included demographic characteristics, smoking status, caffeine consumption, meal timing, frequency of spicy and fast food intake, physical activity level, sedentary behavior, body mass index, stress levels, presence of chronic diseases, and family history of GERD. The presence of GERD was assessed using symptom-based diagnostic criteria in accordance with the Montreal Consensus and the American College of Gastroenterology guidelines. Typical symptoms included heartburn, acid regurgitation, and postprandial chest discomfort, while extra-esophageal manifestations comprised chronic cough, sore throat, hoarseness, dental erosion, halitosis, and dyspnea.

Results and Discussion A total of 65 students participated in the study, of whom approximately 51% were male and 49% female, with the majority aged between 20 and 25 years. Heartburn and acid regurgitation were reported by approximately 30–40% of participants, while postprandial chest discomfort was noted in around 30%, and nocturnal reflux symptoms in about 20%. Among extra-esophageal manifestations, hoarseness and chronic cough were reported by approximately 28% of students, whereas halitosis and dental sensitivity were observed in around 30% of cases.

A total of 67% of students reported eating within 2 hours before bedtime, and an equal proportion consumed spicy or fast food 2–5 times per week. Daily caffeine intake of 1–2 drinks was reported by 65–70% of participants. Most students demonstrated low to moderate levels of physical activity, typically engaging in exercise one to three times per week, and reported prolonged sedentary behavior exceeding four hours per day. The prevalence of smoking was approximately 35%. According to body mass index distribution, 58% of participants had normal weight, 21% were overweight, 12% underweight, and 9% obese.

GERD symptoms were more frequently observed among overweight and obese individuals, as well as among those with late-night eating habits, high consumption of caffeine and spicy foods, and elevated stress levels, which were reported as moderate to high in approximately 70% of students. A family history of GERD was present in about 10% of participants and was associated with a higher frequency of symptoms.

Students with chronic conditions, including diabetes, asthma, and thyroid disorders, also demonstrated a higher prevalence of reflux-related complaints.

Conclusion GERD and its extra-esophageal manifestations are common among medical students at Bukovinian State Medical University and are strongly associated with modifiable lifestyle and dietary factors. Late-night eating, high intake of spicy foods and caffeine, smoking, sedentary behavior, and elevated stress levels appear to play a significant role in the development of symptoms. Preventive strategies focusing on lifestyle modification, dietary regulation, and stress management may significantly reduce the prevalence and impact of GERD in this population.

CRYPTOGENIC LIVER CIRRHOSIS: A CLINICAL CASE REPORT

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Objective. To describe a case of liver cirrhosis of unknown origin, emphasizing clinical manifestations, stepwise diagnostic evaluation, and therapeutic management.

Materials and Methods. A male patient, 35 years old (born in 1990), was admitted to a therapeutic unit in the Kharkiv region on January 13, 2026. He presented with progressive abdominal enlargement, dyspnea at rest, subjective palpitations, persistent bitter taste, and marked fatigue.

Anamnesis Vitae. The patient reported no prior history of infectious diseases such as tuberculosis or viral hepatitis, no endocrine disorders including diabetes mellitus, and no exposure to alcohol, наркотические вещества, or hepatotoxic drugs. He had not received any pharmacological treatment during the previous six months. Allergic reactions were not documented.

Anamnesis Morbi. The onset of symptoms was insidious, developing over approximately one year. During the last several weeks, the patient noted a rapid worsening of his condition, characterized by the appearance of generalized edema, icterus, and dyspeptic complaints, which prompted urgent hospitalization.

Clinical Findings. On admission, the patient's condition was assessed as severe. He was alert and oriented. Body temperature remained within normal limits (36.7 °C). Pronounced jaundice of the skin and sclerae was observed. Peripheral lymphadenopathy was absent. Respiratory examination revealed vesicular breathing with a rate of 18/min. Cardiac auscultation demonstrated a regular rhythm with reduced intensity of heart sounds; blood pressure was 110/70 mm Hg, pulse — 80 bpm. The tongue was moist with a whitish coating. The abdomen was enlarged due to fluid accumulation but non-tender and soft. The liver edge was palpable below the costal margin (approximately 5 cm). The spleen was not clinically palpable. Peripheral edema of the lower extremities was evident. Urinary and bowel functions were preserved.

Diagnostic Results. *Laboratory assessment:* Hematological analysis demonstrated pancytopenia with decreased hemoglobin (98 g/L), erythrocytes (3.1×10^{12}/L), leukocytes (3.2×10^9/L), and platelets (79×10^9/L), along with elevated erythrocyte sedimentation rate (28 mm/h).

Biochemical testing revealed cytolytic and cholestatic syndromes (ALT 62 U/L, AST 88 U/L, ALP 286 U/L, GGT 174 U/L), hyperbilirubinemia (total 67 µmol/L, direct 45 µmol/L), reduced synthetic liver function (albumin 24 g/L, total protein 54 g/L), hypocholesterolemia, and mildly elevated creatinine levels.

Coagulation parameters indicated significant impairment (prolonged prothrombin time, INR 1.9, decreased fibrinogen).

Urine examination showed bilirubin presence, increased urobilinogen, mild proteinuria, and minimal formed elements.

Serological screening excluded viral hepatitis and autoimmune liver pathology (negative HBsAg, anti-HCV, anti-HAV IgM, ANA, SMA, AMA).

Imaging and instrumental studies: Ultrasound imaging demonstrated a deformed liver with nodular architecture, dilation of the portal vein, splenic enlargement, and free intraperitoneal fluid.

Computed tomography confirmed cirrhotic remodeling of the liver, hepatomegaly, collateral circulation within the portal system, ascites, and splenomegaly.

Endoscopic examination revealed grade II varices of the esophagus and features consistent with portal hypertensive gastropathy.

Histopathological evaluation of liver biopsy specimens showed advanced fibrosis (METAVIR stage F4) with regenerative nodules. No morphological evidence supporting viral, alcoholic, autoimmune, or metabolic etiologies (including Wilson's disease, hemochromatosis, or α1-antitrypsin deficiency) was identified, supporting a diagnosis of cryptogenic cirrhosis.

Final Diagnosis. Liver cirrhosis of unknown etiology (cryptogenic), accompanied by pronounced inflammatory activity, hepatic functional insufficiency, portal hypertension (grade I–II), and ascitic-edematous syndrome.

Therapeutic Approach. The treatment regimen included dietary sodium restriction, intravenous infusion therapy (Reosorbilact), proton pump inhibition (Pantoprazole), hepatoprotective agents (Glutargin), antispasmodics (Drotaverine), symptomatic therapy (Renalgan), and pancreatic enzyme supplementation. Considering disease severity, the patient was referred for evaluation at a specialized liver transplantation center.

Conclusions. Cryptogenic cirrhosis is defined as end-stage liver disease in which the underlying cause remains unidentified despite extensive diagnostic investigation. Such cases present significant challenges in clinical practice due to limitations in etiological treatment. Continued research is essential to better understand pathogenetic mechanisms, improve diagnostic algorithms, and expand therapeutic options for this category of patients.