

## PREVENTION AND TREATMENT OF COXILESIS DISEASE

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### *Resume,*

According to the literature, the main role in the formation of clinical manifestations of coxyellosis is played by changes in immunity.

The relevance of the study of coxiellosis lies in its wide spread, polymorphism of clinical manifestations that complicates the diagnosis, the possibility of the formation of hepatitis and pneumonia, subacute and chronic forms of the disease.

Although significant progress has been made in the study of coxiellosis in recent years, the pathogenesis of this disease has not yet been sufficiently clarified.

**Keywords:** coxiellosis, prevalence, epidemic, clinical and laboratory manifestations.

## ПРОФИЛАКТИКА И ЛЕЧЕНИЕ БОЛЕЗНИ КОКСИЛЕЗА

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### *Резюме,*

По данным литературы основную роль в формировании клинических проявлений коксипеллеза играют изменения иммунитета.

Актуальность изучения коксиселлеза заключается в его широкой распространенности, полиморфизме клинических проявлений, затрудняющем постановку диагноза, возможности формирования гепатита и пневмонии, подострой и хронической форм болезни.

Хотя в последние годы произошел существенный прогресс в изучении коксиселлеза, патогенез этого заболевания еще недостаточно выяснен.

**Ключевая слова:** коксиселлез, распространенность, эпидемия, клинико-лабораторные проявления.

## **KOKSILEZNI KASALLIGINI TARQALISHI OLDINI OLISH VA DAVOLASH**

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### ***Rezyume,***

Adabiyotlardan olingan ma'lumotlarga binoan, koksellyozning klinik ko'rinishlarini shakllantirishda immunitetning o'zgarishi asosiy rol o'ynaydi.

Koksiellyozni o'rganishning dolzarbligi uning keng tarqalishi, tashxisni murakkablashtiradigan klinik ko'rinishlarning polimorfizmi, gepatit va pnevmoniya, kasallikning o'tkir va surunkali shakllarini yuzaga keltirishi imkoniyatidir.

Tadqiqotda sezilarli yutuqlarga erishilgan bo'lsada koksiellyozni so'nggi yillarda patogenezi hali etarlicha aniqlanmagan.

**Kalit so'zlar:** koksiellyoz, tarqalishi, epidemiyasi, klinik va laboratoriya ko'rinishlari.

**Introduction.** Coxiellosis (Ku fever) - acute rickettsiosis disease from the group of natural focal zoonoses, characterized by various transmission routes,

general intoxication and polymorphism of clinical manifestations. The causative agent is the gram-negative intracellular bacterium *Coxiella burnetii*. This is one of those rare diseases when, with aerogenic infection, one microorganism can lead to illness [2,5]. In all ways of infection, the pathogen enters the bloodstream, multiplies in the vascular endothelium and causes the development of general intoxication. Unlike other rickettsioses, the pathogen multiplies not only in the vascular endothelium, but also in histiocytes and macrophages of the reticuloendothelial system [4].

The pathogen can persist in the human body for a long time, which explains the possibility of a prolonged and chronic course of coxiellosis. 50-60% of patients infected with coxiellosis are asymptomatic.

The incubation period ranges from 3 to 40 days. More than 30 symptoms characteristic of this rickettsiosis have been described [3]. The polymorphism of clinical manifestations of coxiellosis is determined by the mechanism of transmission, the primary infectious dose of rickettsia and the level of the body's defenses [1].

**The purpose of the study.** To determine the clinical, pathogenetic and prognostic significance of immunological and biochemical markers in patients with coxiellosis for optimizing therapy.

**Materials and methods of research.** Our study showed differences in the distribution of patients by age (under 50 and over 50) and gender. In both groups, men were sick more often than women ( $p = 0.001$ ), which corresponds to the data of other researchers. Although the exact causes of this spread are unknown, it is assumed that sex hormones play a role.

**The results of the study.** Our research has shown that coxiellosis is observed continuously throughout the year with a gradual increase in April-July (60.1%), that is, in the spring-summer period of exacerbation.

The epidemiological history showed that 136 patients (41.5%) lived in rural areas, and 190 people (58.3%) lived in the city, that is, the city's population is 1.4

times larger than that of the rural population with coccellosis ( $p < 0.01$ ). At the same time, the population of 77 cities (23.6%) had dachas.

The uneven territorial spread of coccyellosis is undoubtedly related not only to the degree of activity of natural and anthropogenic foci of infection, but also to the real possibility of their detection. Thus, 91 patients (27.9%) are temporarily unemployed, 41 patients (12.6%) are workers, 36 people (11.0%) are retired, 34 patients (10.4%) are drivers of vehicles, 13 patients (3.4%) are security guards, 12 patients (3.7%) are medical staff.

The remaining 99 patients (30.7%) had different professions: police officers, heads of firms and enterprises, engineers, entrepreneurs, border guards, fishermen, teachers.

