population. Furthermore, 92 (87,6%) patients out of 105 were presented with pneumonia; which subdivided into 86 (81,9%) as unilateral and 6 (5,7%) as bilateral localization, 7 (6,7%) were presented with bronchitis as the primary complain and 5 (4,7%) were presented with upper tract respiratory infection. The demographic division of patient population into city 91(86,7%) and village 14 (13,3%). Co-infections were prominent with 23 (21,9%) out of 105 patients.

It was revealed that during assessment with the application of Mann-Whitney U test for the following parameters such as CRP depending on pneumonia and fever ($p = 0,045$). Pneumonia without fever was predicted at a CRP value below 21,8 (Youden index) by ROC curve (AUC = 0.663; 95% CI: 0.526-0.799, $p = 0,045$). The sensitivity and specificity of the resulting prognostic model were 93,3% and 37,1%, respectively.

The correlation was established between PLR (platelets/lymphocyte ratio) and CRP/eosinophils ($p=0,009$), PLR (platelets/lymphocyte ratio) and NLR (neutrophils/lymphocyte ratio) ($p<0,001$), the analysis of the NMR (absolute neutrophils/absolute monocytes ratio) depending on pneumonia & fever ($p = 0,046$), the MER (absolute monocytes/absolute eosinophils ratio) depending on pneumonia & fever ($p = 0,034$), CRP/platelets depending on fever type ($p=0,004$), CRP/ absolute monocytes depending on fever type ($p = 0,006$). Furthermore, with the application of Student's t-test for assessment of $WBCx10^9$ depending on pneumonia & cough, it was revealed to be highly statistically significant ($p = 0,001$).

Conclusion. An epidemiological shift to pediatric population was observed. It shows a higher correlation between biomarkers such as absolute lymphocytes, WBCs, absolute eosinophils, absolute platelets and absolute monocytes was observed. Presence of co-infection is considered as the variation of immune system caused by *M. pneumonia* after the COVID-19 pandemic.

MULTIDISCIPLINARY APPROACH TO END-STAGE POLYCYSTIC KIDNEY DISEASE: A CASE OF BILATERAL NEPHRECTOMY AND TRANSPLANTATION

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Introduction. Polycystic Kidney Disease (PKD) is a genetic disorder characterized by the formation of fluid-filled cysts in the kidneys, leading to progressive renal impairment and complications such as hypertension, hematuria, and end-stage renal disease (ESRD). Autosomal Dominant Polycystic Kidney Disease (ADPKD) is the more prevalent form, accounting for approximately 85% of cases and is caused by mutations in the PKD1 and PKD2 genes. Despite advances in supportive care, many patients eventually require renal replacement therapy, including dialysis and kidney transplantation. This

case study highlights the management and outcomes of a patient with PKD undergoing bilateral nephrectomy followed by a successful kidney transplant.

Aim of the study. To illustrate the clinical management of advanced PKD, highlighting the roles of bilateral nephrectomy and kidney transplantation in improving patient outcomes.

Materials and methods. A 60-year-old female diagnosed with PKD and liver cysts in 2004 presented in 2019 with flank pain, hypertension, fatigue, polyuria, and polydipsia. Her renal function progressively declined, with creatinine rising to 869 μmol/L and urea to 50 mmol/L by 2022. Hemoglobin dropped to 99 g/L. MRI showed extensive cystic involvement in both kidneys and liver. Hemodialysis was initiated in June 2022. To prepare for transplantation, she underwent a right nephrectomy in June 2023 and a left nephrectomy in September 2023. A cadaveric kidney transplant was performed in October 2023. Post-transplant care included immunosuppressants (mycophenolate mofetil, cyclosporine), antifungal/antibiotic prophylaxis (nystatin, co-trimoxazole, valganciclovir), and antihypertensive management.

Results and discussion. Post-transplant, creatinine decreased to 83 μmol/L and urea to 8.5 mmol/L. Hemoglobin and red blood cell counts stabilized, improving the patient's energy and reducing PKD-related symptoms. PKD is the leading genetic cause of ESRD, with bilateral nephrectomy and transplantation being the most effective treatments, as drugs like tolvaptan only slow cyst growth without curing the disease. This case emphasizes the importance of multidisciplinary care, involving nephrologists, transplant surgeons, and internal medicine specialists. Post-transplant management, including immunosuppression, infection control, and lifestyle modifications, is vital for long-term success.

Conclusion. This case highlights the complexities in managing advanced PKD, emphasizing the necessity for bilateral nephrectomy and timely kidney transplantation in ESRD patients. Post-transplant care, including immunosuppressive therapy and lifestyle modifications, plays a critical role in maintaining graft health and preventing complications. The patient's successful recovery post-transplant demonstrates the effectiveness of a multidisciplinary approach in managing PKD-related ESRD.

ABNORMAL ANATOMICAL VARIANT OF RENAL VEIN

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Introduction. Circumaortic left renal vein (CLRV) is an anomaly of left renal vein when an accessory left renal vein passes posterior to the aorta, along with normal renal vein passing anterior to the aorta. According to the previous