Вывод. Тотальный аномальный дренаж легочных вен относится к группе сложных врожденных пороков сердца. В последние годы благодаря развитию пренатальной и повышению качества постнатальной диагностики, изменению тактики лечения, усовершенствования хирургических методик, уровень послеоперационной летальности значительно снизился.

Ключевые слова: врожденный порок сердца, тотальный аномальный дренаж легочных вен, младенцы.

OUTCOMES OF SURGICAL TREATMENT FOR TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION

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Abstract. Total anomalous pulmonary venous connection (TAPVC) is a rare cyanotic congenital heart defect that occurs from 1% to 3% of all congenital heart abnormalities. Without cardiac surgery, most patients (about 80%) with TAPVC die within the first year of life. The treatment of such patients is a complex and difficult problem. Up to now, surgical correction of this defect is accompanied by a significant mortality rate.

The aim of this work is to analyze the results of surgical treatment of total anomalous pulmonary venous connection in children operated from 2006 to 2018.

Object and methods. For the period from 2006 to 2018 at the "National Amosov Institute of Cardiovascular Surgery" treated 34 consecutive patients with TAPVC. The mean age of the patients was 109.3±101.4 days (from 2 to 505 days), respectively, and mean weight was 4.01±1.1 kg. It was found that in 57.1% (20) patients there was a supracardiac form of anomaly, in 14.2% (5) – an intracardiac form, in 17.1% (6) of patients – infracardiac and in 11.4% (4) – mixed form.

Results. Two patients (5.8%) died in the postoperative period. The causes of death among patients were: progressive heart failure (n = 1), which was a consequence of small size of the left ventricle, one patient died after pulmonary hypertensive crises due to increased reactivity of the pulmonary vessels in the early postoperative period.

Conclusion. Total anomalous pulmonary venous connection belongs to the group of complex congenital heart defects. In recent years, due to the development of prenatal and improving the quality of postnatal diagnosis, changes in treatment tactics, improvement of surgical techniques, the level of postoperative mortality has decreased significantly.

Key words: congenital heart defect, total anomalous pulmonary venous connection, infants.

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LIFE QUALITY OF PATIENTS AFTER ACUTE DESTRUCTIVE PANCREATITIS

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Introduction. The problem of treatment including surgical treatment of acute destructive pancreatitis (ADP), despite certain successes in the diagnosis and pathogenetically determined principles, remains relevant to this day. The current approaches to the treatment of destructive forms of acute pancreatitis have significant and sometimes fundamental disagreements, consisting in a different choice of intensive pharmacotherapy regimens; determination of indications for surgery, the duration and volume of surgical intervention; surgical access, as well as drainage methods of the retroperitoneal space and abdominal cavity, etc. [1,2,3,4].

Analysis of the frequency and structure of complications, postoperative mortality, the length of the bed day, economic costs, the dynamics of changes in laboratory parameters, and the period of temporary incapacity for work does not allow us to fully evaluate the effectiveness of treatment for ADP. In this regard, the study of quality of life (QOL) and long-term results of treatment, can determine the benefits of a particular treatment method, and are the final step in assessing the effectiveness of surgical treatment. The available data on the quality of life of patients who undergo destructive pancreatitis are contradictory – how from a significant deterioration in the quality of life indicators, and to the absence of significant differences from the general population of healthy individuals [5,6,7,8].

The aim of the research: to evaluate the effectiveness of complex treatment of patients with pancreatic necrosis based on the study of quality of life in this category of patients.

Object and methods. In the long-term period, in patients after a previous ADP (observation period ranged from 4 months to 6 years), the quality of life of patients was studied using the MOS SF-36 questionnaire (Medical Outcomes Study 36-item short form health survey). It consists of 36 questions and includes eight scales representing the physical and psychological components of health. Answers to questions are expressed in scores from 1 to 100. A higher score corresponds to a higher level of QOL. Scales are combined in two groups according to the meaning of the questions. Two obtained total indicators characterizing physical (physical activity) and mental (emotional state) health give an idea of the status of QOL against the background of the disease. The category "Physical Functioning – Physical Functioning" – (PF) determines the ability to perform various physical activities. The category "Role-Physical Functioning – Role-Physical Functioning" (RPF) defines the ability to perform a particular job typical for a specific age and

