (DU) in children attracts special attention, as it is very common, the clinical features are both bright and asymptomatic with a high probability of developing serious complications (ulcer bleeding, perforation, perforation) In the formation of duodenal ulcer intestines in children play the main role: neuropsychic, endocrine, hereditary-constitutional factors, drug and toxic effects, food allergies, eating disorders and great importance is attached to the infectious agent Helicobacter pylori. In children and adolescents, there is a tendency to an asymptomatic course of the disease, and in connection with this, cases of hospitalization of children with complications such as bleeding, perforation, and pyloric stenosis without any clinical manifestations have become more frequent. Also, a feature of the disease in adolescents is the localization of the ulcer in its upper part (95%) up to 1 cm in size, occasionally there are ulcers of large sizes from 3 to 6 cm. Often the disease occurs with frequent prolonged exacerbations and in a more severe form, which contributes to the development of complications. Conducting active medical examination and rehabilitation of children with this pathology reduces the likelihood of relapses and complications of the disease.

KEY WORDS: ***duodenal ulcer, clinic, patients, diagnosis, treatment.***

Peptic ulcer of the duodenum is a chronic relapsing disease of the duodenum, manifested by a defect in the mucous membrane (ulcers). These disorders occur against the background of destabilization of the nervous and humoral mechanisms in the human body that regulate secretory-reparative processes in the duodenum. Ulcer disease is characterized by periods of exacerbation (spring and autumn) and remission. The result of the healing of ulcers is the formation of a scar.

Currently, the problem of duodenal ulcer (DU) in children attracts special attention, as it has a high prevalence, clinical features, both bright and asymptomatic course with a high probability of developing serious complications (ulcer bleeding, perforation, perforation) [1 ,2,3,5,7,13,15].

The prevalence of duodenal ulcer in adolescent children is 8 times higher than in children under 10 years of age [2,8,10,12,16]. It is important that diseases of the gastroduodenal zone begin at an early age, often recur, affect the quality of life of children and can lead to early disability.

As you know, an important role in the development of duodenal ulcer in children is played by: a violation of the diet, hereditary-constitutional factors, neuropsychic, endocrine, drug and toxic effects, food allergies, and paramount importance in the formation of ulcers is given to the infectious agent Helicobacter pylori (Hp).

The frequency of Helicobacter pylori infection in children of all age groups is 65-70% [3,4,9,11,14]. Currently, Hp is found in 52–55% of children with chronic gastritis and gastroduodenitis, and in erosive and ulcerative processes, their number increases to 82–98% [3,6]. At the same time, the data of recent studies confirm the changed conditions, there is an increase in atrophic, neoplastic processes of the stomach and duodenum associated with Helicobacter pylori and a decrease in the growth of Hp associated duodenal ulcers.

In the structure of peptic ulcer, duodenal ulcer prevails, which is – 81-87%, gastric ulcer is much less common - 11-13%, as well as the combined localization of ulcerative defects in the stomach and duodenum 4-6% [1,3,9].

The peak incidence in girls is 10–12 years old, in boys it is 12–14 years old, boys and girls get sick equally often. A distinctive feature of peptic ulcer is the cyclical nature of its course, with exacerbations in spring and autumn.

Exacerbation of DU can last from weeks to several months, the remission phase is always much

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longer than the period of exacerbation. In some children, the disease occurs with frequent prolonged exacerbations and in a more severe form, which contributes to the development of complications.

In recent years, there has been a tendency for adolescents to have an asymptomatic course of the disease, and in connection with this, cases of hospitalization of children with complications such as bleeding, perforation, and pyloric stenosis without any clinical manifestations have become more frequent. Also, a feature of the disease in adolescents is the localization of the ulcer in its upper part (95%) up to 1 cm in size, occasionally there are large ulcers from 3 to 6 cm.

Of great importance in the diagnosis of duodenal ulcer in children is the totality of clinical examination data, the results of instrumental, morphological and laboratory research methods. Of primary importance is endoscopic examination, which allows you to clarify the localization of the ulcer and determine the stage of the disease.

It is mandatory to determine Helicobacter pylori using a breath test with urea, serological methods. The above aspects in childhood dictate the need for individual complex treatment, including exposure to aggression factors in order to reduce them and a parallel effect on defense mechanisms to restore the mucous membrane of the stomach and duodenum.

Patients during intense pain need bed rest, followed by its expansion. The diet should be mechanically, chemically and thermally gentle on the gastric mucosa. Acute foods are excluded from the diet, salt is limited, the consumption of foods rich in cholesterol. Meals are taken 4-5 times a day.

Assign with diet No. 1a, No. 1b, No. 1 in the acute phase of the disease. After reducing the severity of the disease, the patient can be transferred to diet No. 5. An analysis of current trends in the problem of Helicobacteriosis made it possible to identify the basic principles of anti-Helicobacter therapy in childhood and to form promising eradication treatment regimens [3,4,8]. The only generally accepted goal of eradicating Helicobacter pylori is to prevent recurrence of ulcers. Antibacterial therapy is indicated for all Helicobacter-associated patients with duodenal ulcer at the first clinical manifestations of the disease [2,4].

The modern approach to treatment involves choosing the most effective combination of drugs that has minimal side effects and is convenient for the patient. Currently, one of the most successful, allowing to destroy the pathogen in 90% of cases, is the so-called three-component therapy, which includes proton pump blockers, amoxicillin, clarithromycin or Macmirror. A two-week course of triple therapy in combination with a six-week intake of colloidal bismuth subcitrate accelerates ulcer healing compared with H2-blocker monotherapy and reduces the recurrence rate to 15% or less. After monotherapy with H^2-blockers, relapses occur in 60-100% of patients. At the second stage, when it is possible to achieve control over aggressive factors, the main emphasis in treatment is shifted to the activation of defense factors in order to restore its resistance. The duration of this stage is 14–20 days.

At the last stage, non-drug interventions are preferable: physiotherapy, psychotherapy and restoration of the functional state of the gastrointestinal tract, aimed at local and general regulatory systems of the child's body. Its duration can be 1-3 months. This approach makes it possible to achieve good results in the treatment of DU and will create the preconditions for achieving a long-term and complete remission.

Thus, peptic ulcer of the duodenum in adolescents has its own age characteristics and determines the need for a differentiated approach to the treatment of patients with the obligatory consideration of the infectious factor. When establishing Hp associated peptic ulcer in adolescent children, it is necessary to carry out eradication therapy based on modern principles recommended in pediatrics as part of the complex treatment of such patients. Conducting an active medical examination and rehabilitation of children with this pathology will reduce the likelihood of relapses and complications of duodenal ulcer.

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