

THE ORIGIN, CLINICAL COURSE AND SPECIFICITY OF TREATMENT OF ACUTE MIDDLE OTITIS

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Abstract:

In the treatment of patients with acute purulent otitis media, at present, three main directions can be distinguished: conservative with the help of various drugs; surgical, including micro-surgical interventions; physiotherapeutic.

In recent years, many complex treatments for acute purulent otitis have been developed. However, this problem has led otorhinolaryngologists to the need to revise traditional conservative methods due to their inefficiency and search for new treatments. One of these methods is to apply different types of physical energy: magnetic, laser, electromagnetic, etc. among them, the most effective is laser therapy (LT), which is widely used in inflammatory diseases of the QTB organs.

The appointment of rational antibiotic therapy (rabt) is a very urgent problem, the solution of which depends on a number of factors of undoubted interest for practice.

Keywords: low intensity laser radiation, acute purulent otitis media, acute otitis media, ear, throat, nasal organs, antibiotic therapy.

Introduction

In recent years, many complex treatments have been developed for Oyo [9]. However, this problem has led otorhinolaryngologists to the need to revise traditional conservative methods due to their low effectiveness and search for new treatments.

Oyo treatment optimization is still one of the main tasks of Otorhinolaryngology today. Improving the methods of their treatment remains one of the pressing problems of Otorhinolaryngology to this day, which is not always associated with a significant prevalence of otitis and satisfactory treatment results [5,8].

In recent years, the number of antibiotic-resistant strains of microorganisms has been increasing due to the prevalence and often unjustified prescribing of antibacterial drugs, which in turn leads to an increase in the percentage of otitis chronication, the appearance of various complications [4,6,7]. Thus, the question of the adequacy of antibiotic therapy is very relevant.

The choice of antibacterial agents in the treatment of inflammatory diseases of the middle ear is an important task for an otorhinolaryngologist. The need to take into account social and economic factors, the results of Bacteriological Analysis emanating from the middle ear, the severity of the disease, the presence of complications makes this task very responsible for the practical doctor [5,6,7].

For ŌYO, the question of the appropriateness of the use of systematic Abt remains controversial. In most patients, the symptoms of the disease go away on their own within 24-72 hours without treatment, and effusion in the tympanic cavity is resolved within 2 weeks. However, most otiatrs recommend the use of antibiotics because the risk of developing intracranial complications cannot be compared to the risk associated with the systematic use of antibacterial drugs [9].

The most optimal thing when prescribing ABT is the study of ear detachment with determination of sensitivity to plants and antibiotics [1,2,5]. However, it is not always possible to carry out such a study, in addition, antibiotic therapy is sometimes required immediately.

Bacteriological Analysis of purulent discharge from the ear in patients with inflammation of the middle ear revealed the 3 most common pathogens: *S. pneumonia*, *H influenzae* (B-lactam-producing strains isolated in more than 35% of cases), *M. Catarrhalis* (B-lactam-producing strains isolated in more than 85% of cases) [69,74,88]. OGSO can also cause other bacterial and viral pathogens, the relative frequency of which varies depending on the age of the patients and the epidemiological situation [3,4,9]. The importance of intracellular pathogens is also being studied [8,9].

All other bacteria associated with OGSO account for more than 10% of cases: here is the grampositive *S. Pyogenes* and *S. Aureus* is dominant, the presence of bacterial associations is very rare (including in the presence of anaerobic bacteria); only neonates with OGSO Enterobacteriaceae spp. and a little less-*S. Aureus* [1,5]. *S. In* addition to pyogenes, all types of these bacteria have the ability to resist certain antibacterial drugs. Thus, planning for initial empirical antibiotic therapy requires consideration of this condition.

Due to the fact that the blood vessels of the middle ear form contact with blood vessels of the intracranial cavity, and in young children the thoracic-to-body bone slit is open, they develop signs of irritation of the cranial membranes, i.e. signs of meningism (vomiting, dizziness, pulling the ensa muscle, throwing the head back and crying, increased limb muscle tone, seizures). Such signs are caused by exposure of the cranial membranes from bacterial toxins. Signs of meningism soon disappear after the mucous membrane is pierced and the middle ear cavities empty from the purulent separation.

Young children with acute middle otitis sometimes experience gastrointestinal dysfunction, i.e. symptoms of acute diarrhoea (vomiting, diarrhea).

