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ЖУРНАЛ ГЕПАТО-ГАСТРОЭНТЕРОЛОГИЧЕСКИХ ИССЛЕДОВАНИЙ

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ANTIBACTERIAL TREATMENT OF ACUTE BACTERIAL DISEASES OF THE UPPER RESPIRATORY TRACT IN CHILDREN

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ANNOTATION

In acute respiratory viral infections (ARVI) in children, antibacterial therapy is required in only 6-8% of cases accompanied by bacterial complications. This article discusses only lesions of the upper respiratory tract and some types of bronchitis (caused by mycoplasma and chlamydia), for which the use of antibacterial agents is indicated. Unfortunately, the frequency of prescribing antimicrobial drugs to children with ARVI significantly exceeds this figure, reaching 65-85% in outpatient clinics and 98% in hospitals, with antibacterial agents administered parenterally in more than 40% of outpatient clinics and 70% in hospitals [1,2]. With this approach, there are 39 injections per inpatient with uncomplicated ARVI (laryngitis, bronchitis), and 74 per patient with acute pneumonia.

Key words: respiratory viral infection, antibacterial agents, children.

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АНТИБАКТЕРИАЛЬНОЕ ЛЕЧЕНИЕ ОСТРЫХ БАКТЕРИАЛЬНЫХ ЗАБОЛЕВАНИЙ ВЕРХНИХ ДЫХАТЕЛЬНЫХ ПУТЕЙ У ДЕТЕЙ

АННОТАЦИЯ

При острых респираторно-вирусных инфекциях (ОРВИ) у детей антибактериальная терапия требуется всего в 6-8% случаев, сопровождающихся бактериальными осложнениями. В настоящей статье рассматриваются только поражения верхних дыхательных путей и некоторые виды бронхитов (вызванные микоплазмой и хламидиями), при которых показано назначение антибактериальных средств. К сожалению, частота назначения противомикробных препаратов у детей с ОРВИ существенно превышает эту цифру, достигая в поликлиниках 65-85% и в стационарах - 98%, причем антибактериальные средства в поликлинических условиях парентерально вводят более чем в 40%, а в стационарах - в 70% случаев [1,2]. При таком подходе на одного стационарного больного с неосложненной ОРВИ (ларингит, бронхит) приходится 39 инъекций, а на одного больного острой пневмонией - 74.

Ключевые слова: респираторно-вирусная инфекция, антибактериальные средства, дети.

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BOLALARDA YUQORI NAFAS YULLARINING O'TKIR BAKTERIAL KASALLIKLARINI ANTIBAKTERIAL DAVOLASH

ANNOTASIYA

Bolalardagi o'tkir respirator virusli infeksiyalarda (ARVI) bakterial asoratlar bilan kechadigan atigi 6-8% hollarda antibakterial terapiya talab qilinadi. Ushbu maqolada faqat yuqori nafas yo'llarining infeksiyalari va antibakterial vositalar ko'rsatilgan bronxitning ayrim turlari (mikoplazma va xlamidiya sabab bo'lgan) muhokama qilinadi. Afsuski, o'tkir respiratorli virusli infeksiyalari bo'lgan bolalarga mikroblarga qarshi dori-darmonlarni buyurish chastotasi bu ko'rsatkichdan sezilarli darajada oshadi, ambulatoriyalarda 65-85% va shifoxonalarda 98% ga etadi, antibakterial vositalar 40% dan ko'prog'ida parenteral yuboriladi. Ushbu yondashuv bilan asoratlanmagan o'tkir respirator virusli infeksiya (larinit, bronxit) bilan kasallangan bemorga 39 ta, o'tkir pnevmoniya bilan kasallangan bemorga 74 ta in'ektsiya to'g'ri keladi.

Kalit so'zlar: respirator virusli infeksiya, antibakterial vositalar, bolalar.

It is obvious that in case of viral etiology of the disease, antibiotics are at least useless, and most likely harmful due to the disruption of the respiratory tract biocenosis and their colonization by flora that is not

typical for this biotope, most often intestinal flora [3]. In addition, one should always keep in mind the significant risk of allergic reactions to antibiotics. Of course, this situation needs to be changed, most likely

based on the development of rational recommendations for antibacterial treatment of children with acute respiratory diseases and their strict implementation in practice.

Diagnostic criteria for bacterial complications of acute respiratory viral infections. If there is an obvious source of bacterial inflammation in a child with ARVI, the diagnosis is simple; the following can be used as diagnostic criteria.

Tonsillitis. Hyperemia and swelling of the pharynx and tonsils, purulent plugs or plaque. Most pharyngitis in young children is caused by viruses (adeno-, enteroviruses), but with age, the proportion of pharyngeal infections caused by hemolytic streptococcus group A increases, which are fraught with immunopathological changes, in particular rheumatism.

