ISSN: 2692-5206
AMERICAN ACADEMIC PUBLISHER
INTERNATIONAL JOURNAL OF MEDICAL SCIENCES

SYMPTOMS OF ATYPICAL PNEUMONIA IN CHILDREN

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Abstract: The article is devoted to atypical pneumonias caused by Mycoplasma pneumoniae, their clinical features, diagnostics and treatment. The article presents cases of clinical observation of children with mycoplasma pneumoniae.

Keywords: mycoplasma pneumonia, method, children.

INTRODUCTION

Recent studies indicate an increasing role in the development of bronchopulmonary diseases in children of atypical pneumotropic pathogens, such as Mycoplasma pneumoniae, Chlamydophila pneumoniae, respiratory viruses, etc. The term "atypical pneumonia" (caused by these pathogens) was introduced 20-30 years ago due to their course, which differed from typical pneumonia caused by extracellular agents - streptococci, staphylococci, etc., as well as the difficulty and rarity of their detection in past years. Today the situation has changed. Technical and methodological capabilities for diagnosing these infections have appeared and approaches to the etiotropic treatment of diseases caused by them have been determined.

MATERIALS AND METHODS

According to a number of authors, the share of Mycoplasma pneumoniae in the etiology of lower respiratory tract diseases in children ranges from 20 to 40% [1, 2]. The pathogenesis of mycoplasma pneumonia is characterized by the intracellular location of the pathogen, which requires the use of antibiotics that penetrate into the cell, creating high concentrations of the drug, as well as the use of immunomodulators [4]. Immune disorders predominate in the T-system of immunity: there is a deficiency of T-cells, a decrease in the number of CD3+, CD4+ lymphocytes, which is accompanied by an imbalance of cytokines, IgM hyperglobulinemia [5].

RESULTS AND DISCUSSION

We present clinical cases of our own observations.

Case 1. Child L., 7 years old, was admitted to the pediatric infectious diseases department on 09.09.23 with complaints of cough, fever up to febrile numbers, sore throat, single vomiting when coughing, general weakness.

From the medical history: has been sick since 06.09.23, when a sore throat appeared, the temperature rose to subfebrile numbers. The next day, a dry cough joined in, on 08.09.23, a rise in temperature to 39.5 ° C was noted. The local pediatrician

09.09.23 prescribed cefodox, prospan. By the evening

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AMERICAN ACADEMIC PUBLISHER
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09.09.23, the condition worsened: the cough intensified, became obsessive, vomiting appeared at the height of the cough, the temperature rose to 40 ° C. The child was delivered by an ambulance team to the infectious diseases department.

From the anamnesis of life: the child is from the 1st, normally proceeding pregnancy. The first delivery, term, birth weight 2700 g. The child was breastfed for up to 8 months. In the 1st year of life, she did not gain weight well. She was registered with a congenital heart defect, an open oval window. Vaccinated according to the calendar. She had acute respiratory viral infection, acute bilateral purulent otitis, chickenpox, often suffers from tonsillitis. In 2022, she was diagnosed with mitral valve prolapse. Allergic reaction to augmentin. The child's mother has hay fever.

On admission (09.09.23) the general condition is moderate, subfebrile fever, temperature (T) is 37.5 °C, heart rate (HR) is 120 per 1 minute, respiratory rate (RR) is 26 per 1 minute. The response to examination is adequate. The patient is concerned about a dry, obsessive cough, which intensifies in the supine position, as well as with deep breathing. Nasal breathing is moderately difficult, there is no discharge from the nasal passages. Moderate intoxication syndrome, respiratory failure of the first degree (RF I). Correct build, adequate nutrition. The skin is clean, pale. The mucous membrane of the palatine arches is moderately hyperemic, diffuse hyperemia and granularity of the posterior pharyngeal wall. The tongue is moist, coated with a white coating. Peripheral lymph nodes are small and mobile. The boundaries of the lungs and heart correspond to the age norm. Percussion of the chest reveals a box percussion sound. Auscultation reveals harsh breathing in the lungs, isolated dry wheezing rales, moist coarse bubbling rales on both sides. Heart sounds are sonorous, rhythmic, rapid, systolic noise at points I and V. The abdomen is soft and painless on palpation. The liver protrudes 3 cm below the edge of the costal arch, the spleen - 2 cm. Stool and urination are not impaired.

An X-ray examination of the lungs was performed (10.09.23): the pulmonary pattern on both sides is enhanced, enriched and deformed in the root zones, unclear, looped, against the background of moderately reduced pneumatization. The roots are poorly structured, the sinuses are free. The heart is without pathological changes (Fig. 1).

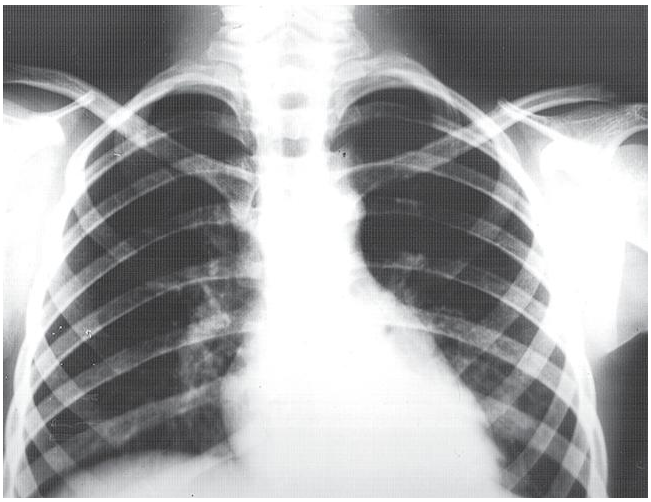

Figure 1. X-ray of child L. from 09/10/23

ISSN: 2692-5206
AMERICAN ACADEMIC PUBLISHER
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Blood analysis from 09/10/23 revealed leukocytosis (12.4 × 109/l), band shift of the leukocyte formula to the left (19%), increased ESR (38 mm/h): erythrocytes - 4.35 × 1012/l, hemoglobin - 124 g/l, hematocrit - 38.5%, leukocytes - 12.4 × 109/l, band - 19%, segmented - 32%, lymphocytes - 27%, monocytes - 22%, platelets - 307 × 109/l, ESR - 38 mm/h. Blood biochemistry test from 09/13/13: total bilirubin - 14.4 µmol/l, indirect - 13.4 µmol/l, direct - 1.0 µmol/l, AST - 47.5 U/l (normal < 36.0 U/l), ALT - 57.8 U/l (normal < 29.0 U/l), glucose - 5.26 mmol/l, Ca2+ - 2.07 mmol/l.

CONCLUSION

Oropharyngeal scraping from 10/15/23: Mycoplasma pneumoniae DNA — 3.3 U/ml (normal 0–2.5 U/ml). Control from 12/19/13: Mycoplasma pneumoniae DNA — 1.3 U/ml. Blood test from 12/19/13: IgM to Mycoplasma pneumoniae — 2.45 U/ml (normal < 0.95 U/ml), IgG to Mycoplasma pneumoniae — 1.44 U/ml (normal < 0.95 U/ml). Control chest radiography from 12/04/13: positive dynamics. The pulmonary pattern is enhanced due to the linear-cellular component. The sinuses are free.

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