

METHODS OF CLINICAL-MORPHOLOGICAL EXAMINATION OF CHRONIC TONSILLITIS

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Abstract

During the research, 25 patients and 25 volunteer workers were selected for the control group, who applied to the ENT polyclinic of the Tashkent Medical Academy. Pathological microflora is found in the obtained smears, the phagocytic activity of leukocytes decreases, and multinucleated types of leukocytes appear in the blood, and lymphocytes decrease.

Keywords. Chronic tonsillitis, chronic pharyngitis, lacunae, lymphocyte.

Introduction

When we talk about chronic tonsillitis, we mean chronic inflammation of the palate with specific pathophysiological and morphological qualities, consisting of non-specific factors affecting the body's natural resistance and disruption of humoral and cellular links of immunity. Chronic tonsillitis does not always occur after the patient has angina. In most cases, the disease develops without knowing it (a form of chronic tonsillitis without angina) passing as ORVI, adenoid, stomatitis, periodontosis, or in fact, the palatal mucosa returns to the inflammatory process, actively carrying out protective work in these cases.

The purpose of the study. The diagnosis of the disease is based on general and local symptoms, patient's complaint, medical history, results of laboratory tests. In some suspected cases, examination of lacunae and smears taken from the surface of the gland helps to fully confirm the diagnosis of the disease.



Immunological examination of patients BDSST (1980,1987) and O'z.Res . SSV was conducted on the basis of standard tests of the Commission on the Evaluation of Problems in the Epidemiology of Immune Status and Immune Deficiency. In order to determine the immune status of the patients , before and after the treatment, analyzes were conducted to determine the dynamics of immunoglobulins in the blood of the patients who were in hospital treatment (Table 2). Blood analyzes were conducted at the "Etalon" diagnostic center .

Antigens were obtained according to Boaven - complex microbial antigen (BoivinA, by extracting the milk culture of microorganisms with trichloroic acid (TCH) .

Is determined by the usual method of calculating the percentage of absorption of microbes - phagocytic numbers (FCH) and phagocyte completion (PZF) . Daily cults such as E coli, S aureus and S pyogenes belonging to the p-hemolytic streptococcus group were used as test microbes. Hemagglucination (RGA) and reverse hemagglucination (RNGA) reactions were carried out according to the commonly used methodology from rabbit and sheep erythrocytes (RGA) using erythrocyte diagnostic series created by the Scientific Research Institute of Vaccine and Serum Production (RF) in Nizhnogorod .

Antibody titer S aureus, (Lot 32/ SA) staphylococcal erythrocyte diagnostic; S epidermidis, (Lot 32/ SE) staphylococcal erythrocyte diagnosticum, EcoliM-17 (Lot 16/M-17), E.coli 026 (Lot 16/026); E.coli 055 (Lot 16/055) was detected using erythrocyte diagnostics such as Escherichia coli erythrocyte diagnostic. Antibody titers were expressed as the negative log of 2($\lg 2 + \text{Slg}$). (K-coefficient) was taken as a relative indicator to take into account the probability of excretion of antibodies (in the case of high proteinuria) in the urine

K— AT/OB

The K-coefficient reflects the ratio of antibodies (AT) in infected blood to total protein (protein) in the blood (OB).

Studied collection strains were revived from semi-liquid agar before culturing was inactivated . Subsequent cultivation and identification were performed according to the generally accepted (Bergy, 1997) and Manual of Systematic Bacteriology (1999) methods.

Susceptibility to antibacterial drugs was determined by discodiffusion method . The following antibiotic discs were used: oxacillin, amoxicillin/clavulanate (amoxiclav), cefazolin, cefuroxime, cefotaxime, ceftriaxone, cefoperazone, cefepime and cephalexin.

Saliva and blood serum were determined by the simple radial immunodiffusion method according to Mancini (1964).

To assess the cellular composition of peripheral blood, we used the general analysis of blood in an expanded form and determined the essence of the following parameters (Table 1).

Table 1. Peripheral blood studies

No	Research method	Number of patients (persons)
1	Leukocytes (x 10 11)	50
2	Neutrophils (x 10 1/1)	50
3	Lymphocyte PK (x 10 1/1)	50
4	Monocytes (x 10 1/1)	50
5	Erythrocytes (x 10 1/1)	50
6	Hemoglobin (g/l)	50
7	SOE (mm/h)	50



Principles of immune correction during antibacterial therapy in patients with chronic tonsillitis .

All patients were divided into 2 groups depending on the administration of immunocorrective therapy :

Group 1 - a control group consisting of 25 patients, who received standard treatment + lacunal lavage .

Group 2 - a research group of 25 patients, in the treatment of which standard treatment + lavage of lacunae + local immunotherapy using Thymogen spray (Fig. 6).

Table 2. According to forms of chronic tonsillitis .

Shaped	Control group		Research group	
	abs	%	Abs	%
Simple	12	48	14	56
Toxic-allergic I-level	8	32	9	36
Toxic-allergic level 2	5	20	2	8
Total	25	100	25	100

Examination of the oral cavity - during pharyngoscopy, hypertrophy of the pharyngeal mucosa is observed, which is filled with bluish or pale pink mucous liquids. Tonsils are enlarged. When vasoconstrictor drugs are instilled, the mucosal inflammation does not go away. Rhinoscopy is necessary for differential diagnosis with diseases of other ENT organs (sinusitis, nasal obstruction, polyps, tumors). To determine the presence of additional diseases, such as laryngitis, pharyngitis, chronic and moderate otitis, hearing loss, headache.

changes are observed in chronic tonsillitis .