The diagnosis is made on the basis of patient complaints, onset of the disease, clinical signs, otoscopy landscape, radiography, computed tomography, tympanopunction, anthropunction, parasentesis, bacteriological and other laboratory tests. The correct

assessment of the otoscopy scene in young children is important for timely detection of the disease. In young children, the fact that The Shape of the external auditory canal is slit-like, in which there is a set of displaced epidermis, the almost horizontal location of the mucous membrane makes otoscopy examination much more difficult. In addition in young children, the mucous membrane is relatively thick, which is easily reddened when cleaning the ear or when the child cries. [7]. In the picture of otoscopy in crying young children, it is necessary to observe the patient for several times to distinguish the redness of the mucous membrane from bright hyperemia in acute middle otitis. If the color of the hyacinth is slightly pale during the time when the crying child calms down and breathes freely, then it can be considered that there is no inflammation in the middle ear.

Diffuse redness of the mucous membrane, infiltration, inaccuracy of the points of knowledge indicate acute inflammation of the middle ear. Emergency tympanopunction or paracentesis surgery is performed when other clinical signs of acute purulent middle otitis are detected in the child. In some cases, the mucous membrane is covered with a dull, gray or yellowish displaced epidermis, in other cases it becomes thinner and a pale stain-like pus appears through the front parts, while the presence of infiltration and bulging in one of the four parts is also a characteristic sign of this cassock. [2,4,6].

Even in young children, acute purulent middle otitis occurs in three stages. But due to the fact that in young children the hymen is thick, the mucous membrane of the thoracic cavity has the ability to quickly absorb the detachment into it, and the separation of the middle ear is easily removed through a wide and short auditory tube, the hymen is often not pierced in them, and the process in most cases ends with healing.

The purpose of the examination. The occurrence of acute middle otitis among diseases of the ENT organs of the catarrhal and purulent form, increase the clinical course and effectiveness of treatment.

Research materials and methods. The tests will be carried out in 2021-2024 among patients treated in the Department of Otorhinolaryngology of the adti clinic and in the LOR Department of the multidisciplinary Central Hospital of the Andijan region.

- Anamnesis data

- General clinical planks (general blood planks, general urine planks, mining biochemical planks, ECG)

- Endoscopy and otoscopy

- MSGT, MRT, CT

Data on the transferred tasricks hack.

Research results. In the control group, 12.7 ± 3.1 (42.3%) patients experienced "pronounced" swelling and hyperemia of the eardrum during hospitalization. On the 5th day of treatment, there was a significant decrease -6.3 ± 2.2 patients, which is 50.5%

less than the initial data. A downward trend continued in the following days. If "moderate" swelling and hyperemia of the tympanic membrane was reported in 3.5 ± 2.1 patients on Day 5 of treatment, then before emptying it would not exceed 1.8 ± 1.0 patients, which is 66.7% and 82.8%, respectively. when accepted ($p < 0.05$). Patients in the control group had very little "absence" of swelling and hyperemia of the tympanic membrane when hospitalized - 1.8 ± 1.2 patients. On the 2nd day of treatment, this figure increased slightly-by 11.0%. In the following days, this rate increased significantly by 21.0% on the 3rd day of treatment to 8.1 ± 1.9 patients. ($p < 0.05$). Before release, this difference was 87.5% - 28.1 ± 2.9 patients.

As a result of conventional therapy, "severe" headaches decreased by 42.4% on Day 4 compared to initial data, and on Day 5 of treatment they decreased by 4.2 ± 1.9 patients, 70.1% less than taken ($p > 0.05$). When taken, the "average" incidence of this indicator was reported in 10.6 ± 2.8 (35.3%) patients. On the 5th day of treatment, a significant decrease in this indicator was observed- 2.1 ± 1.7 patients, which is 80.2% less than the initial data ($p > 0.05$). When taken, 3.1 ± 1.2 (10.3%) patients in the control group had "no" headache. A significant increase in this rate was observed in 10.5 ± 1.1 (24.7%) patients on Day 3 of treatment, and before discharge, the rate was 81.0%- 27.4 ± 2.4 patients.

Most of the patients were bedridden with fever. 11.3 ± 2.8 (37.6%) patients showed a "clear" manifestation of this sign, while 9.7 ± 2.7 (32.3%) patients showed this symptom "moderately".

