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илмий-адабий манбалар, исм ва
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Summary. A thorough analysis of literary sources devoted to currently existing methods of treating patients with anomalies and deformations of the middle zone of the skull was carried out. The current aspects of unresolved issues are emphasized, mainly with the simultaneous movement of osteotomized

fragments of the maxillary complex. Issues of regenerative processes in the lamellar bone tissue of the middle zone of the facial skull are discussed.

Key words: occlusion anomaly, upper jaw, osteotomy, osteogenesis, distraction, regeneration.

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MODERN VIEW ON THE ETIOLOGY AND PATHOGENESIS OF ABSCESSES AND PHLEGMONS OF THE MAXILLOFACIAL AREA



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The problem of treating acute infection has remained the focus of attention of many clinicians and researchers for many years. Despite the improvement of surgical and drug treatment methods and the use of non-pharmacological agents, the number of patients with acute purulent-inflammatory diseases in maxillofacial departments ranges from 40 to 70% of the total number of hospitalized patients [3,5,7,10,16]. The use of modern methods in the treatment of periostitis, osteomyelitis, abscess and phlegmon of the maxillofacial area, such as: hyperbaric oxygenation, laser, ultrasound, ozone, administration of antibiotics intravenously, intraarterially, through the lymphatic tract, significantly increased the therapeutic effect, but did not allow to avoid complications in the form of meningitis, vein thrombosis face, sepsis. Complications with phlegmon of the maxillofacial area are observed in approximately 2-7% of cases. In addition, there is a tendency to increase the number of patients with an atypical course of the disease, a tendency to progression and generalization of the process [1,2,6,11].

In terms of age, there are two peaks in the incidence of abscess and phlegmon of the maxillofacial area: 9-12 and 20-35 years [4,8,11].

The first peak occurs during the period of mixed dentition, when the intensity of damage to primary molars is combined with a high susceptibility to caries of the first molars. The second peak is associated with an increase in the intensity of caries in permanent teeth and frequent complications during the eruption of lower permanent teeth [9,12,14].

The infectious process is a manifestation of a macroorganism and microorganisms. The course of the inflammatory process depends on indicators of the body's reactivity, determined by the action of acute phase proteins, cytokines, the activity of the phagocyte system, the state of specific resistance mechanisms, hereditary factors, coagulation, and antioxidant systems of the body. The molecular and cellular mechanisms of the immune system play a significant role in the pathogenesis of inflammation. The choice of treatment

tactics and prevention of local and general complications largely depends on the degree and nature of their changes [2,11,13].

In patients with purulent-inflammatory diseases of the maxillofacial area, 3 immunological variants of the course of the inflammatory process are distinguished: normergic, hyperergic and hypoergic. The normergic type is characterized by an adequate response of the body to inflammation and is compensatory in nature. Immunological parameters are normal, but if immunological reactions are low, inflammation from a protective reaction turns into a pathological one and proceeds as hypo and hyperergy. Studying the immunogram parameters of A.I. Volozhin (1996) noted an increase in the phagocytic activity of leukocytes by 2-4 times, and concluded that the immune reactions in some patients were inferior.

Moreover, if the normergic inflammatory reaction proceeds within normal limits, that is, the number of T and B cells remains within normal limits. With a hyperergic reaction, which accounts for approximately 16.5% of all cases of purulent-inflammatory diseases of the maxillofacial area, the introduction of opportunistic microorganisms is observed, which contributes to chronic endogenous intoxication.

Recently, works have appeared devoted to changes in the parameters of mucosal immunity in patients with purulent-inflammatory diseases of the maxillofacial area. In particular, A.M. Ahmed (2012) revealed a dissonance in the indicators of nonspecific resistance of the oral cavity in patients with diffuse inflammation, an increased salivary level of peroxidase against the background of a reduced content of lysozyme, acid and alkaline ribonuclease, while in patients with limited purulent processes, the levels of ribonuclease were determined to be normal.

The significant role of lipid peroxidation (LPO) in the pathogenesis of purulent-inflammatory processes in the maxillofacial area has been proven. One of the reasons for the severe course of acute osteomyelitis, complicated by phlegmon of the maxillofacial area, is the activation of LPO against the

background of a decrease in the activity of the antioxidant system. A change in the ratio of biochemical inflammatory factors (pro-oxidants) and antioxidants that regulate the normal course of redox processes characterizes metabolic disorders in wound tissues, which leads to a weakening of repair processes. Intensification of LPO, disruption of the metabolism of microelements due to a decrease in the stock and activity of the antioxidant system cause tissue damage during the phase of purulent inflammation, which determines the severity of the disease [4,9,14,15,17].

