

it . After mobilization of the head of the pancreas, invasion of the tumor into the portal vein along the right semicircle with a section of 3 * 5 mm was established. Marginal compression of the portal vein was performed. Produced marginal ellipsoid resection of the right semicircle of the portal vein. Suturing with a twisting suture with polypropylene 5.0. A satisfactory diameter of the anastomosis and blood flow through the vein were stated.

Results and discussion. The results of histological examination: chronic indurative pancreatitis with the presence of a cyst and the development of well-differentiated adenocarcinoma G1. Atypical cells were not found in the margins after surgical incisions. The final diagnosis was made: C 25.0 Disease of the head of the pancreas T2 N0 M0 2b stage, II clinical group. The postoperative period proceeded without complications. The patient was discharged with recovery three weeks after the surgery.

Conclusions. This clinical observation indicates the complexity of surgical intervention for pancreatic head cancer. The presented version of the operation expands the possibilities of treating pancreatic cancer with invasion into the great vessels and allows performing a radical operation.

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PLASTIC BRONCHITIS AND A NOVEL MANAGEMENT APPROACH WITH STREPTOKINASE INHALATION THERAPY: A CASE STUDY

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Relevance. Plastic bronchitis (PB) is an uncommon and underdiagnosed disease of obstructive airway casts characterized by the formation and expectoration of bronchial casts of amorphous material, which can be potentially fatal [1]

Object. To analyze a rare case of an adult patient with a history of bronchial asthma (non-allergic form of neutrophil phenotype) who applied to the Grodno University Clinic with expectoration of hard, long and branched bronchial casts.

Research methods. To make the diagnosis, a clinical examination, computed tomography of the chest, bronchoscopy, and histopathological examination were performed.

Results and discussion. A 39-year-old female, with a history of Bronchial asthma (non-allergic form neutrophilic phenotype), started suffering from paroxysmal coughing and mild expectoration of sputum from the onset of the spring season, in 2022. She did not seek any medical or professional consultation at the beginning of the disease course, disregarding the condition as a normal cough associated with seasonal shifts. There was a progression of cough and a gradual increase in sputum expectoration. Roughly four months after the onset of the symptoms, the patient sought professional help leading to hospitalization based on the presenting features. On hospitalization, a chest CT examination showed an interstitial (inflammatory) type of pneumonia most likely due to viral etiology (Likely COVID-19 infection). A bronchoscopy done a week later showed focal hyperemia observed in the bronchi on the right and left upper lobe branches. The lumen of the bronchus of the middle lobe was obstructed by a thick clot. A grey-green color clot was extracted using an endoscope. Clot size 8.0×2.0 cm. The patient was treated symptomatically and after stabilization, the patient was discharged with continuous high-dose combined antiinflammatory therapy: Tiotropium bromide (2.5 mcg) inhaler, beclomethasone (100 mg) and formoterol fumarate (6 mg) inhaler, methylprednisolone, azithromycin (500 mg q.d.), mucolytics-long-term (ambroxol 30 mg 1 tab 3 times a day or inhalation through a nebulizer). This initial therapeutic approach did not relieve the patient's symptoms and the standard mucolytic therapy did not prove to be very effective. Six months after the initial presentation of symptoms and after seeking the initial therapeutic approach the patient now presented to us at the outpatient department of Grodno university clinic with complaints of cough with sputum discharge in the form of firm, long, and bronchishaped casts. There was noticeable shortness of breath at rest and even with slight exertion. A provisional diagnosis of PB was placed. The patient was questioned for relevant history while also examining her past medical record and treatment regimens. The patient was started on SK inhalations (1.5 million diluted in 10 ml solution. Inhalations of 1.5 ml per 2 ml of physical solution through a nebulizer 2 times a day), tiotropium bromide (2.5 mcg) inhaler, Beclomethasone (100 mg) and formoterol fumarate (6 mg) inhaler. The patient was recommended to undergo Lymphangiography to investigate for any possible lymphatic malformations.

Conclusions. Our patient was found to have many concomitant anomalies like a left adrenal gland adenoma of unspecified hormonal activities with a nodular knot-like structure with calcification; heterogeneous thickening of renal parenchyma of kidneys, and an angiomyolipomalike formation in the right kidney. Isoechoic nodules in the right lobe of the thyroid gland. An additional lobe in the right lung and an abnormally located azygous vein. Although PB is rarely seen in clinical practice,

clinicians should be aware that PB can be possible under the following circumstances. In such cases, aggressive treatment, including bronchoscopy and adjuvant therapies, such as inhaled SK, is the key to saving lives and reducing sequelae. We propose a few hypotheses for PB based on our case study.

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INCREASING BURDEN OF MICROBIAL RESISTANCE ISOLATED FROM PATIENTS WITH COVID-19 IN THE ERA OF OMICRON

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Relevance. High rates of utilization of antimicrobial agents in patients with COVID-19 has led to an accelerated increment in the burden of microbial resistance which poses a threat to infection control measures related to bacterial infections [1].

Object. To establish the incidence of continuing trends of antimicrobial resistance in patients with COVID -19 in the Era of Omicron.

Research methods. Analysis of antibiotic susceptibility of various bacterial strains isolated from 154 patients of COVID-19 with a positive bacteriological analysis, that were hospitalized at the Grodno Regional Infectious Diseases Clinical Hospital in 2022.

Results and discussion. Among the admitted 154 patients of COVID-19 with a positive culture, 13 patients (8.4%) displayed features of antimicrobial resistance. Isolates were drawn from various sampling sites of the body where 173 cultures demonstrated bacterial colonization, 15 (8.6%) of those cultures demonstrated resistance to antibiotics. These 15 samples were extracted from various sites- throat swab (7 samples; 46.7%), sputum (3 samples; 20.0%), urine (3 samples; 20.0%), rectal swab (2 samples; 13.3%). The pathogens most commonly isolated were: *Streptococcus pneumoniae* (comprised 46.7% burden of all resistant bacteria), *Proteus mirabilis* (20.0 %), *Klebsiella pneumoniae* (13.3%), *Escherichia coli* (6.7%), *Citrobacter freundii* (6.7%), *Pseudomonas aeruginosa* (6.7%). As per the number of antibiotic included in our antibiogram *Streptococcus pneumoniae* displayed a moderate to severe resistance to 4 out of 6 antibiotics (66.7%), *Proteus mirabilis* – 3/5 antibiotics (60.0%), *Klebsiella pneumoniae* – 5/7 antibiotics (71.4%), *Escherichia*