



(1,0%). Childhood droplet infections were registered during all year. The highest incidence was registered in May – 40 (21%) cases. Among patients prevailed students – 117 persons (61,6%). The highest number of patients were in aged of 18-29 years – 175 patients (92,1%); 12 patients (6,3%) belonged to the age group of 30-39 years, and only 3 patients were older than 40 years.

Conclusions. 1. In the period from December 2012 till December 2013 chickenpox (76,8%) and rubella (15,3%) dominated in the morbidity structure of childhood droplet infections in Kharkiv region. 2. Males of age 18-29 years prevailed among the patients.

Movsesian A., Bezyazichna N., Solomenic N., Bondar A., Korzh E., Vaniyants A.
THE ANALYSIS OF MEDICAL WORKERS CONTAMINATION WITH
HEPATITIS C ACCORDING TO THE KHARKIV REGIONAL HEPATOLOGY
CENTER

Kharkiv national medical university, Kharkiv, Ukraine
Department of Infectious Diseases

Introduction. Due to the widespread prevalence of viral hepatitis and their high sickness rate they are a serious medical and social problem for world healthcare. According to WHO, one third of the world population is infected with various types of hepatotropic viruses. There are above 70% of all liver diseases that caused by chronic hepatitis C (CHC). HCV is an etiological factor in 40% cases of liver cirrhosis and in 60-70% of hepatocellular carcinoma.

Aim. It is known that medical staff (MS) is one of the risk group to be infected with HCV. Thereby, the purpose of our research is to analyze the incidence of MS among HCV patients according to the data of Kharkiv Regional Hepatology Center.

Materials and methods. We have observed 2719 patients with CHC. Diagnosis was based on standard clinical, laboratory and instrumental criteria. Etiology of the disease was confirmed by the identification of specific markers by ELISA, as well as the detection of HCV RNA in blood serum by PCR. Statistical analysis was performed by using Pearson goodness of fit χ^2 .

Results. Among the observed population we revealed 192 MS diagnosed with chronic hepatitis C (7.06%). Their average age was $41,09 \pm 0,85$ years. Among MS diagnosed with chronic hepatitis C there were 166 (86.46%) women, and 26 (13.54%) man. MS was divided by post and specialty as follows: Nurses - 137 (71.35%), paramedics - 9 (4.69%), doctors - 46 (23.96%), among them physicians - 10 (21.73%), laboratory assistants - 9 (19.56%), anesthesiologists - 4 (8.7%), TB specialists - 4 (8.7%), dentists - 4 (8.7%), gynecologists - 4 (8.7%), pediatricians - 4 (8.7%), surgeons - 3 (6.52%), epidemiologists - 3 (6.52%), interns - 1 (2.17%).

Conclusions. Among all patients with CHC who were registered in Kharkiv Regional Hepatology Center, 6.57% were MS. Moreover, among the MS CHC appeared more frequently than CHB ($p < 0.01$), while the share of MS among all patients with HCB was significantly lower than that among all patients with chronic virus hepatitis ($p < 0.01$). Draws also attention the sex structure of patients with CHC among MS: there was a significant predominance of women over men, in comparison with the total sample ($p < 0.01$). At the same time men were more frequent among MS with CHB, than in the MS with CHC patients ($p < 0.02$). In the structure of MS with chronic virus hepatitis, nursing staff



prevailed much more over doctors ($p < 0.01$). Ratio of surgeons and therapists with chronic virus hepatitis was 1:1.

Omowole Oladipupo, Zolataya V.

CLINICAL FEATURES OF EISENMENGER SYNDROME

Kharkiv national medical university, Kharkiv, Ukraine

Department Of Internal Medicine

Introduction. Eisenmenger syndrome is a cyanotic heart defect characterized by a long-standing intracardiac shunt that eventually reverses to a right-to-left shunt. This syndrome is less frequent today because of medical screening with echocardiography early in life. Eisenmenger's syndrome specifically refers to the combination of a cardiac shunt (systemic-to-pulmonary), significant enough to cause cyanosis and, over time, pulmonary hypertension. Eisenmenger's syndrome can cause serious complications in pregnancy, though successful delivery has been reported. Maternal mortality ranges from 30% to 60%, and may be attributed to syncope, thromboembolism, hypovolemia, hemoptysis or preeclampsia. Most deaths occur either during delivery or within the first weeks after.¹ Pregnant women with Eisenmenger syndrome ["ES"] should be hospitalized after the 20th week of pregnancy - or earlier if clinical deterioration occurs. Symptoms related specifically to pulmonary hypertension result from the inability to increase pulmonary blood flow in response to physiologic stress. Other symptoms are caused by various multisystem complications associated with cyanotic congenital heart disease. Examination findings vary with the progression of the disease. Early in life, infants with a large systemic-to-pulmonary communication may demonstrate mild pulmonary overcirculation with symptoms of cor pulmonale. Initially, cyanosis is absent, and infants present with the signs and symptoms of heart failure. Physical examination may reveal tachypnea, nasal flaring, grunting, retractions, and tachycardia.

Results. Laboratory studies used in the diagnosis of Eisenmenger syndrome include complete blood count, biochemical profiles, and iron studies, in addition to blood gas assessments. Imaging studies can reveal cardiac structural defects and pulmonary changes, including irreversible alterations in the pulmonary system. Electrocardiography can also reveal signs of underlying cardiac defect and of right ventricular hypertrophy, while histologic findings can be used to determine the stage of pulmonary vascular pathology. If the pulmonary artery pressures do not fall with inhalation of 100% oxygen or nitric oxide, the pulmonary hypertension is considered irreversible, and the patient is not a candidate for surgical repair. Pulmonary angiography can reveal structural alterations in the pulmonary vascular bed. Irreversible changes (consistent with Heath-Edwards III severity) can be visualized and may include loss of normal arborization, as well as tortuosity, narrowing, or cut-off of small pulmonary arteries. In the early stages, chest radiography reveals a typical appearance of increased pulmonary flow with right ventricular or biventricular enlargement, right atrial or biatrial enlargement, pulmonary vascular plethora, and an enlarged main pulmonary artery. Advancing pulmonary vascular disease appears as a normal cardiac silhouette with dilated main and branch pulmonary arteries without evidence of pulmonary overcirculation. In patients with severe pulmonary vascular disease, radiography reveals a normal-sized heart, pruning of the pulmonary vasculature, pulmonary infarction, and/or calcification of a patent ductus arteriosus. In severe pulmonary vascular disease, histologic