symptom severity. The minimal clinically meaningful change in score is 10 points.[8,9] Scores on three subscales of the OSDI (ocular symptoms, vision-related function, and environmental triggers) also range from 0 to 100, with higher scores indicating greater symptom severity.
Results. A total of 349 patients were assigned to the active supplement group and 186 to the placebo group; the primary analysis included 329 and 170 patients, respectively. The mean change in the OSDI score was not significantly different between the active supplement group and the placebo group (−13.9 points and −12.5 points, respectively; mean difference in change after imputation of missing data, −1.9 points; 95% confidence interval [CI], −5.0 to 1.1; P=0.21). This result was consistent across prespecified subgroups. There were no significant differences between the active supplement group and the placebo group in mean changes from baseline in the conjunctival staining score (mean difference in change, 0.0 points; 95% CI, −0.2 to 0.1), corneal staining score (0.1 point; 95% CI, −0.2 to 0.4), tear break-up time (0.2 seconds; 95% CI, −0.1 to 0.5), and result on Schirmer's test (0.0 mm; 95% CI, −0.8 to 0.9). At 12 months, the rate of adherence to treatment in the active supplement group was 85.2%, according to the level of n−3 fatty acids in red cells. Rates of adverse events were similar in the two trial groups.
Conclusion. Among patients who had moderate-to-severe dry eye disease despite the use of other treatments and were randomly assigned to receive either n−3 fatty acid or placebo supplements, symptoms and signs had improved. We found no evidence of a beneficial effect of n−3 fatty acid supplements as compared with placebo supplements among patients with dry eye disease.

UDC 616.633.963.42-036-07

MASKS OF MARKAIAFAVA-MICHELI'S DISEASE IN THE PRACTICE OF A PHYSICIAN

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Introduction. Markaiafava-Micheli-Stryubing's disease or paroxysmal nocturnal hemoglobinuria is an acquired hemolytic anemia associated with intravascular destruction of defective red blood cells, characterized by chronic hemolytic anemia, intermittent or permanent hemoglobinuria and hemosiderinuria, thrombosis and bone marrow hypoplasia. The relevance of this pathology is caused not so much by its prevalence (for 500 000 healthy people 1 case of this disease occurs), but by a variety of nonspecific manifestations and its combination with other prognostically unfavorable hematological diseases such as aplastic anemia, myeloid proliferative diseases and myeloid leukemia. The difficulties of timely diagnosis, the peak incidence at a young age, short life expectancy from the moment of pathology, explain the need for general practitioners to be aware of Markiafava-Micheli's disease.
The aim of the study was to identify the most frequent first clinical manifestations, the so-called "masks" of Markiafava-Micheli-Stryubing's disease, which therapists encounter.
Materials and methods. We analyzed outpatient cards and case histories of therapeutic patients, as well as data from domestic and foreign medical literature in the aspect of classical and atypical manifestations of paroxysmal nocturnal hemoglobinuria.
Results. According anamnesis diseases patients we studied the most frequent clinical manifestations are first change urine color (dark, black color - after receiving Ferum

supplementation); hemorrhages, dizziness, decreased performance, fatigue, pallor or icteric skin and mucous membranes, heartbeat. Objective examination of common clinical findings were pallor or ictericity of the skin and moderate splenomegaly. The most common preliminary diagnoses were iron deficiency anemia, anemia of unknown origin, and aplastic anemia. The third part of patients received therapy with Ferum-containing drugs, which significantly aggravated their condition. Among the results of laboratory and instrumental examination methods, such changes prevailed: in the clinical analysis of blood, pancytopenia, reduction in the number of reticulocytes, accelerated ESR; in the clinical analysis of urine - hemoglobinuria, hemosiderinuria; Gregersen's positive benzidine test with urine. The final stage of diagnostic search in this category of patients was a hematologist consultation with trepanobiopsy.

Conclusions. The most common "mask" of Markiafava-Micheli's disease is aplastic anemia, hyporegenerative anemia of unknown origin. The most common first complaints of patients with this pathology were discoloration of urine, manifestations of hemorrhagic and anemic syndromes. Detection of splenomegaly in patients with aplastic anemia should serve as a basis for further examination in order to exclude paroxysmal nocturnal hemoglobinuria.

UDC 616.633.963.42-07(477)

PROBLEMS OF DIAGNOSING PAROXISM NIGHT HEMOGLOBINURIA IN UKRAINE

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Introduction. Paroxysmal nocturnal hemoglobinuria (PNH) belongs to orphan diseases, and its prevalence is about 0.006%, there is some data suggesting that the true numbers are much higher. A possible explanation is the fact that the disease can be hidden, often combined with other pathologies (aplastic anemia or myeloproliferative diseases). Due to the variety of symptoms, patients are seen not only in the practice of hematologist, but in the practice of any specialty. The timely diagnosis may be difficult due to the lack of awareness of doctors. This leads to late detection of the disease, and, given that the average lifetime after diagnosis is 10 years, the identification of problems are particularly relevant for practical health care.

The aim of the study was to analyze the causes of late PNH detection and the main diagnostic errors of this category of patients.

Materials and methods. We have analyzed the case histories of patients with PNH who were hospitalized at the hematology department of the Kharkiv Regional Oncology Center. According to the medical records, we have analyzed the main clinical manifestations of PNH, the history of the disease, laboratory and instrumental diagnostic methods that were performed for patients. In addition, we have studied the capabilities of modern diagnostic methods in Ukraine and nearby countries.

Results. Studying the anamnesis of this patients, we have found that for most patients the period from the onset of the first symptoms of the disease to the correct diagnosis has taken 1.5-2 years, it worsened the quality of life and even in some cases, led to the disability of the patients. Most patients had a preliminary diagnosis of anemia of unknown origin, aplastic anemia or hemolytic anemia. Modern specific methods for the diagnosis of PNH are Hema test, sucrose test, immunophenotyping using flow cytometry. A new research