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ANALYSIS OF CLINICAL CHANGES IN CHILDREN WITH ACUTE RESPIRATORY VIRAL INFECTIONS AND TORCH-INFECTION

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Cytomegalovirus infection (CMVI), cytomegaly - an infectious disease caused by the herpesvirus cytomegalovirus type 5, characterized by polymorphic clinical signs and a specific morphological picture. CMV is the most common causative agent of congenital infection.[2]
Cytomegalovirus infection is widespread throughout the world. In the world, from 20 to 60% of children and from 40 to 95% of adults (according to different epidemic data in different regions) are infected with CMV. The frequency of detection of antibodies to CMV among pregnant women, according to various studies, is from 40 to 90% [1,3].

Objective: To develop criteria for diagnosing the risk of acute respiratory viral infections and TORCH infection in patients with clinical and laboratory changes.

Materials and methods. This study was a single-center retrospective cohort study, selected from all patients with confirmed acute respiratory infections and TORCH infection admitted to the regional infectious diseases hospital in Bukhara in 2023-2024. Clinical data were obtained from electronic medical records, including demographic data, exposure history, signs and symptoms, and laboratory data at admission.

Results of the study. 300 patients with ARI and TORCh infection were analyzed, of which 115 children were prospectively analyzed, and all of them formed the main group of our study. . 41 (35.7%) of our main group were children living in urban areas, and 74 (64.3%) were children living in rural areas. When analyzing the gender of the patients in the main group of our study, 53 were girls, and 62 were boys. When

analyzing the age classification of people in the study group, 57 children under 2 years old were analyzed, 39 children aged 3-7 years old were analyzed, 10 children aged 8-12 years old were analyzed, and 9 were 13 years old and older.The frequency of incorrect initial diagnoses, equal to 81.6%, recommends testing patients with fever for CMV infection, and patients with prolonged subfebrile temperature in the presence of hepatosplenomegaly, relative lymphocytosis, enzyme induction ALT, AST, LDH, GGT and ALP.

The following studies are necessary to determine the diagnosis and course of CMV infection with a high probability of resolution: determination of CMV-IgM and CMV-IgG, determination of CMV-IgG avidity in dynamics by enzyme immunoassay, as well as cytomegalovirus DNA in blood and urine. The primary form is diagnosed based on the detection of CMV-IgM negative CMV-IgG and subsequent seroconversion, or the presence of CMV-IgG with an avidity of less than 50%. Reactivation of cytomegalovirus infection is diagnosed based on the detection of CMV-IgG with a low avidity of 50% or CMV-IgM. The detection of CMV DNA in the blood in combination with the detection of CMV-IgM is of diagnostic value for determining the severity of the infectious process.

For primary acute diagnosis and differential diagnosis, CMV infections can be classified according to the frequency of occurrence of clinical symptoms in decreasing order: 1) increased body temperature (99.0%); 2) general weakness (98.1%); 3) splenomegaly (83.3%); 4) hepatomegaly (76.7%); 5) febrile condition (74.8%); 6) acute onset (69.9%); 7) oropharyngeal hyperemia (37.9%); 8) headache (35.0%); 9) body aches (31.1%); 10) cough (28.2%); and in reactivated patients, respectively: 1) general weakness (100.0%); 2) increased body temperature (83.3%); 3) splenomegaly (70.6%); 4) hepatomegaly (52.9%); 5) fever (50.0%); 6) acute onset (45.8%); 7) headache (41.7%); 8) enlarged lymph nodes (33.3%); 9) sweating (29.2%); 10) body aches (25.0%).