A reliable criterion for diagnosing bacterial tonsillitis is the isolation of (β -hemolytic streptococcus group A from the pharynx; this study, unfortunately, is not carried out everywhere in Uzbekistan. According to clinical data, pharyngitis of this etiology is reliably diagnosed with scarlet fever or a similar picture of the pharynx, in other cases the diagnosis is presumptive and requires bacteriological confirmation. The main goal of antibacterial therapy is the elimination of streptococcus for the prevention of rheumatism, this treatment does not always affect the clinical manifestations of pharyngitis (possibly due to a combined infection with viruses).

Otitis media. Ear pain, high temperature, often symptoms of intoxication, discharge from the ear. The diagnosis is made based on clinical data, confirmed by otoscopy. In the etiology of otitis, pneumococcus is in the first place, less often otitis is caused by non-capsular *Haemophilus influenzae* or *Moraxella catharralis*. *Staphylococcus* and *Pseudomonas aeruginosa* usually cause otitis in children with immune deficiency (prematurity, severe illness).

Non-purulent sinusitis. Radiographic and echographic signs of sinusitis (darkening of the paranasal sinuses) are detected in 70% of children with respiratory viral infection; these conditions do not require antibacterial treatment [4]. The diagnosis of non-purulent bacterial sinusitis is made if these changes persist for more than 3 weeks and there are clinical manifestations in the form of a long-lasting runny nose, nasal congestion, and mild pain in the sinus area.

The main pathogens are *S. pneumoniae*, *Haemophilus influenzae*, less often *Staph. aureus* (purulent sinusitis!) or *Moraxella catharralis*. Purulent sinusitis. Usually, acute staphylococcal sinusitis is characterized by high temperature, intoxication, swelling of the cheek and periorbital tissues.

Lymphadenitis. Enlargement and soreness of the lymph node (usually tonsillar), often with swelling of the surrounding tissue, with fluctuation in case of suppuration.

Etiology - streptococcal, rarely - staphylococcal.

Acute bronchitis. Cough, dry and various-sized moist rales, in the absence of infiltrative or focal changes in the lung tissue on the radiograph. Most acute bronchitis (85-95%) has a viral etiology, so the use of antibacterial agents is not required. The use of these drugs in the late stages of bronchitis with increased sputum discharge (often greenish) is also not justified.

In 5-15% of cases in preschool and school-age children, especially in the autumn, bronchitis caused by *Mycoplasma pneumoniae* is observed, they are characterized by an abundance of fine bubbling rales and their asymmetry, as well as the presence of conjunctivitis (without abundant effusion). Bronchitis in children aged 0-5 months can be caused by *Chlamidia trachomatis*, in adolescents - *C. pneumoniae*; their frequency is not exactly known, but there is reason to believe it is small. Bacterial bronchitis is observed in infants with habitual food aspiration syndrome, usually accompanying aspiration pneumonia. Bacterial descending tracheobronchitis is observed as a complication of croup (during intubation).

These data show that antibacterial treatment of acute bronchitis is indicated in a small percentage of cases; to calculate the need, it can be assumed that it is necessary in 15% of cases.

Pneumonia. The presence of respiratory disorders of varying severity and characteristic physical changes (shortened percussion sound, bronchial or weakened breathing, fine-bubble moist rales over a limited area of the chest). Radiographic confirmation is based on the

detection of focal or infiltrative changes on the radiograph. This article does not consider the problem of treating pneumonia.

Suspected bacterial infection. In addition to diseases with an obvious bacterial focus based on clinical or paraclinical data, in practice there are often cases in which, despite the absence of an obvious focus (with the available "depth" of examination), it is not possible to exclude a bacterial infection. The category of patients with acute respiratory viral infections with a reasonable suspicion of a bacterial infection, including pneumonia (in the absence of obvious symptoms during examination) includes children with one or more of the following signs:

- temperature above 38°C for more than 3 days;
- dyspnea: with 60 or more breaths per 1 min in children 0-2 months, 50 or more in children 3-12 months and 40 or more in children 1-3 years in the absence of bronchial obstruction;
- retraction of compliant parts of the chest or grunting breathing in the absence of bronchial obstruction;
- severe toxicosis;
- leukocytosis - more than 12,000 in 1 μ l, shift of the formula to the left, ESR more than 20 mm / h.