1. Epithelial layer or changes around it

Changes in the parenchyma ;

3. Changes in peritonsillar tissue .

In chronic tonsillitis , changes in the epithelial layer develop mainly in lacunae, where the epithelium thickens as a result of inflammation, and their migration is observed in places. The change of the epithelium depends on the width and length of the crypts, their branching. These changes depend on the level, time, duration of the inflammatory process and the patient's age, so the epithelium thickens or thins in places, undergo metaplasia, and sometimes this layer is completely flattened. In some cases, leukocytes and lymphocytes are released from the crypts due to sharp infiltration of the epithelial layer. Crypts merge with parenchyma and cause various inflammatory processes.

Changes in the parenchyma . It appears in two ways :

a) the first is an active inflammatory process

b) the second is a complication of the inflammatory process

the changes of the first group, the formation of infiltrates and abscesses is observed in the glands, the infiltrates are single or concentrated, located in different places of the parenchyma, cover several follicles with unclear edges. The infiltrate located in the center spreads to the



periphery and reaches the capsule of the gland. An abscess formed in the center of some infiltrates can be seen. Abscess covers the entire follicle or several follicular groups. As a result of this inflammatory process, lymphostasis is observed in the lymphatic channels of the palate glands.

The second group of changes in the glands includes scar sclerotic conditions, which is the end stage of inflammation. In this case, the crypts in the gland decrease and are located on the surface. The epithelium is thickened, there are few follicles, because they are replaced by connective tissue, sometimes lymphoid infiltration is observed.

The peritonsillar and paratonsillar tissue are sclerotic in nature, in which the strong connective tissue covers not only the outer part of the glands, but also the capsule. Symptoms of inflammation are not fully manifested in reduced lymphoid tissues. Peritonsillar tissue infiltration or peritonsillitis is observed inside and outside the gland capsule. This condition often occurs in the upper part of the gland.

Active participation of tonsils in the formation of local and general immunity in the body is their main protective function. Palate cells, located at the intersection of the respiratory tract and gastrointestinal tract, come into direct contact with antigens entering the body, and the anatomical features (the presence of crypts, flexible character) allow exogenous substances to be in long contact with organ tissues. provides, in which contact is necessary for the formation of specific and non-specific biologically active elements, as well as cell elements such as lysozyme, interferon, interleukin, immunoglobulin (IgA, IgM, IgG, sIgA), lymphocytes, plasma cells, macrophages.

The lymphoid (lymphoid) ring of the larynx and the lymphoid tissue of the throat are of great importance in protecting the tissues of the body from the flow of antigens. In adults, palatine tonsils participate in the formation of local immunity, because they contain plasma cells (IgA). In children, these cells perform two tasks: based on the cell composition, local reactions are carried out in them as well as general system reactions of immunity. This can be explained by the large number of plasma cells and IgG in children.

Of tonsil parenchyma with connective tissue is the leading pathophysiological process of the disease. As an initial factor in the development of chronic tonsillitis, the reduced potential of pus collection, antigenic stimuli, and the presence of mimic antigens in its structure, which escapes adequate immunological control, are assumed to be triggers. Therefore, along with the elements of productive inflammation in the tonsils, they are exchanged with the parenchyma's slow connective tissue. These actions are carried out due to the cell-fibrous transformation of fibroblasts, the formation of encapsulated points of necrosis and the involvement of regional lymph nodes in the inflammatory process. At the same time, sequestered antigens of tonsils in the center of micronecrosis and mimic antigens of the causative agent induce an immunopathological background. This background is manifested in the formation of humoral and cell-type autoimmune reactions against the tissues of the tonsils and the polyferable connective tissue. As a result of this, 'autoimmuncases of immunological tolerance disorders, which form a pathological status, arise. B. S. Preobrazhenskyi and VT Palchuna's clinical classification reflects this, the pathogenesis of chronic tonsillitis. It consists of three stages.



The normal form or the initial stage, at this stage there is not a history of frequent angina, but local symptoms (the presence of purulent fluid or purulent-caseous plugs in the lagoons of the tonsils, subepithelial purulent follicles with signs of Zaka, Gize, Preobrazhensky, etc. zi enlargement of regional lymph nodes and pain on palpation), in which chronic tonsillitis can also be observed in etiologically and pathologically unrelated diseases.

Toxic-allergic form I (TAF I) is determined by the presence of angina from time to time in the anamnesis, and all the above symptoms are combined with general toxic-allergic processes (periodic rise in subfebrile fever, tonsillogenic intoxication with weakness (nausea) conditions are observed, pain, rapid exhaustion, pain in the joints, pain in the heart that is not reflected in the ECG during the period of exertion), these symptoms are any acute respiratory diseases or aggravated after angina, leaving an asthenic complication of functional disorders. Toxic-allergic form II (TAF II) in which the symptoms of form I are more pronounced (functional disturbance of heart activity reflected in the ECG, pain in the heart and heart rhythm disorders even during angina and when there is no exacerbation of chronic tonsillitis, subfebrile fever long-term elevation, functional disorders of the kidneys, liver, vascular system, joints determined by laboratory methods) are associated with diseases with etiopathogenetic factors combined with chronic tonsillitis: local (paratonsillar, abscess, parapharyngitis, pharyngitis) and general (acute and chronic tonsillogenic sepsis, rheumatism, infectious arthritis, acquired heart attack, diseases of the urinary system, prostate gland, thyroid gland, and cerebral cortex).

Returning to the clinical-anatomical characteristics of the structure and function of the palate, we note that chronic tonsillitis is a very dangerous disease, the first signs of which are a hematogenous and lymphogenous infectious-allergic attack on the body.

Inflammatory process in the lymphoepithelial ring of the throat and tonsils of the palate is the source of homotoxicosis, which harms the endoecology of the body. It turns out that we should accept chronic tonsillitis as a center of infection, the elimination of this infection is necessary for good treatment of diseases and maintenance of human health in general.

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