Polymorphism of transmission pathways was noted. Given the place of residence of all the examined patients in the endemic focus of coxiellosis, there was a high probability of aerogenic infection. Infection in 59.8% of cases can occur with alimony. So, 119 patients (36.5%) consumed homemade dairy products, 10 people (3.0%) – pasteurized milk, 67 patients (20.2%) – meat (shish kebab), which was not sufficiently heat-treated. In 54 patients (16.5%) who recorded the absorption or removal of ticks, transmission of coxiella infection was possible. The transfer can be carried out in 28 patients (8.6%) who often go fishing by water. 69 patients (21.1%) saved their pets: cattle, rabbits, hamsters, poultry, dogs and cats, both large and small.

Compared to the data from a decade ago [38], there have been changes in the transmission pathways of coxiella. In modern conditions, the transmission pathways of Coxiella Burnet are alimentary and were observed 1.7 times more often during transmission 4.3 times more often. Patients with coxiellosis received an average of 6.2 days, with a disease duration of more than 0.2 days, and they often had the symptoms shown in Figure 3. One of the leading signs was fever (326 people). The majority of patients had remitting fever (280 people, 85.4%), rarely acute fever (34 people, 10.4%) and persistent fever (12 people, 4.3%). The

duration of the fever period ranged from 5 to 35 days and averaged 13.5, respectively, 0.8 days. Fever lasting 1 week was reported in 100 patients (30.5%), after 2 weeks – in 163 patients (50.0%). In 25 patients (7.6%) with coxiellosis, fever duration was observed for 3 weeks, in 38 patients (11.7%) fever was observed for 4-6 weeks. At the beginning of the disease, the temperature in patients increased to 39-40C, an average of 13.0 degrees Celsius on day 0.5, the temperature decreased to subfebrile levels.

Intoxication involved the relevant parts of the nervous system in this process, which was observed in 315 people with weakness, headache in 266 patients, muscle pain in the upper and lower extremities and lower back in 225 patients. A decrease in appetite was observed in 138 patients.

Fever was accompanied by chills in 165 patients, sweating was observed in 54 patients (16.6%). Hyperemia of the oropharyngeal mucosa was observed in 204 patients, while hepatomegaly was observed in half of the patients.

The presence of hepatomegaly does not always characterize the degree of liver damage, a violation of its functions, since an enlarged liver can function normally. 152 patients (46.6%) had ssle, 127 had joint pain. 90 patients complained of coughing, dryness or sputum production, pain or tightness in the chest. At the same time, auscultation was performed on dry wheezing in 156 patients (47.8%) with heavy breathing. Although damage to the cardiovascular system was noted in the form of tachycardia in 213 (65.3%) and bradycardia in 25 (7.7%), some clinicians noted the presence of bradycardia in the predominant number of patients with coxiellosis [38, 119, 154]. Arterial hypotension was detected in 78 (23.9%) patients, and tonal or deaf heart tones were detected in 91 (27.9%) patients. K. M. Loban (2002) believes that toxicosis in coxiellosis is a consequence of the causal action of N-terminals. disorders of the metabolic processes of the myocardium, leading to the development of changes in the vagina and its nuclei, are also assessed in clinical practice as an "infectious heart". 49

patients complained of dull abdominal pain localized in the epigastrium and right hypochondrium.

In 57 patients (17.5%), pain in the epigastrium and right hypochondrium was noted on palpation. In 60 patients, yellowing of the mucous membranes and skin was noted, which indicated a violation of bilirubin metabolism due to the development of hepatitis. Intoxication syndrome manifested itself in 48 patients with nausea, which was accompanied by vomiting in 28 people. 19 patients developed hemostatic disorders, manifested by bleeding from the gums, nosebleeds and hematomas at the injection sites. In 18 patients with coxiellosis, exanthema was detected on the 3rd-16th day of the disease in the form of localized lesions, lesions of papular and hemorrhagic elements in the upper and lower extremities, back, chest and tail.

The age of patients with subacute coxiellosis was 1.2 times higher than the age of patients with the acute form (47.1 years and 1.8 years and 39.9 years and 3.8 years,  $p < 0.001$ ). The duration of the disease in the subacute form was 2.1 times higher than in the acute form ( $p < 0.001$ ). As can be seen from Table 10, in patients with the subacute form of the disease, fever was observed 2.4 times, weakness and arthralgia 2.3 times, chills, sweating, myalgia and decreased appetite 2.2 times, cough 2.1 times, headache 2 times, hyperemia of the oropharyngeal mucosa and multiple sclerosis 1.9 times. compared with patients with acute coxiellosis, conjunctivitis, hepatomegaly 1.8 times, abdominal pain 1.7 times, jaundice 1.6 times, nausea 1.5 times.

**Conclusion.** Thus, these studies have shown that the current course of coxiellosis in the Andijan region is still accompanied by a polymorphism of clinical manifestations of this disease. The detection of various clinical symptoms depends on the patient's gender, the duration of which depends on the patient's age. In recent years, in addition to tetracycline-type drugs, a number of alternative antibacterial drugs have been used as etiotropic therapy for the treatment of

coxyellosis. It has been shown that etiotropic and pathogenetic therapy, if necessary, should be carried out in parallel with immunocorrection.

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