Sensitivity of pneumotropic flora. In many countries of the world over the last decade there has been an increase in the resistance of pneumococci circulating among the population to penicillin, reaching 40-50% of all isolated strains in southwestern European countries [5]: our observations have shown the absence of such a trend in Moscow. All penicillins, macrolides lincomycin, cephalosporins are highly active against this pathogen; aminoglycosides and tetracycline are practically inactive. Based on our own 15-year observations, we can say that the sensitivity of *Haemophilus influenzae* (both capsular and non-capsular) to ampicillin and azithromycin, doxycycline and tetracycline, aminoglycosides, 2nd and 3rd generation cephalosporins, rifampicin also remains at a fairly high level.

In relation to this pathogen, however, we observe a decrease in sensitivity to penicillin and first-generation cephalosporins (cephalexin, cefazolin), erythromycin; many strains of this pathogen turned out to be insensitive to second-generation macrolides and resistant to lincomycin, oxacillin, oleandomycin. Hemolytic streptococcus group A retains high sensitivity to all antibiotics except aminoglycosides. Nevertheless, the use of many drugs often gives unsatisfactory results, which is associated with the inactivation of penicillins and other lactam drugs by lactamase secreted by the flora accompanying streptococcus (*hemophilus*, *moraxella*, *staphylococci*) [6]. Streptococci of other groups are sensitive to oxacillin, 2nd-3rd generation cephalosporins, lincomycin and rifampicin, and somewhat less sensitive to other penicillins and macrolides.

Moraxella (*Branchamella*) *catharralis*, even if it does not cause an inflammatory process, is capable of producing lactamase and worsening the results of treatment, for example, of streptococcal pharyngitis with penicillins.

Strains of this pathogen are highly sensitive to macrolides, 2-3rd generation cephalosporins, aminoglycosides and rifampicin, but are resistant to penicillins and lincomycin.

Community-acquired strains of *Staphylococcus aureus* in 1995-1996 were characterized by a fairly high percentage of resistance to cephalexin (43%), cefaclor (30%), ceftibuten (92%), oxacillin (28%) and a small percentage (12-15%) to erythromycin and oleandomycin. In children with recurrent sinusitis and otitis and in those previously treated with antibiotics, one can expect resistance of flora (especially *Haemophilus influenzae* and *Moraxella*) to antibiotics, which must be taken into account when choosing initial therapy.

Antibacterial treatment of respiratory diseases

Recommendations for the treatment of bacterial ARIs with antimicrobial agents are presented in the table.

Acute pharyngotonsillitis. In the treatment of streptococcal pharyngotonsillitis, the main goal is the persistent elimination of group A streptococcus, which creates the risk of developing rheumatism. Bacteriological control is desirable not only after 10 days of treatment, but also after 4-6 weeks, when bacteriological relapses are often observed.

In order to eliminate the pathogen, most antibiotics are used to which this pathogen is sensitive (except for aminoglycosides). Contrary

to previous recommendations on the need for parenteral administration of penicillin in such patients, the sanitizing effect of oral drugs has been proven, in particular, penicillin 50 mg/kg/day, amoxicillin 40

mg/kg/day or macrolides: oleandomycin 250 - 1000 mg/day or erythromycin - 30 mg/kg/day (but not more than 1.5 g/day). Duration of treatment is at least 10 days.

Antibiotics for bacterial infections of the upper respiratory tract

Form	Exciter	Starter drug	Replacement if ineffective
Acute otitis media	S. pneumoniae, H. influenzae, less often S. aureus	Orally phenoxymethylpenicillin (FMP), amoxicillin: erythromycin, other macrolides	Orally co-amoxiclav, cephalosporin 2-3rd generations orally, intramuscularly
Acute non-purulent sinusitis	S. pneumoniae, H. influenzae	Orally FMP, amoxicillin: erythromycin, other macrolides	Orally amoxicillin/clavulanate (AMC/CL), 2nd-3rd generation cephalosporin orally, intramuscularly
Sinusitis purulent	S. aureus	Intravenous oxacillin or cefazolin + gentamicin	Lincomycin or vancomycin intramuscularly or intravenously
Otitis, recurrent sinusitis, treated with antibiotics	Resistant S. aureus, less commonly Moraxella catarrhalis H. influenzae	Orally co-amoxiclav, orally or intramuscularly cephalosporin 2-3rd generation	Intramuscular oxacillin, intramuscular cephalosporin 1-3rd generation + gentamicin
Acute tonsillitis	Str. pyogenes (b-hemolytic, group A)	Orally FMP, macrolides, cephalexin 10 days, cefuroxime axetil, cefibuten 5 days	
Bronchitis	Viruses	Antibacterial treatment is not carried out	
Bronchitis	M. pneumoniae	Erythromycin, other macrolides	
Bronchitis	Chlamidia spp.	Erythromycin, other macrolides	Co-trimoxazole

Since a 10-day course of treatment with rapid improvement of the patient's condition is not maintained by all parents, the frequency of bacteriological relapses is quite high. Searches for the possibility of shorter courses have shown that, for example, a 3- or 5-day course of azithromycin gives a higher frequency of relapses than a 10-day course of phenoxymethylpenicillin [7]. Data on a successful 5-day course of treatment with cefibuten 9 mg/kg/day (no more than 400 mg/day) or cefuroxime-axetil 20 mg/kg/day have been published. [8].