The rate of this indicator decreased to 3.1 ± 1.7 and 3.2 ± 1.7 patients on Day 4 of conventional treatment, respectively 72.5% and 67.0%, from preliminary data ($p < 0.05$) and as of Day 5. treatment this difference was 90.2% and 87.6% respectively ($p < 0.05$). After admission, 24.0% of patients have a "mild" increase in body temperature. A significant improvement in this indicator was noted on the 5th day of treatment-in 1.2 ± 0.5 patients. 2.2 ± 1.2 (7.3%) patients in the control group were observed to have a "lack" of this indicator when taken. A significant increase in this rate was observed in 9.8 ± 1.9 (25.3%) patients on Day 3 of treatment ($p > 0.05$).

In the control group, there was a "severe" weakness when 56.0% of patients were hospitalized. On the 5th day of treatment, there was a significant decrease- 3.8 ± 1.2 patients, which is 77.3% less than the initial data. When taken, "moderate" manifestations of this indicator were reported in 10.1 ± 2.7 (33.6%) patients. On the 5th day of treatment, there was a significant decrease in this indicator- 2.3 ± 1.2 patients, which is 77.2% less than the initial data ($p > 0.05$). Patients in the control group had a very low "absence" of weakness when hospitalized- 1.3 ± 0.6 patients. On the 2nd day of treatment, this figure increased by 9.7%. The next day, the rate increased significantly by 19.3% to 7.1 ± 1.4 patients. Before release, this difference was 89.3% - 28.1 ± 1.1 patients. ($p < 0.05$).

Of great interest are the dynamics of the assessment of the therapeutic effect of treatment for Oyo by the patients themselves. For this purpose, we conducted daily

surveys using a questionnaire. According to the patients themselves, the final results were found to be "inconsistent", "satisfactory", "good" and "excellent" according to the sum of the scores.

The dynamics of treatment outcomes in control group patients showed that 22.8 ± 2.5 - 76.0% of patients reported an "unsatisfactory" condition, and 5.8 ± 1.6 - 19.3% reported a "satisfactory" condition. Significant improvements in these rates were observed on the 4th to 5th day of treatment- 9.8 ± 1.4 and 1.7 ± 1.1 patients, respectively 57.0% and 70.6% ($p < 0.05$), with less source data. After admission, 10.6% of patients in the control group felt in "good" condition. In 1.3 ± 1.0 (2 times) patients, a significant increase in this indicator was observed on the 3rd day of treatment. Not all patients in the control group reported an "excellent" condition after hospitalization. A reliable "excellent" condition in the control group was observed on the 3rd day of treatment in 28.6% of patients.

The next day, the rate increased to 2.2 times and was 13.5 ± 2.1 patients, and 92.0% - 27.6 ± 2.8 patients reported "excellent" before discharge.

Of great interest are the dynamics of clinical manifestations of symptoms in Oyo. When taken, mucous-purulent and/or purulent discharge from the ear was observed in 22.6 ± 4.3 (53.8%) patients in the main group, and 13.4 ± 3.3 (32.0%) patients showed a "moderate" appearance of the sign. Pain in the affected ear area has been reported in almost all patients in different severity. Many of the patients were laid with complaints of hearing loss. 19.2 ± 2.9 (45.7%) patients showed a "clear" manifestation of the sign, while 15.8 ± 2.7 (37.6%) patients showed the sign "moderately". "Severe" headaches and mastoid pain during palpation were reported in 39.0% and 41.6% of the main group of patients, respectively. When taken, "severe" swelling and hyperemia of the tympanic membrane was observed in 16.2 ± 3.2 (38.7%) patients and "moderate" manifestation of this sign in 14.1 ± 2.7 (33.5%) patients. In almost half of patients in the main group of different severity, an increase in body temperature and weakness were noted.

The dynamics of the results of complex treatment in patients with OYO in the main group showed that 22.6 ± 4.3 (53.8%) patients reported "severe" mucous-purulent and / or purulent discharge from the ear and "moderate" manifestations. this symptom is 13.4 ± 3.3 (32.0%).

Conclusions

The use of laser therapy and the drug cefuroxime aksetil for inflammatory syndrome against the background of Oyo is pathogenetically justified, since it leads to the rapid elimination of the clinical picture of the disease, has a positive effect on the course of the disease and contributes to exacerbation. reducing the effectiveness of drug therapy and the time of treatment.

Laser therapy using the preparations cefuroxime acetyl and sinupret is a minimally invasive, inexpensive and effective method of therapy in the complex of therapeutic measures and can be used in all otorhinolaryngological hospitals.

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