concurrent inflammatory bowel disease. There is no epidemiological data or case series on PSC from Tropical Africa.

Jones et al, (1979) reported the case of a 39-year old Tanzanian man who presented with cholestatic jaundice and required diagnostic laparotomy, intraoperative cholangiograpy and liver biopsy for establishing the diagnosis of PSC.

In developed Western countries, diagnosis of PSC is currently made using ERCP. The advent of MRCP as a screening tool for suspected patients has made non-invasive, early and pre-icteric diagnosis possible. In these subjects, localized areas of dilatation proximal to multifocal biliary strictures produces a characteristic beaded appearance on cholangiography.

Although there is a lack of statistical data about the incidence and prevalence of PSC in Nigeria, Owoseni O.O. et al described a case of a 47-year old woman who presented with a 6 month history of right upper quadrant pain, associated with intermittent jaundice, and generalized pruritus and weight loss. She also complained of intermittent loose stools 4 to 6 times daily, associated with mucus.After extensive investigations, and based on the clinical presentation, the diagnosis was confirmed to be PSC, The patient was started on symptomatic management for pruritus initially with cholestyramine, but this was later changed to ursodeoxycholic acid and antihistamines with good clinical and biochemical response.

A diagnosis of PSC is based on a constellation of clinical, biochemical, and typical cholangiographic features, and usually without the need for liver histopathology. Further understanding into PSC pathogenesis is desperately required in order to effectively improve our current approaches to the management of this disease.

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CHRONIC CHOLECYSTITIS AND GOUT - AN UNFAVORABLE TANDEM WITH DANGEROUS CONSEQUENCES

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The study features of any disease in the conditions of polimorbidity is important from the standpoint of increased risk of mortality, disability and significant deterioration in quality of life. In conditions of comorbidity and polimorbidity largest attention is deserved comorbid diseases which have common pathogenetic links with the main disease or other mechanisms that increase the risk of complications. Complicated impact of comorbid diseases

encourages researchers to study in detail the common mechanisms of the development of each diseases.

In the structure of gastrointestinal diseases chronic noncalculous cholecystitis and biliary tract pathology occupy the first place and account for about one third part. At the same time, and gout is one of the most common chronic diseases locomotor system with a tendency to increase in incidence. Great prevalence of both diseases with chronic stages (alternating remission and active process), the young contingent of patients, develop frequent complications of both diseases, provides the diseases medical and social status.

Due to common pathogenic mechanisms of both diseases, one of the dangerous consequences of such a tandem can be osteodeficit. Both the chronic diseases of the gallbladder and gout arthritis significantly associated with osteoporosis. The negative impact of osteoporosis on quality and duration of life, significant economic costs of treatment and social adaptation of patients make this problem as topical for doctors of any specialties. Considering that osteoporosis is easier and cheaper to prevent than to cure, early detection of preclinical osteoporosis (osteodeficit) in patients with chronic cholecystitis and gout is optimal in the management of the patients. One of the methods for early diagnosis of possible complications osteodefitcit is estimation of bone remodeling.

The purpose - study of the characteristics of bone homeostasis in patients with chronic non-calculous cholecystitis, combined with gout.

Materials and methods. Pathology of the digestive tract was diagnosed according to the criteria relevant diagnostic nosology. For the diagnosis of gout we used criteria S.L. Wallace et al. State of bone metabolism, we evaluated by the activity of biochemical markers of bone remodeling: bone formation - bone isoenzyme of alkaline phosphatase (BIAP) and bone resorption - the level of tartratresistant acid phosphatase (TRAF). Normally the processes of bone metabolism are balanced. Using the determination of biochemical indicators of bone metabolism can establish whether defect formation of osteoporosis prevails in the pathogenesis or bone resorption increased. To obtain standard indicators we examined 20 healthy individuals similar age and sex.

Results. The study involved 33 patients (26 men and 7 women - the main group of patients), mean age was 51 ± 8 years. We found an imbalance of bone remodeling: insufficient bone formation and a bit increased bone resorption. The marker of bone formation was significantly lowest ($P < 0.05$) and equaled 52,81±3,96 U/L patients in the main group whereas in the control group of healthy patients it was 84,31±4,45 U/l. Activity index of bone resorption was increased and amounted to 14,93±0,51 nmol/(s•L) against the control 12,74±0,36 nmol/(s•L). To study the impact of duration of existence of chronic cholecystitis on parameters of bone metabolism, we divided the patients into 3 groups: chronic cholecystitis with a duration of 5 years (n = 7), 5-10 years (n =

8) and over 10 years. We found that TRAF had a tendency to increase in activity over the years, while as an indicator BIAP contrary decreased (with statistically significant difference in meaning between the indicators I and III subgroups of patients). Thus, the severity of bone remodeling parameters directly affects the duration of the existence of chronic cholecystitis: the more there is this pathology, the clearly marked imbalance between new bone formation and bone resorption. Value indices of bone remodeling were analyzed from the standpoint of the impact of gout, namely duration of its existence. We found similar trends.

Conclusions. The features of bone metabolism in the patients is a disturbance of bone remodeling, namely the enhancement of bone resorption and decrease bone formation activity. On the severity of bone homeostasis parameters directly affects the duration of the existence of both chronic cholecystitis and gout: the more there is a basic and comorbidities, the clearly marked imbalance between new bone formation and bone resorption. Since osteoporosis usually has not specific clinical manifestations until the appearance of complications, such as fracture, detection among these patients people with osteodeficit (disturbances of bone remodeling, initial decrease in bone mineral density) is extremely important.

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CLASSIFICATION AND DIAGNOSTIC CRITERIA OF HEPATIC ENCEPHALOPATHY.

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Hepatic encephalopathy (HE) is a serious neuropsychiatric complication of liver disease (mostly liver cirrhosis) which is characterized by impaired cognitive functions causing confusion, memory loss, changes in mood. The impairment of the cognitive functions is caused by toxins (mostly ammonia) that the liver was unable to clear.

Based on the nature and severity of clinical manifestations, HE can be classified into two forms: covert and minimal. Covert HE - occurs in 30 to 45% of liver cirrhosis patients and 10 to 15% of transjugular intrahepatic portosystemic shunt (TIPS). A classic feature is flapping tremor or asterixis.

Minimal HE affects approximately 20-60% of patients with liver disease. Unlike covert, minimal HE is not easy to diagnose.

OTHER CLASSIFICATIONS AND CRITERIA