Another important component in the development of a purulent-inflammatory process is the microbial factor. In case of infection, a mixed flora is sown from the lesion: 65% anaerobic microorganisms, 35% aerobic. The most frequently identified are obligate gram-negative anaerobes (*Bacteroides* spp, *Fusobacterium* spp), anaerobic gram-positive bacteria (*Peptostreptococcus* spp) and facultative anaerobic gram-positive streptococci (*Streptococcus milleri*). Other infectious agents include *Lactobacillus* spp, *Diphtheroides* spp, *Actinomyces* spp, *Eilinelles* spp. Features of the microflora with phlegmon and abscesses were revealed: with phlegmon, mixed flora predominates (78.3%), and aerobes are sown only in 21.7%; in abscesses, only anaerobic microflora is determined in 62.5%; in the remaining observations, associations of aerobes and anaerobes are detected.

It is considered a proven fact that the penetration of pathogens of purulent infection into the tissues of the body does not mean the inevitable occurrence of an infectious-inflammatory process, assessed as a disease. The "clinically significant concentration" of microorganisms, which takes into account intermicrobial associations, localization of the process and tissue resistance, is of decisive importance. The accepted level of "critical concentration" is considered to be 105 colony-forming units per 1 ml of exudate (CFU/ml). However, according to some authors, the quantitative composition of the microflora of a purulent wound of patients with phlegmon depends on the type of inflammatory reaction

of the macroorganism. A number of researchers note that for a purulent complication to occur, the etiologically significant concentration of the pathogen can be no more than 103 CFU/ml.

Yes, G.L. Ter-Asaturov (2005), having morphologically examined soft tissue biopsies with phlegmon, concluded that: 1) inflammatory diseases resulting from exacerbation of chronic periodontitis (abscesses and phlegmon) develop against the background of previous chronic nonspecific inflammation and are a consequence of its exacerbation, and not an independent disease, 2) the occurrence of secondary foci of productive inflammation in chronic periodontitis, as well as the primary result of an immunopathological reaction. Damage to nonspecific and specific protective factors is considered possible conditions for its occurrence [3,5,12,17,18].

The severity of the general condition of the patient with extensive localization of the inflammatory process is determined by the high intoxication of the body, while the danger of phlegmon of the maxillofacial area is determined by both the proximity of vital formations and the anatomical and topographical features of this area, which contribute to the spread of the inflammatory process. In this case, the mediastinum, orbit, and sinuses of the dura mater are affected.

If, with an abscess, tissue compaction is observed, which is accompanied by swelling of the face and neck and, if the purulent process is located in the pterygomandibular and peripharyngeal spaces, in the cripopalatine and infratemporal fossae, then one can often observe a symptom of fluctuation, which arises as a result of the presence of pus enclosed in the cavity with elastic walls, which transmits shocks from one wall to all directions [4,12,13].

A feature of an abscess as a purulent process is the presence of a pyogenic membrane - the inner wall of an abscess lined with granulation tissue, therefore clinical symptoms of intoxication may be absent or mildly expressed. Moreover, the ability of the surrounding soft tissues to create a granulation shaft is a normal protective reaction of the body, aimed at isolating a purulent lesion, but if the

