

school age, the percentage of young people aged 17 to 30 among patients with acute tonsillitis is up to 70%. It is believed that viral forms of acute tonsillitis predominate in children under 3 years (70-90%), after 5 years, bacterial forms become more frequent (up to 30-50%). The main causative agent of tonsillitis is beta-hemolytic streptococci group A.

About pathogenesis. When an inflammatory process occurs in the tonsils, toxins, and products of the inflammatory reaction are absorbed into the bloodstream, which in turn causes fever and intoxication of the whole body, possibly affecting the heart, joints, and kidneys.

The incubation period, as a rule, does not exceed 1-2 days. The onset of the disease is acute, accompanied by an increase in body temperature to febrile or high numbers, headache, aches in the muscles of the arms and legs, general weakness. Against this background, there is a sore throat and a feeling of discomfort when swallowing.

Diagnostics include an examination of tonsils, a general blood test with formula, blood sugar, general urine test, bacterioscopy, and bacteriological culture of smears from inflammatory foci to determine the pathogen and sensitivity to antibiotics.

Pharmacotherapy includes general and local treatment. General treatment includes etiotropic antibacterial therapy. The following groups of drugs are recommended: inhibitor-protected penicillins: penicillin antibiotics: amoxicillin 500 mg every 12 hours for 10-14 days; amoxicillin clavulanate 625 mg orally with an interval of 8-12 hours. In the presence of contraindications to the use of penicillins, the recommended II generation cephalosporins: cefuroxime axetil 0.5 g orally after meals with an interval of 12 hours; cefaclor 0.5 g orally every 8 hours; cefprozil 500 mg once a day for 10 days; III generation cephalosporins – cefixime 400 mg once a day and cefdinir 600 mg once a day for 10 days. Reserve drugs in the treatment of acute tonsillitis in case of intolerance to β -lactam antibiotics or their ineffectiveness are macrolides: azithromycin – 0.5 g orally with an interval of 24 hours; clarithromycin – 0.25-0.5 g orally with an interval of 12 hours for 10 days. Locally appoint for the throat with disinfecting warm solutions: furacilin, ethacridine lactate, infusions of sage, chamomile. Symptomatic pharmacotherapy to lower the temperature: antipyretic drugs – acetaminophen 500 mg 3-4 times a day, ibuprofen – 200-400 mg every 6 hours. For prevention: shows active dispensary observation within a month after the disease; hardening of the body (sports and physical education, the correct mode of work and rest), the elimination of foci of infection contributes to the prevention of tonsillitis.

Conclusions. The core of the tonsils is a storehouse for many bacteria. of different genera were recorded in our study. Children and people under 30 have there is a high probability of infection for many reasons. We always need future research in the war of resistance to antibiotics used in human treatment.

PHARMACOTHERAPY OF ALLERGIC RHINITIS

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Introduction. Allergic rhinitis is intermittent or persistent inflammation of the nasal mucous membrane and nasal sinuses due to allergens action. Atopic IgE-mediated allergic rhinitis affects approximately 25–30% of the adult population in Western Europe. Besides, approximately 10% of adults have chronic non-allergic rhinitis caused by hypersensitivity.

Aim. Get acquainted with modern protocols of allergic rhinitis treatment.

Materials and methods. Modern protocols of Ukraine have been considered and compared with foreign ones, which were published in the Medscape database.

Results and discussion. The goal of pharmacotherapy is to eliminate acute symptoms and prevent the disease relapse in future. Treatment of allergic rhinitis takes place in 2 stages. The therapy at the first stage is completely directed to acute symptoms of the disease eliminating. For this purpose, the effect of pathogenic allergens is eliminated and antihistamines and sorbents are prescribed. In turn, antihistamines effectively eliminate such symptoms such as sneezing, runny nose, itching and tearing. Such preparations are widely used in combination with decongestants that eliminate nasal congestion. Doctors often prescribe eye drops to relieve redness, itching and tearing. The second stage of allergic rhinitis treatment is aimed at disease relapse preventing in future and increase the body's resistance. For this purpose, corticosteroid preparations are used together with antihistamines. They help to eliminate the symptoms of allergic rhinitis, because they are the most effective remedies for most people. Also intranasal anticholinergic remedies (that reduce rhinorrhoea), mast cell stabilizers (which inhibit mast cell degranulation and affect the granulocyte chemotaxis), leukotriene receptor antagonists (alternative to oral antihistamines), anticongestant remedies and decongestants that stimulate vasoconstriction by direct activation of α -adrenergic receptors of the respiratory mucous membrane, are used. One of a few methods of allergy treatment that allows to ensure a stable health condition for many years is allergy-specific immunotherapy. This method prevents the symptoms appearance and "switches" the mechanisms of the human immune system.

Conclusions. The patients' proper treatment with allergic rhinitis provides complete control of the disease.

MODERN PHARMACOTHERAPY OF ANAPHYLAXIS

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Introduction. Anaphylaxis (anaphylactic shock) is a systemic generalized immediate-type response to allergen re-administration due to massive IgE-mediated mediator release. Every year the number of anaphylactic reactions increases, especially to drugs, which can reach 0.5-1.6% of patients.

Aim. Analysis and research of ukrainian and foreign recommendations regarding complex pharmacotherapy of anaphylactic shock.

Materials and methods. We have compared ukrainian Unified clinical protocol for primary, emergency, secondary (specialized) and tertiary (highly specialized) care: medical care "Drug allergy, including anaphylaxis" with similar recommendations from NICE, SIGN.

Results and discussion. To provide emergency medical care, epinephrine should be administered intramuscularly in the middle of the outer thigh at a dose of 0.01 ml / kg body weight to a maximum total dose of 0.5 ml. When using an autoinjector with epinephrine, patients weighing 7.5 kg to 25 kg should receive 0.15 mg; 25-30 kg – 0.3 mg. The dose can be repeated after at least a 5-minute interval. After administration of epinephrine it is necessary to stop action of the trigger of anaphylactic reaction. Next, a patient with anaphylaxis should be placed on his back with his lower limbs raised if he has circulatory instability, transferred to a sitting position if he has respiratory failure, or to a rescue position on his side if the patient has lost consciousness. It is then necessary to