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ADDITIONAL MODERN DIAGNOSTIC TESTS FOR CHRONIC PANCREATITIS

Umarova T. A.

assistant of the department of clinical laboratory
diagnosis with the course of clinical laboratory diagnostics of PGD;

Kudratova Z. E.

PhD, Ass. Professor of the department of clinical laboratory
diagnosis with the course of clinical laboratory diagnostics of PGD;

Toshpulatova M.

Cadet of the department of clinical laboratory d
iagnosis with the course of clinical laboratory diagnostics of PGD;
Samarkand state medical university, Samarkand, Uzbekistan

Examination of serum IgG4 levels is recommended in patients with suspected autoimmune pancreatitis and in the differential diagnosis with pancreatic cancer [1,2].

Keywords: chronic pancreatitis, pancreatic cancer, serum, antinuclear antibodies, differential diagnosis;

Meta-analysis data show high specificity and relatively low sensitivity of IgG4 and IgG elevation in the diagnosis of autoimmune pancreatitis and differential diagnosis of focal pseudotumor pancreatitis with PG cancer. Clinically significant serum parameters for the diagnosis of AIP, differential diagnosis with PG cancer include hypergammaglobulinemia, elevated serum IgG levels, elevated serum IgG levels and the presence of antinuclear antibodies to Sm antigen. Timely detection of this condition is important because it is well-tolerated with corticosteroids for systemic use [3,4,5,6].

Assessment of nutritional status using clinical and biochemical methods is recommended for all patients with CP at admission to the hospital, as well as in



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outpatient treatment to assess the severity of the course of CP and to predict the risk of complications and adverse outcomes. The assessment is based on the calculation of body mass index (BMI), statement of the fact of weight loss and its severity, the presence of indirect signs of trophological insufficiency in the general examination of the patient - signs of anemia, trophic skin disorders [4,5,6,7].

Laboratory assessment of nutritional status is for most clinics generally available and indicative even when using a combination of simple tests - determination of total protein, albumin, absolute number of peripheral blood lymphocytes, hemoglobin level. Expansion of the spectrum of biochemical markers of trophologic insufficiency up to determination of concentrations of retinol-binding protein, vitamin B, folic acid, transferrin, magnesium, zinc allows to estimate nutritional status of a patient with CP in detail. Since 90% or more of CP patients with various markers of trophological insufficiency have weight reduction, the practitioner should be aware that even CP patients with normal or elevated BMI often develop trophological insufficiency, and weight reduction is the most significant potential risk marker for trophological insufficiency [7,8,9,10].

In patients with CP it is recommended to perform a single assessment of bone mineral density (by X-ray densitometry) for early diagnosis of osteoporosis that develops against the background of exocrine pancreatic insufficiency and vitamin D malabsorption. Osteoporosis is a proven complication of CP resulting from pancreatogenic malabsorption, including in the absence of obvious signs of exocrine pancreatic insufficiency [9,10,11,12].

In patients with recurrent abdominal pain with negative CT results, endoscopic ultrasonography (EUS) is recommended for differential diagnosis of CP and other inflammatory and tumor diseases of the stomach, as well as to obtain information about the state of the duodenum in the presence of its cystic-inflammatory transformation. Endoscopic ultrasonography is the most sensitive method for detection of CP at an early stage [12,13].

ESRD is a minimally invasive imaging method, which is also used for therapeutic purposes. The severity of CP is assessed according to a classification adopted in 2007 (Rosemont classification). Rosemont criteria include: 6 parenchymatous signs, reflecting the state of the organ parenchyma, which are divided into large



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(A, B) and small: hyperechogenic foci with shadow, lobularity of “bee honeycomb” type, lobularity without “bee honeycomb” sign, hyperechogenic foci without shadow, hyperechogenic tracts, cysts and 5 ductal criteria, which are also divided into large A sign and small signs: presence of concrements, dilatation of the GPP, dilatation of the lateral branches, irregularity of the main duct, hyperechogenicity of the duct walls [4,5,6].

There are 4 groups of signs according to the reliability of the diagnosis of CP: definite, presumptive, indeterminate and normal. The use of elastography or contrast during ESRD can increase the sensitivity of the method in the detection of CP and differential diagnosis with tumors [7,8,9].

Differential diagnosis between inflammatory and malignant masses, as well as early detection of malignant masses in patients with diagnosed CP remains a difficult task for all imaging methods, but the method that gives the most accurate tissue characterization is ESRD with fine-needle puncture biopsy. Under endosonographic control, diagnostic puncture biopsy can be performed for cytological and histological verification of doubtful areas for differential diagnosis of CP, autoimmune pancreatitis and tumor lesions. ESPBZ is recommended for patients with suspected or diagnosed CP as the most informative method in diagnostics of early CP (CP of minimal changes), especially at secretin stimulation, contrasting and elastography of PG, but this method requires high qualification of a specialist and strictly standardized approach. Endoscopic endosonography of pancreatobiliary zone is recommended for patients with suspicion of obstructive etiology of pancreatitis (clinical or radiological signs of pancreatic or biliary hypertension, endoscopic signs of changes on the side of large duodenal papilla) [8,9].

It is recommended to perform MRI in patients with intolerance to iodine-containing contrast agents in order to detect CP and differential diagnosis of the causes of biliary and pancreatic hypertension. MRI data indicating CP are local or diffuse changes of signal intensity on T1VI and T2VI, including suppression of signal from adipose tissue, contrast reduction in arterial and venous phases in dynamic MRI and contrast enhancement in delayed phase due to fibrous tissue contrast.



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MRI is preferable in patients with intolerance to iodine-containing contrast agents. Magnetic resonance cholangiopancreatography (MRCPG) can accurately identify fluid-filled structures, such as ductal and pseudocysts. MRCPG is the most informative in differential diagnostics of causes of biliary and pancreatic hypertension and is recommended for patients with CP in order to clarify changes in ductal system [10,11,12,13].

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