

## LITERATURE

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## ASSESSMENT OF LIVER FIBROSIS STAGE BY FIBROELASTOMETRY IN PATIENTS WITH CHRONIC HEPATITIS C BEFORE INITIATING ANTIVIRAL THERAPY

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**Relevance.** For a long time, liver biopsy was the gold standard for diagnosing liver fibrosis; however, it is an invasive procedure associated with a risk of complications. Consequently, non-invasive methods for diagnosing fibrosis, including the determination of serum fibrosis markers and fibroelastometry, have become widespread in clinical practice [1, c. 73].

**Target.** To analyze the results of liver fibroelastometry in patients with chronic hepatitis C (CHC) before the start of antiviral therapy.

**Research methods.** A retrospective analysis was conducted of fibroelastometry data from 111 patients with CHC who were referred to the Consultative and Dispensary Department of the Grodno Regional Infectious Diseases Clinical Hospital to consider prescribing antiviral therapy in 2021-2025. The following ultrasound elastography methods were used to assess liver stiffness: Shear Wave Measurement (SWM) and Real-Time Tissue Elastography (RTE). The SWM method included measuring the absolute value of the shear wave velocity  $V_s$  (m/s) and its pressure  $E$  (kPa). The RTE method included determining the Liver Fibrosis Index (LF Index). The conclusion was presented according to the METAVIR score.

**Results and their discussion.** The mean age of the examined patients was 49.9 years, with a median of 47 years (range 20–93 years). Among the total number of patients examined, 25 (22.5%) had practically no liver fibrosis (F 0-1), 11 (9.9%) patients were classified with stage 1 fibrosis (F 1), 31 patients (27.9%) – F 1-2,

5 patients (4.5%) – F 2, 13 patients (11.7%) – F 2-3, 1 patient (0.9%) – F 3, 13 patients (11.7%) – F 3-4, and 12 patients (10.8%) – F 4. Liver stiffness  $E$  ranged from 1.49 to 29.5 kPa. The mean  $E$  value for patients with F 0-1 was 3.69 kPa, for patients with F 1 was 4.53 kPa, for patients with F 2 was 6.77 kPa, for patients with F 2-3 was 6.95 kPa, for patients with F 3-4 was 11.61 kPa, and for patients with F 4 was 17.27 kPa. It should be noted that liver stiffness values  $E$  exceeding 20 kPa, combined with clinical signs of decompensated liver cirrhosis and a high MELD score, often indicate the need for liver transplantation. In 6 out of 111 patients, this indicator exceeded 20 kPa. The  $V_s$  value in patients varied in the range from 0.94 to 3.14 m/s. The LF Index in patients ranged from 0.48 to 3.06.

**Conclusions.** Analysis of fibroelastometry in patients with CHC before the start of antiviral therapy revealed a predominance of individuals with significant fibrosis (stages F2–F4 accounted for 61.3%), including 10.8% of patients with liver cirrhosis (F4). A wide variability in liver stiffness measurements was recorded (from 1.49 to 29.5 kPa), with values exceeding 20 kPa in 6 patients, indicating a risk of decompensation. Elastography demonstrates high informativeness as a non-invasive method for assessing the stage of fibrosis, which is necessary for choosing the antiviral therapy strategy.

#### LITERATURE

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## KEY AREAS OF INTEGRATION OF SURGICAL PRACTICES IN THE AYURVEDA CONCEPT

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**Relevance.** In the era of modern high-tech surgery, traditional practices, including those established by Ayurveda, continue to be relevant. Taking into account individual characteristics, careful preparation for surgery, postoperative care and rehabilitation are considered not only as technologies, but also as science, art and philosophy. Sushruta's systematic approach to Ayurvedic surgery, including herbal anesthetics and careful postoperative care, is a fundamental foundation that is relevant today [1].

Knowledge of the history of Ayurvedic surgery is critical both for Ayurvedic surgeons who master modern procedures such as laparoscopy, and for doctors of modern medicine who integrate traditional methods such as to optimize rehabilitation.