social affiliation (walking to work, work itself, household work). The category "Intensity of pain – Bodily pain" (BP) defines the value of physical pain, which can cause a limitation of the patient's usual activity. The category "General Health – General Health" (GH) evaluates the subjective perception of previous, current health status and allows you to determine its prospects. The category "Vital Activity – Vitality" (VT) evaluates the feeling of internal energy, the absence of fatigue, and the desire for energetic action. These categories represent the physical component of health. The category "Social Functioning – Social Functioning" (SF) reflects the ability to develop, fully communicate with relatives, friends, family, the possibility of adequate professional communication. The category "Role functioning due to emotional state – RoleEmotional (REF) reflects the patient's emotional status, the influence of emotions on everyday activities, and behavior when communicating with others. The Mental Health category (Mental Health) reflects the presence of neurotization, a tendency to depressive states, a feeling of happiness, peace, and peace of mind. These categories represent the psychological component of health. The study included patients (main group – MG) with previously confirmed, reliably diagnosed ADP (n = 55), as well as a clinical comparison group (CCG) – patients without pathology from the gastrointestinal tract (n = 20). The groups were comparable by age and gender. The results are presented as a median with upper (75%) and lower (25%) quartiles. The significance of the differences in the obtained data (p) in the compared samples was determined by the Mann-Whitney criterion. Differences between indicators were considered statistically significant at $p < 0.05$.

Results and discussion. The QOL indices in patients after the transferred ADP in almost all categories were significantly lower than in CCG. The components of QOL in first group were as follows: PF-85, RPF-70, BP-74, GH-75, VT-70, SF-72, REF-66.6, MH80. In SCS, the similar components of QOL are as follows: PF-95, RPF-85, BP84, GH-87, VT-80, SF-87.5, REF 84.3, MH-88. The results are shown in **table 1.**

Thus, the physical component of health in patients after the transferred ADP is significantly lower in all categories, and the psychological component in this category of patients is significantly lower in the category of social functioning. In the study of QOL in patients after an ADP, we proceeded from the assumption about the likely impact on the outcome of the disease of the volume of damage to the pancreas and retroperitoneal space and the severity of the condition, as well as the method of surgical treatment and the period after the pancreatic necrosis.

When analyzing QOL, depending on the volume of pancreatic necrosis and the severity of patients, it was noted that in the group of patients with extensive necrosis of the pancreas and retroperitoneal space and severe condition of patients on the SAPS integrated scale (group 1), QOL was significantly lower in categories of physical functioning, pain intensity, general health and vitality, which reflects the physical component. According to the indicators of the psychological component of health, no significant difference between the groups was revealed. The results are presented in **table 2.**

Table 1 – QOL components after ADP

Quality of life components	MG n=55	CCG n=20
PF	85	95
RPF	70	85
BP	74	84
GH	75	87
VT	70	80
SF	72	87.5
RE	66.6	84.3
MH	80	88

When studying the effect on the QOL of the volume and method of surgical treatment of ADP, all patients were divided into two groups.

The first group (n = 23) consisted of patients who underwent a laparotomy, in which the form and degree of damage to the pancreas and parapancreatic fiber were clarified, the nature of the effusion in the abdominal cavity was assessed, and metered pancreatic necrectomy and abdomination were performed. The operation was completed by drainage of the abdominal cavity, and in cases of biliary hypertension was supplemented with cholecystostomy. The second group consisted of patients (n = 22), who adhered to active wait-and-see tactics and applied an integrated approach in the treatment of this severe pathology. The latter consisted in the application, along with the starting full-format intensive therapy, of various endovideo surgical technologies and puncture drainage methods, as well as, according to indications and early energetic nutrition **(table 3).**

Table 2 – QOL components depending on the volume of pancreatic necrosis

QOL components	Group 1 n=40	Group 2 n=15
CT severity index (Balthazar)	6	3
SAPS	9	7
Age	52	58
PF	75	85
RPF	75	75
BP	64	84
GH	55	78
VT	70	80
SF	75	78
RE	66.6	66.6
MH	80	89

From the table it follows that QOL in patients of the first group is significantly lower in all categories of the physical component, but no significant differences were obtained in terms of the psychological component.

Table 3 – QOL depending on type of surgery

	Group 1 n=23	Group 2 n=22
CT severity index (Balthazar)	6	5.5
SAPS	9	7.5
Age	48	52
PF	72.5	90
RPF	50	75
BP	63.5	84
GH	55	78
VT	65	80
SF	75	82
RE	66.6	66.6
MH	76	89

When studying QOL, depending on the period after the transferred ODP, all patients were divided into three groups: the first group – up to 1 year, the second group – from 1 year to 3 years and the third group – patients after 5 years after the transferred ODP. The groups were comparable by age, gender, severity of the condition, as well as the volume of surgical intervention **(table 4).**

It was established that the lowest QOL indices are found in patients of the first group.

