

Conclusion. Thus, we have studied and analyzed the current standards of medical care for patients with schizophrenia, according to which treatment is performed according to the individual development of the disease.

PHARMACOTHERAPY OF THE COMMUNITY-ACQUIRED PNEUMONIA

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Introduction. Despite of success achieved by mankind in diagnostic and treatment of community-acquired pneumonia (CAP), this infectious disease keeps on being a life-threatening condition. Therapy lines often change due to different reasons: creation and emergence of new antibiotics more effective than existing drugs, increasing of pathogen resistance and others. Different countries sometimes offer identical therapy regimens for treatment of CAP but sometimes they are critically different. That encourages healthcare providers to constantly monitor new protocols of medical help and proposed combination of antibiotics.

Aim. To review medical care protocols with recommendations from Nice GuideLine, Merck Manual, American Thoracic Society and to compare them with Ukrainian adapted clinical guidance (last version, 2019).

Materials and methods. Theoretical methods were used (searching, collecting, comparing, analyzing and processing of information) in creation of the work. The exploration was hold by the analysis of the literature sources - European guidelines, treatment protocols of for the treatment of community-acquired pneumonia.

Results and discussion. Almost all of the guidelines divide lines of therapy for four different groups of patients: group of low severity without modification factors, group of low severity with modification factors, group of moderate severity and group of high severity. First two groups can be treated in the outpatient setting, other two groups are only for the inpatient treatment or even intensive care unit. Thus, the severity of the patient`s condition determines the location of treatment. It is often impossible to determine the main pathogen immediately, so people with CAP receive empirical antibiotic therapy to the moment of obtaining the results of presence bacterial culture in patient`s expectoration.

Group of low severity without modification factors is treated with aminopenicillin as first-choice drug, macrolide or tetracycline as alternative drug, or fluoroquinolone as second-line drug. Oral monotherapy is recommended.

Group of low severity with modification factors is treated by protected aminopenicillin as first-choice drug, fluoroquinolone or cephalosporin of the third generation as alternative one. Fluoroquinolones are also used in second-line treatment. Foreign protocols recommend combining protected aminopenicillin with macrolide or tetracycline, another combinations – cephalosporin of the second or the third generation with macrolide or with tetracycline. Oral use is preferred both for monotherapy and for combinations.

Group of moderate severity has combination of macrolide with protected aminopenicillin or with cephalosporine of the third generation as the first-choice therapy. Second-line treatment includes parenteral monotherapy with fluoroquinolone, or macrolide and carbapenem combination, or macrolide and cephalosporin of fifth generation combination. Macrolides must be applied only orally, other antibiotic in the combination is for the parenteral use. Therapy by the foreign protocols is identical, but they also offer a combination of the beta-lactam (penicillin or cephalosporin of the third and the fifth generations) with tetracycline.

Group of high severity without risk of *Pseudomonas aeruginosa* infection is treated by combination of the beta-lactam (protected penicillin, cephalosporin or carbapenem) and macrolide as the first-line therapy with parenteral form for both drugs. In alternative therapy line macrolide is replaced with fluoroquinolone.

In case of having the probability of infection with *Pseudomonas aeruginosa* it is recommended to choose combination of anti-pseudomonas cephalosporin with aminoglycoside or fluoroquinolone. The alternative treatment line includes carbapenem with aminoglycoside or fluoroquinolone. Also empirical therapy is applied using Piperacillin-tazobactam, Aztreonam, Ceftazidime, Cefepim, Meropenem or Imipenem in parenteral forms.

Patients with high severity and risk of having methicillin resistant staphylococcus aureus (MRSA) as pathogen are treated with Vancomycine and Linezolid in the form of parenteral use.

Therapy duration for the first and the second group ranges from five to seven days in average case, shorter therapy is permissible while treating the first group with Azithromycin. Patients from the third and the fourth groups should be treated from seven to ten days. Also, therapy must last from ten to fourteen days if mycoplasmal or chlamydial infections have been found.

Conclusions. Choosing drugs for the start of the empirical antibiotic therapy must be based on the patient's condition, local data about the pathogen resistance, pharmacokinetics and pharmacodynamics of the chosen antibiotic. All the prescribed schemes of the treatment must be strictly conformed to the protocol requirements. Correctly selected empirical therapy can significantly reduce the risks of complications from CAP and improve the patient's condition in short terms. Information about the newest antibiotics and recommendations for their use from not only national but also foreign sources will help healthcare specialists to provide first-class help to the population.

MODERN PHARMACOTHERAPY OF CUSHING'S DISEASE

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Cushing's disease is one cause of Cushing's syndrome characterised by increased secretion of adrenocorticotrophic hormone (ACTH) from the anterior pituitary (secondary hypercortisolism).

Cushing disease is caused by a tumor or excess growth (hyperplasia) of the pituitary gland. The pituitary gland is located just below the base of the brain. A type of pituitary tumor called an adenoma is the most common cause. An adenoma is a benign tumor (not a cancer).

With Cushing disease, the pituitary gland releases too much ACTH. ACTH stimulates production and release of cortisol, a stress hormone. Too much ACTH causes the adrenal glands to make too much cortisol.

Pituitary adenomas are responsible for 80% of endogenous Cushing's syndrome, when excluding Cushing's syndrome from exogenously administered corticosteroids.

Symptoms of Cushing disease include:

1. Upper body obesity (above the waist) and thin arms and legs;
2. Round, red, full face (moon face);
3. Slow growth rate in children.

Treatment for Cushing's Syndrome is designed to reduce the high levels of cortisol in your body. Treatment options include:

1. If the cause is prolonged use of corticosteroid drugs, then the doctor should reduce the dosage of the drug over a period of time, while still managing asthma, arthritis or any other condition.
2. If the cause of Cushing's syndrome is a tumor, the doctor may recommend complete surgical removal.