information, clinical test of the blood, bacteriological tests, ELISA and PCR - verification etiology of pneumonia, results of the X-ray of the chest.

Results. In patients with bacterial pneumonia we found high fiver (more than 38,5 C), dry cough, moist rales, crepitation- on auscultation; shortness of percussion sound- on percussion, x-ray examination: infiltration in low areas of lungs. Features of Chlamydia pneumonia: gradually beginning of the desease (7-10 day), sings of broncho-spastic syndrom, absence of signs of intoxication, hard breathing, dry rales - on auscultation, x-ray: interstitial changes and peribronchial, perivascular infiltration Viral pneumonia characterized by acute, quick manifistation of clinical signs (2-3 day); catharal changes of nasopharynx. Auscultate and percutate pathological changes aren't typical in this case. Dyspnea, perioral cyanosis, increase of respiration rate and pulse. x-ray: «cellular» changes of lungs tissue were determined in this patients.

Conclusions: So, the clinical signs in patients with different etiology pneumonia are different. Based on this clinical peculiarities, we can improve etiological treatment of this patients.

Mogilenets O.I., Bondarenko A.V., Solomennik A.O., Iurko K.V., Vinokurova O.N., Akhverdieva I.V.

SORE THROAT (ANGINA) AS ONE OF THE EARLIEST MANIFESTATIONS OF TUBERCULOSIS

Kharkiv National Medical University, Kharkiv, Ukraine

Introduction. In recent years Ukraine has noted the rise of morbidity due to tuberculosis (TB). One of the manifestations of TB may be involvement of oropharynx (angina).

Objective. Optimisation of TB diagnostics in patients with angina.

Results. Over the past two years in our clinic, two patients admitted with a diagnosis of angina, were later diagnosed with TB. There is a case study of a 56 y.o. woman who was admitted to the infectious disease hospital four days following complaints of slightly painfull swallowing, general weakness and low grade fever. On examination: skin was pale, mucous membrane of oropharynx was pink, on the upper pole of the right tonsil – an ulcer, 0,5 cm in diameter, covered with a white coating, difficult to remove, the surface did not bleed after removal of film. In the lungs: harsh breathing, RR – 20 beats/min. No shortness of breath. Heart sounds were muffled. Tachycardia – 96 beats/min. BP – 170/85mmHg. The rest of the organs and systems were normal findings. In the past medical history – iron deficiency anemia, chronic gastritis, hypertension. She denied TB.

On the 5th day of illness, a dry cough appeared, the chest X-ray revealed features of bilateral pneumonia (right upper lobe, left – total). In the blood test – anemia (RBC – 3,48*10^{12}/l, Hb – 94g/l), raised ESR (76mm/hr). In the following days the patient's condition progressively deteriorated. On 6th-7th day of illness significant weakness, sweating, headache, productive cough, changes on percussion and auscultation (over the basal zone noted percussion dullness, decreased breath sounds, rales) were noted.

On the 9th day – shortness of breath at minimal activity. On the 10th day – haemoptysis, significant deterioration in the X-ray findings. Disseminated pulmonary TB was diagnosed and the patient was put under the care of TB Dispensary.

Conclusion. In case of atypical course of angina examination of the patients must include a radiographic examination.

Mouhammad Dali

WHAT DOES THIS PATIENT HAVE A PLEURAL EFFUSION ORIGIN?

Kharkiv National Medical University, Kharkiv, Ukraine

Introduction. Pleural effusion (PE) is a common finding among patients presenting with respiratory symptoms. It indicates the presence of a disease that may be pulmonary, pleural, or extrapulmonary in origin. Twenty percent of PE cases among all attendances to general medical outpatient department remain undiagnosed despite extensive investigations. Whereas tuberculosis is the most common cause of exudative PE (67.5%), the incidence of parapneumonic effusions ranges from 20% to 57%. There is a considerable variation in the aggressiveness and course of parapneumonic and granulomatous effusions, and, therefore, the spectrum of the appropriate therapy may vary from a conservative approach in uncomplicated effusions to aggressive intervention in a advanced multiloculated empyemas.

Purpose. To appraise the diagnostic accuracy of the routine investigations to diagnose a pleural effusion origin, which becomes customary in the phthisiatrician practice.

Materials and methods. This descriptive study was conducted in outpatient department of Kharkov regional anti TB dispensary №1.Cases were confirmed through history, clinical examination and routine investigations. In every patient informed consent was taken, followed by detailed clinical history including occupation and contact with tuberculosis patient. A thorough clinical examination was performed, looking for signs helpful in the diagnosis of the cause of effusion. A posteroanterior and lateral X-ray chest was performed in all cases. The cause was confirmed by laboratory investigations which included Hb, TLC, DLC, ESR, along with serum protein levels. Mantoux test, sputum for acid fast bacilli (AFB) where indicated. In same cases CT chest and bronchoscopy were also done where necessary. Pleural fluid was aspirated and examined for color, total proteins and cholesterol, cell, AFB and bacterial culture.

Results. Pleural puncture was performed in 17 patients with pleural effusions; 12(70.5%) males and 5(29.5%) females. The average age was 47 years. Exudates were present in all 17 cases. Out of 17 cases, 10 (59%) had a granulomatous inflammation, 7(41%) parapneumonic. Regarding symptoms of patients who presented with pleural effusion, non-productive cough was mostly found in 13(76%) patients, 13(76%) patients with chest pain, 17 patients (95%) presented with breathlessness, whereas 14 patients (82%) had fever.

Conclusion. Tuberculosis was the commonest cause of pleural effusion 10 (59%) even though etiologic diagnosis was difficult followed by parapneumonic effusion 3 (17%) and TB empyema 4 (24%). A thorough laboratory tests and X-ray examination