process is not treated, then diffuse purulent inflammation develops - phlegmon, which can be located under the skin, mucous membrane, between muscles and fascia. The threat of developed phlegmon of the maxillofacial area is a high degree of intoxication, affecting the functioning of the body's systems, as well as the development of severe and dangerous complications, such as sepsis, toxic-infectious shock, septic meningoencephalitis, brain abscess, thrombosis of cerebral vessels, septic endomyocarditis. Depending on the ratio of the main components of the inflammatory reaction, phlegmon with a predominance of exudation (serous, purulent) and phlegmon with a predominance of alteration (purulent-necrotic) are distinguished. The first type is characterized by pronounced swelling of the tissue with diffuse infiltration of leukocytes; in addition, in the affected tissue there are multiple areas of tissue necrosis with signs of purulent melting. There is no clear demarcation zone for the spread of the infectious process. With purulent-necrotic phlegmon, the leading picture of inflammation is necrotic changes in the form of confluent areas of necrosis of fiber, fascia and sometimes adjacent muscles. There are multiple areas of hemorrhage; severe swelling is accompanied by moderate cellular infiltration. The course and outcome of purulent inflammatory diseases largely depend on the immunological reactivity of the patient's body. The clinical course of maxillofacial phlegmon can be different in the severity of inflammation symptoms: hyperactive (with the development of severe local and general manifestations), moderately active, hyporeactive (long-term, sluggish, without significant general and local manifestations). The likelihood of an infectious-inflammatory process depends on the virulence of the pathogen (pathogenic properties of microorganisms and their quantity), as well as on the state of the nonspecific antimicrobial resistance system and the level of immunological reactivity of the macroorganism. A number of lysosomal enzymes are released from damaged cells: proteolytic, glycolytic, lipolytic. These enzymes, in turn, damage cell membranes and such structural components of connective tissue

as collagen, proteoglycans, and glycosaminoglycans [5,8,9,14].

It is known that the development and outcome of infection is influenced by the state of the body's immunological reactivity. The features of immunological phenomena that arise with the participation of resident microflora activated in the pathological focus remain poorly understood. Microbiological and immunological changes are in constant interaction. The first line of defense is the phagocytic function of neutrophils. The index of digestion of the bacterial agent indicated the disorder itself in neutrophils in the majority of patients with abscesses and phlegmons of the maxillofacial area. At the same time, the phagocytosis completion index was absent in more than 80% of those examined. Consequently, phlegmon develops against the background of insufficiency or dysfunction in humoral and cellular factors of immunological indicators.

According to various authors, sources of infection in the maxillofacial area can be:

1. Foci of acute, chronic apical, or marginal periodontitis, odontogenic periodontitis and periostitis of the jaws.

2. Acute or chronic diseases of the oral mucosa

3. Acute sinusitis, sinusitis, frontal sinusitis

4. Acute mumps, tonsillitis, adenoid diseases

5. Acute otitis, perichondritis, mastoiditis, epitympanitis.

6. Boils, carbuncles, erysipelas. Most authors note that in different categories of patients, phlegmon occurs differently. Some patients may experience a violent reaction spreading to surrounding tissues and the vascular system with the formation of thrombosis, diffuse edema, involvement of lymph nodes in the process and the development of severe general intoxication, which can lead to death.

Here we are talking about a hyperergic reaction.

In another category of patients, the process may proceed more slowly, the general reaction of the body is expressed in a slight increase in temperature, changes in the composition of peripheral blood have an adequate character. Having carried out a comparative analysis of the

inoculation of microbial cultures in abscesses and phlegmons, many authors note that in abscesses aerobic (94.5%), anaerobic (5.5%), monocultures are more common (92.7%) than their associations (3%). Among aerobes, the most common are *Staphylococcus aureus* (52.9%), epidermal (19.7%), *Staphylococcus*, less commonly *Streptococcus* (11.8%), intestinal (5.9%), *Pseudomonas aeruginosa* (5.9%), *Proteus* (3.8%). Gram-negative anaerobes (*Veillonella*, *Bacteroides*) were found only in associative relationships with aerobic microbes. With phlegmon, the inoculation rate of microbes was slightly different from that in abscesses, since not only aerobes (78.8%) were found, but also anaerobes (21.2%). Microorganisms were found both in monoculture (67.5%) and in associations (32.5%). Moreover, if in monoculture there were 56.7% aerobes, 8.8% anaerobes, then in associations there were 20.0% aerobes, 2.5% anaerobes, 10.0% aerobes and anaerobes). Aerobes were represented by *Staphylococcus aureus* and *Staphylococcus epidermidis*, *Escherichia coli*, hemolytic *Streptococcus*, *Enterococcus*, *Proteus* and *Diplococcus*. Among the anaerobes there were gram-negative (*Veillonella*, *Bacteroides*) and gram-positive (*Peptostreptococci* and *Eubacteria*). In monoculture, *Staphylococcus aureus* and *Staphylococcus epidermidis*, *Veillonella*, *Peptostreptococcus* and *Eubacteria* are sown [4,7,16,18].