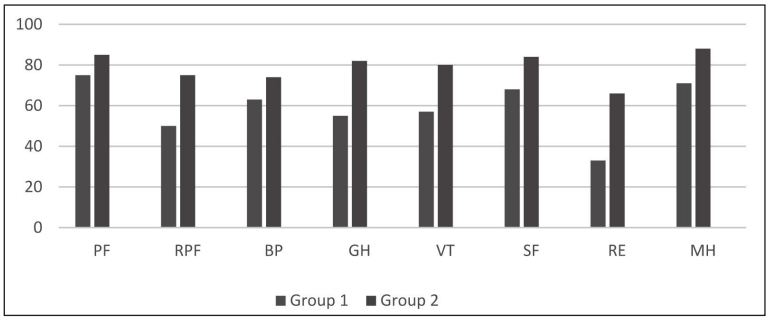

Figure – QOL components in patients with recurrent acute pancreatitis.

Table 4 – QOL components depending on duration after ADP

	Group 1 n=20	Group 2 n=20	Group 3 n=15
PF	77.5	82.5	95
RPF	50	75	100
BP	63.5	79	84
GH	48	69.5	89.5
VT	65	75	76
SF	63	75	87
RE	66.6	66.6	100
MH	76	80	95

Over time, these indicators increase and the highest values were found in patients of the third group. In addition, QOL was analyzed in patients with a recurrent course of pancreatitis. It was established that relapses of the disease (patients of the first group n = 24) significantly reduce both the physical and psychological components of QOL **(figure).**

Thus, the quality of life is significantly higher in patients who have undergone minimally invasive surgery. The quality of life is affected by both the severity of the condition and the degree of damage to the pancreas and parapancreatic fibers. With an increase in the period after acute destructive pancreatitis, the quality of life of patients increases. Relapses of the disease significantly reduce both the physical and psychological components of the quality of life in this category of patients.

Conclusion. A comprehensive and individual approach to the treatment of patients with acute destructive pancreatitis can improve the quality of life in the postoperative period.

Prospects for further research. It is planned to further develop methods for the correct selection of treatment tactics and the volume of surgery to reduce relapses of the disease.

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ЯКІСТЬ ЖИТТЯ У ХВОРИХ ПІСЛЯ ПЕРЕНЕСЕНОГО ГОСТРОГО ДЕСТРУКТИВНОГО ПАНКРЕАТИТУ

Казімзаде Дж. Р.

Резюме. Вивчено якість життя (ЯЖ) у 55 хворих після перенесеного гострого деструктивного панкреатиту (ГДП) за допомогою опитувальника MOS SF 36. Проведено аналіз впливу на ЯЖ обсягу і способу хірургічного лікування, обсягу ураження підшлункової залози і тяжкості перебігу захворювання, терміну після перенесеного панкреонекрозу і рецидивного перебігу панкреатиту. Виявлено, що підвищити ЯЖ дозволяє комплексний і індивідуальний підхід при лікуванні ГДП. На якість життя впливає як тяжкість стану, так і обсяг ураження підшлункової залози. При збільшенні терміну після перенесеного гострого деструктивного панкреатиту якість життя хворих зростає. Рецидиви захворювання значно знижують ЯЖ у цієї категорії хворих.

Ключові слова: панкреонекроз, хірургічне лікування, якість життя.

КАЧЕСТВО ЖИЗНИ У БОЛЬНЫХ ПОСЛЕ ПЕРЕНЕСЕННОГО ОСТРОГО ДЕСТРУКТИВНОГО ПАНКРЕАТИТА

Казимзаде Дж. Р.

Резюме. Изучено качество жизни (КЖ) у 55 больных после перенесенного острого деструктивного панкреатита (ОДП) при помощи опросника MOS SF 36. Проведен анализ влияния на КЖ объема и способа хирургического лечения, объема поражения поджелудочной железы и тяжести течения заболевания, срока

после перенесенного панкреонекроза и рецидивирующего течения панкреатита. Выявлено, что повысить КЖ позволяет комплексный и индивидуальный подход при лечении ОДП. На качество жизни влияет как тяжесть состояния, так и объем поражения поджелудочной железы. При увеличении срока после перенесенного острого деструктивного панкреатита качество жизни больных возрастает. Рецидивы заболевания значимо снижают КЖ у этой категории больных.