Since it is impossible to clinically differentiate between sore throats with and without streptococcal culture, it is important to know the groups of patients in whom the presence of streptococcus is more likely. According to WHO data [9], which coincide with ours, streptococcus is more often isolated in children with sore throat over 5 years of age; cultures are more often positive in the spring. These parameters can be used as a guide when deciding on antibacterial treatment of tonsillopharyngitis if bacteriological examination is impossible.

Otitis media. Detection of otitis media in acute respiratory viral infections serves as the basis for prescribing antibacterial therapy with oral medications. The following are active against both pneumococcus and Haemophilus influenzae: amoxicillin 20-50 mg/kg/day orally, ampicillin 50-80 mg/kg/day, erythromycin base 30-50 mg/kg/day (no more than 2 g/day). The following are active mainly against pneumococcus: penicillin 50 mg/kg orally, oleandomycin 250-1000 mg/day, josamycin 30-50 mg/kg/day (no more than 1000 mg/day), roxithromycin 50-100 mg/day, midecamycin 30-50 mg/kg/day (no more than 1200 mg/day). Most authors indicate the need to treat otitis for at least 10 days.

We have seen the high effectiveness of oral antibacterial therapy (penicillin, ampicillin, amoxicillin, cotrimoxazole, macrolides).

If these agents are ineffective, as in children who received antibiotics before the disease, it is justified to use second-line drugs - amoxicillin / clavulanate 50 mg / kg / day, cefuroxime axetil 25 - 50 mg / kg / day, cefaclor 20 mg / kg / day, cefibuten 9 mg / kg / day or azithromycin 5 mg / kg / day (3-5 days). In severe cases, a combination

of gentamicin (6 mg / kg / day) with ampicillin (100 mg / kg / day) or cefamandole (100 mg / kg / day), as well as third-generation cephalosporins are administered parenterally. In case of recurrent otitis, one should be guided by the results of ear discharge culture and discuss the need for surgical treatment with an ENT specialist (adenotomy, shunting).

Non-purulent sinusitis. Treatment is carried out using the same tactics as for otitis; it should be remembered that antibiotics do not affect the clinical picture and the rate of reverse development of changes in the sinuses in the acute period of ARVI, since they reflect purely viral inflammation of the mucosa. The question of treating sinusitis should be raised only on the 3rd - 4th week of ARI, while maintaining clinical and radiological data.

Purulent sinusitis. The disease requires intensive care and often surgical intervention. In it, parenteral administration of oxacillin 150 mg / kg / day or cefamandole 100 mg / kg / day is indicated, preferably in combination with gentamicin 6 mg / kg / day, which also suppresses the growth of staphylococcus. Acute bronchitis. Since in most cases the etiology of bronchitis (including obstructive bronchitis in young children) is viral, their antibacterial treatment is not indicated. During viral bronchitis, as with any acute respiratory viral infection, non-invasive reproduction of pneumococcus and Haemophilus influenzae (but not staphylococcus) in sputum occurs, however, as controlled trials have shown, antibacterial treatment does not affect the course of the disease. Antibacterial treatment is indicated for 2 forms of bronchitis. In preschoolers and schoolchildren during the epidemic rise of mycoplasma infection, bronchitis of this etiology can be treated with macrolides [10]. Erythromycin base 30-50 mg/kg/day (but not more than 2 g/day) or oleandomycin 250-1000 mg/day for 5 days can be used. They can be replaced by other macrolides: roxithromycin 50-100 mg/day, midecamycin 30-50 mg/kg/day (no more than 1200 mg/day) or josamycin 30-50 mg/kg/day (no more than 1000 mg/day). For chlamydial bronchitis in children in the first six months of life (perinatal

infection), macrolides are used in the indicated doses, as well as co-trimoxazole at 6-8 mg/kg/day according to trimethoprim; such treatment can speed up recovery [11]. For the treatment of chlamydial bronchitis in adolescents, the same drugs and doses are used as for mycoplasma bronchitis.

Conclusion

The progress of our knowledge about bacterial respiratory diseases and the expansion of the spectrum of antibacterial agents has

significantly improved their prognosis. Now the task is to narrow the indications for antibacterial treatment as much as possible and simplify it, make it targeted and less traumatic, safer and cheaper. Pediatricians should develop a self-monitoring system that would reduce the unnecessary use of antibacterial agents and reduce trauma and other undesirable manifestations of their use.

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