paraclinical test is rather suitable for verification of this phenotype (Sp – 84.6% (95% CI 75.9-91.1)) than for its detection (Se – 36.4% (95% CI 26.9-46.6)). Concentration of total IgE in serum of more than 545.3 IU/ml in children doubles the chances of severe asthma being present. Increased sensitivity to domestic allergens (hyperemia more than 15.0mm) allows severe asthma specificity verification (81.5%) and personalization of treatment policy in these patients.

Koval V.

DIFFERENTIAL DIAGNOSIS OF TROMBOCYTOSIS IN CHILDREN BASED ON CLINICAL EXPERIENCE

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Actuality. The most common reason of thrombocytosis is a secondary or reactive process, caused by infection, trauma, operation, anemia, congenital adrenal hyperplasia, medications (corticoids, sympathomimetics) and other reasons. Primary thrombocytosis (family thrombocytosis, megakaryocytic leukemia) caused by clonal proliferation of bone marrow is about 10% of cases. There are principal differences between the primary and secondary thrombocytosis in etiopathogenesis and clinical manifestations, but often it is difficult to differentiate these types basing on clinical symptoms and laboratory data.

Results: a boy was born from the 5th pregnancy, 2nd premature delivery in gestational age of 32 weeks with body weight of 2240 g, body length of 44 cm, Apgar score of 3-4 points. Condition was very severe and resuscitation with non-invasive respiratory support was held. Since birth the neonate had severe respiratory and neurological disorders, then hemorrhagic and hepatolienal syndrome appeared. In clinical blood tests there was anemia, leukopenia, thrombocytosis (up to 1300×109), distinct myeloid irritation. Congenital megakaryocytic leukemia was supposed. But myelogram was not held due to severe condition. In spite of intensive therapy the infant died at 9 days of life. Results of autopsy confirmed primary thrombocytosis due to congenital megakaryocytic leukemia.

A boy was born from 4th pregnancy 2nd delivery in the gestational age of 40 weeks, cesarean section with birth weight of 3500g, body length of 51 cm, Apgar score of 8-9. Hyperpigmentation of genitals

was observed. Condition deteriorated in the first weeks of life, when anxiety, flacidity, repeated vomiting, refusal to eat, loss of body weight appeared. Basing on complaints, electrolyte and hormonal disorders congenital adrenal hyperplasia, salt-wasting form was diagnosed. In a clinical blood test there was high thrombocytosis (up to 800×109), granulocyte shift, anemia. Child received substitution corticosteroid therapy, antibiotics, correction of fluid and electrolyte disorders. To eliminate heamoblastosis with primary thrombocytosis myelogram was conducted, pathology was not revealed. After empirical antibiotic therapy by meronem general improvement and normalization of all parameters of blood test were observed. In this case there was a secondary thrombocytosis associated with the underlying disease in combination with microbial infection processes on the background of immunodeficiency.

Conclusions: in the case of a transient thrombocytosis, which disappear after treatment of background cause, heamotological examination is not necessary. In cases of combined reasons of thrombocytosis (congenital adrenal hyperplasia and infections) thrice bacterial inoculation of all biological fluids should be included to plan of examination to provide target antibiotic therapy. Conversely, in the case of persist thrombocytosis in absence of an obvious cause, total hematological examination must be conducted.

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PEDIATRIC SPINAL MUSCULAR ATROPHY AS A SYNDROME OF FLACCID CHILD

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Proximal spinal muscular atrophy (SMA) of childhood is a severe, often fatal monogenic disease, inherited in an autosomal recessive manner. Pathogenetic basis of the disease is an affection of motor alpha neurons of the anterior horns of the spinal cord. This disease is connected with mutation of gene SMN1 (survival motor neuron-1) in 5q13.

Case report. The child N. of 1 year 4 months was admitted to the department of anesthesiology and intensive therapy with complaints of the absence of physical activity in the upper and lower limbs, cramps, refusal to eat, weight loss, dyspnoe. The boy was born from the second normal pregnancy in gestational age of 40 weeks. Delivery was physiological. The older child in