Ключевые слова: панкреонекроз, хирургическое лечение, качество жизни.

LIFE QUALITY OF PATIENTS AFTER ACUTE DESTRUCTIVE PANCREATITIS

Kazimzade J. R.

Abstract. *The aim of the research:* to evaluate the effectiveness of complex treatment of patients with pancreatic necrosis based on the study of quality of life in this category of patients.

Object and methods. In the long-term period, in patients after a previous ADP (observation period ranged from 4 months to 6 years), the quality of life of patients was studied using the MOS SF-36 questionnaire (Medical Outcomes Study 36-item short form health survey). It consists of 36 questions and includes eight scales representing the physical and psychological components of health. Answers to questions are expressed in scores from 1 to 100. A higher score corresponds to a higher level of QOL. Scales are combined in two groups according to the meaning of the questions. Two obtained total indicators characterizing physical (physical activity) and mental (emotional state) health give an idea of the status of QOL against the background of the disease. The Mental Health category (Mental Health) reflects the presence of neurotization, a tendency to depressive states, a feeling of happiness, peace, and peace of mind. These categories represent the psychological component of health. The study included patients (main group – MG) with previously confirmed, reliably diagnosed ADP (n = 55), as well as a clinical comparison group (CCG) – patients without pathology from the gastrointestinal tract (n = 20). The groups were comparable by age and gender. The results are presented as a median with upper (75%) and lower (25%) quartiles.

Results. The QOL indices in patients after the transferred ADP in almost all categories were significantly lower than in CCG. The components of QOL in first group were as follows: PF-85, RPF-70, BP-74, GH-75, VT-70, SF-72, REF-66.6, MH80. In SCS, the similar components of QOL are as follows: PF-95, RPF-85, BP84, GH-87, VT-80, SF-87.5, REF 84.3, MH-88. Thus, the physical component of health in patients after the transferred ADP is significantly lower in all categories, and the psychological component in this category of patients is significantly lower in the category of social functioning. In the study of QOL in patients after an ADP, we proceeded from the assumption about the likely impact on the outcome of the disease of the volume of damage to the pancreas and retroperitoneal space and the severity of the condition, as well as the method of surgical treatment and the period after the pancreatic necrosis.

It follows that QOL in patients of the first group is significantly lower in all categories of the physical component, but no significant differences were obtained in terms of the psychological component. When studying QOL, depending on the period after the transferred ODP, all patients were divided into three groups: the first group – up to 1 year, the second group – from 1 year to 3 years and the third group – patients after 5 years after the transferred ODP. The groups were comparable by age, gender, severity of the condition, as well as the volume of surgical intervention. Over time, these indicators increase and the highest values were found in patients of the third group. In addition, QOL was analyzed in patients with a recurrent course of pancreatitis. It was established that relapses of the disease (patients of the first group n = 24) significantly reduce both the physical and psychological components of QOL. Thus, the quality of life is significantly higher in patients who have undergone minimally invasive surgery. The quality of life is affected by both the severity of the condition and the degree of damage to the pancreas and parapancreatic fibers. With an increase in the period after acute destructive pancreatitis, the quality of life of patients increases. Relapses of the disease significantly reduce both the physical and psychological components of the quality of life in this category of patients.

Conclusion. A comprehensive and individual approach to the treatment of patients with acute destructive pancreatitis can improve the quality of life in the postoperative period.

Key words: pancreatitis, surgical treatment, quality of life.

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ПСИХО-ЕМОЦІЙНІ ЗМІНИ У ХВОРИХ НА МІАСТЕНІЮ

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Зв'язок публікації з плановими науково-дослідними роботами. Дослідження виконано у рамках науково-дослідної роботи «Клініко-нейрофізіологічні особливості формування нейромедіаторних порушень в клініці нервових хвороб», № державної реєстрації 0114U000929. Прикладна. Ініціативна.

Вступ. Міастенія – це хронічне неврологічне захворювання нервової системи, в основі якого лежить порушення нерво-м'язової передачі внаслідок ураження пост-синаптичної терміналі нервово-м'язових синапсів. В основі патогенезу міастенії лежить вироблення антитіл до рецепторів ацетилхоліну (AchR) або до м'язово-специфічної тирозин-кінази (MuSK). Крім того, існують вказівки на роль антитіл до титину та до SOX1 у розвитку міастенії [1-3].