Determination of antibiotic sensitivity showed that monocultures of staphylococci sown in patients with limited inflammatory diseases of soft tissues exhibit sensitivity to most of their studied antibiotics.

Thus, the cause of the development of abscesses and phlegmons in childhood are staphylococci and streptococci. The mechanism for the emergence of acute abscesses and phlegmons consists of modified macrophages, T-, B-cells of the immune system.

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- Аннотация.** Анализ литературы, посвященной проблемам лечения инфекции челюстно-лицевой области у детей, показал, что необходимо дальнейшее изучение и разработка новых способов прогнозирования характера течения и повышения эффективности лечения. Сформулировано представление о этиологии и патогенезе гнойно-воспалительных заболеваний челюстно-лицевой области у детей, необходимости разработки новых лечебных мероприятий по борьбе с гнойными заболеваниями у детей.
- Ключевые слова:** гнойно-воспалительные заболевания, челюстно-лицевая область, этиология, патогенез.
- Annotatsiyasi.** Bolalarda maxillofasiyal infektsiyalarni davolash muammolariga bag'ishlangan adabiyotlarni tahlil qilish shuni ko'rsatdiki, kursning tabiatini bashorat qilish va davolash samaradorligini oshirishning yangi usullarini yanada o'rganish va ishlab chiqish zarur. Bolalarda jag'-jag' sohasining yiringli-yallig'lanish kasalliklarining etiologiyasi va patogenezi, bolalarda yiringli kasalliklarga qarshi kurashning yangi terapevtik chora-

tadbirlarini ishlab chiqish zarurligi haqida fikr shakllantirildi.

Kalit soʻzlar: yiringli-yalligʻlanish kasalliklari, yuz-jagʻ sohasi, etiologiyasi, patogenezi.

Summary. An analysis of the literature devoted to the problems of treating infections of the maxillofacial area in children has shown that further study and development of new ways

to predict the nature of the course and improve the effectiveness of treatment are necessary. An idea has been formulated about the etiology and pathogenesis of purulent-inflammatory diseases of the maxillofacial area in children, the need to develop new therapeutic measures to combat purulent diseases in children.

Key words: purulent-inflammatory diseases, maxillofacial area, etiology, pathogenesis.

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РАННЕЕ ОРТОДОНТИЧЕСКОЕ ЛЕЧЕНИЕ ДЕТЕЙ С ДВУСТОРОННЕЙ РАСЩЕЛИНОЙ ВЕРХНЕЙ ГУБЫ И НЁБА



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Дети с расщелиной губы и неба (РГН) нуждаются в комплексном лечении с участием педиатра, ортодонта, челюстно-лицевого хирурга, отоларинголога, логопеда, врача-генетика и других специалистов [2,5,6,9,14,16].

В последние годы накоплен большой опыт по совершенствованию методов хирургического лечения РГН, разработаны новые виды операций, изменен подход к возрастным показаниям к лечению, усовершенствована ортодонтическая помощь, развивается и внедряется медико-генетическое обследование (Старикова Н.Б.). Возросли значение и роль психолого-педагогической работы с семьями, имеющими детей с врожденной расщелиной. Однако, как отмечают некоторые авторы, эти работы освещают в основном положительный опыт по сказанию помощи таким детям [1,10].

Анализ результатов клинического и рентгенологического обследования больных разных возрастных групп выявил наиболее характерные нарушения роста лицевого че-

репа для каждой из этих групп (Катасонова Е.С., 2012). Считают, что поэтапный комплексный подход и своевременное прогнозирование роста и возможных деформаций лицевого скелета позволяют выработать определенный алгоритм действий врача-ортодонта на различных этапах реабилитации больных.

Двусторонняя расщелина верхней губы, альвеолярного отростка, твердого и мягкого неба является наиболее сложной из всех врожденных пороков челюстно-лицевой области (ЧЛЮ). Для двусторонней РГН характерны разделение верхнечелюстной дуги на три сегмента: межчелюстная кость и два фрагмента челюсти (правый, левый). Кроме того, имеет место анатомический дефект твердого и мягкого неба на всем протяжении, разобщение круговой мышцы рта, недоразвитие центрального фрагмента верхней губы, врожденное укорочение или отсутствие кожной части перегородки носа, различная степень протрузии межчелюстной кости