



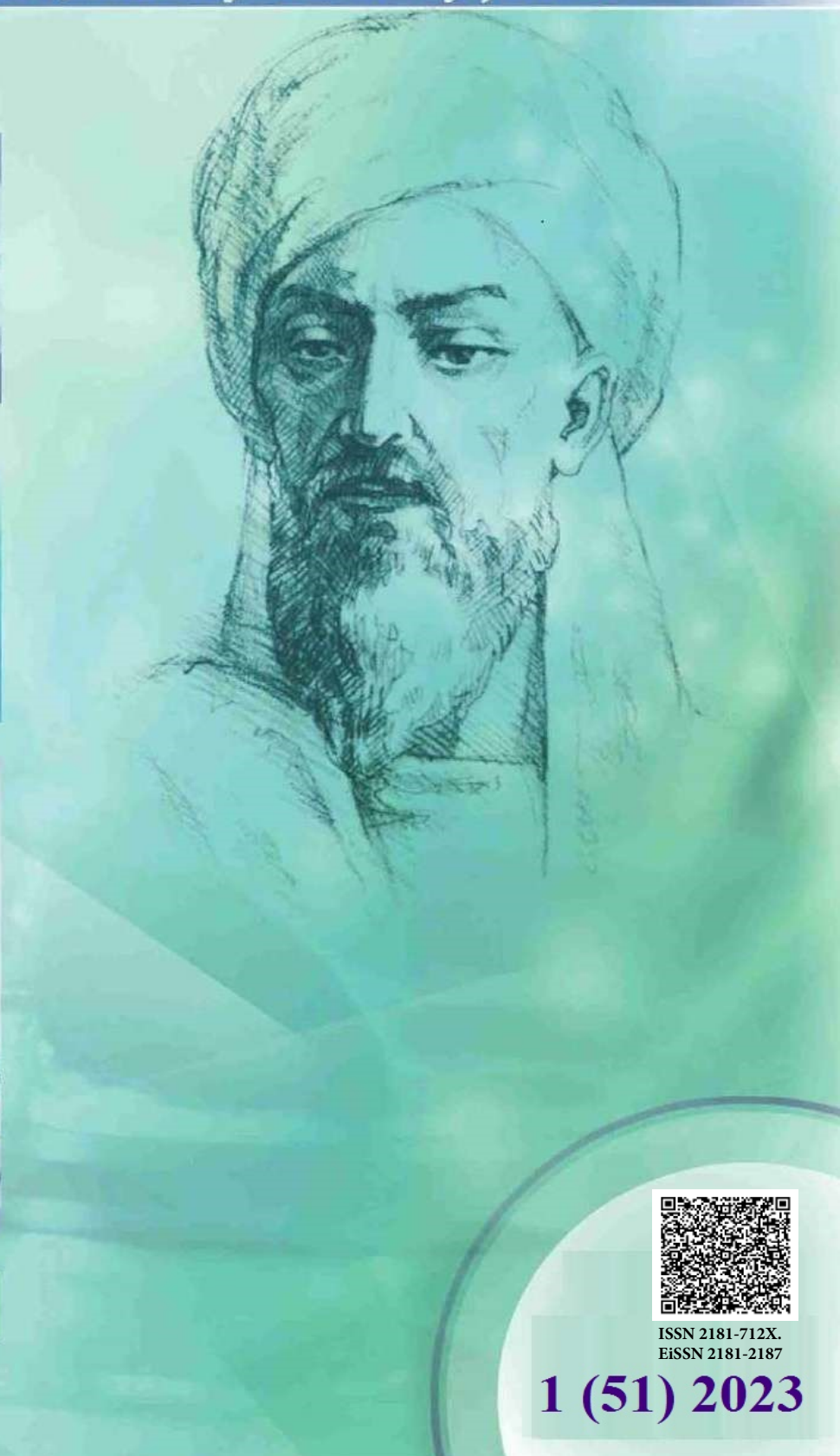
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**ТИББИЁТДА ЯНГИ КУН
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CLINICAL COURSE OF SPONDYLITIS DEPENDING ON TRIGGER FACTORS IN REACTIVE ARTHRITIS

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✓ *Resume*

The scientific study is devoted to the analysis of the features of the clinical course of reactive arthritis, depending on the trigger factors for the formation of structural changes in the joints and spine.

Key words: reactive arthritis, spondylitis, joints syndrome, Chlamydia trachomatis, Yersinia enterocolitica

РЕАКТИВ АРТРИТДА СПОНДИЛИТНИНГ ТРИГГЕР ОМИЛЛАРИГА КЎРА КЛИНИК КЕЧИШИДА ЎЗИГА ХОС ЖИҲАТЛАРИ

Халметова Ф.И., Ахмедов Х.С., Буранова С.Н., Ботирбеков А.Н.

Тошкент тиббиёт академияси

✓ *Резюме*

Реактив артритга чалинган беморларнинг бўғимларда ва умуртқа поғонасидаги структур ўзгаришларнинг шаклланишида триггер омилларига кўра клиник кечишида ўзига хос жиҳатларини таҳлил қилишга бағишланган.

Калит сўзлар: реактив артрит, спондилит, бўғим синдроми, Chlamydia trachomatis, Yersinia enterocolitica

КЛИНИЧЕСКОЕ ТЕЧЕНИЕ СПОНДИЛИТА В ЗАВИСИМОСТИ ОТ ТРИГГЕРНЫХ ФАКТОРОВ ПРИ РЕАКТИВНОМ АРТРИТЕ

Халметова Ф.И., Ахмедов Х.С., Буранова С.Н., Ботирбеков А.Н.

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✓ *Резюме*

Научное исследование посвящено анализу особенностей клинического течения больных реактивным артритом в зависимости от триггерных факторов формирования структурных изменений в суставах и позвоночнике.

Ключевые слова: реактивный артрит, спондилит, суставной синдром, Chlamydia trachomatis, Yersinia enterocolitica

Relevance

Reactive arthritis (ReA) attracts the attention of all aspects of medicine. ReA is characterized by a specific clinical course and functionally important joint damage, which causes disability, especially in young and middle-aged patients, and determines the social importance and urgency of the problem.

Immunological disorders are the basis of ReA pathogenesis, and in 88-96% of cases, inadequate cytostatic immunological response to HLA-B27-antigen, i.e., cytostatic immunological response from T-cell plays an important role.

Although ideas about its etiopathogenetic mechanisms have been created, the course of the joint syndrome in it with different features is the reason for the formation of different, sometimes contradictory opinions from scientists. At the same time, one of the reasons for the awakening of attention and interest in ReA is that destructive processes, even ankylosis, are formed in the joints of patients with a number of chronic processes. This indicates the complexity of the mechanisms of development of the pathological process in this disease.

The fact that disease develops on the basis of various trigger factors (*Chlamydia trachomatis*, *Yersinia enterocolitica*, *Salmonella enteritidis*, *Shigella flexneri* and *Campylobacter jejuni*) and therefore has a heterogeneous nature is related to specific complex immune inflammatory processes that form the pathogenetic basis of ReA. On the other hand, joint syndrome, enthesitis and spondylitis formed in the spine in the disease have different manifestations depending on the inability to obtain a stable tone of pro-inflammatory cytokines (IL 1, IL 6 and TNF- α) in the immunological response. As a result, erosions in the corresponding bones and, as a result, degenerative changes appear in the ankle. At this point, it is worth saying that this process increases the synthesis of collagenase and matrix metalloproteinase enzymes and stimulates the breakdown of type 2 collagen.

The purpose was to study the clinical course of spondylitis depending on trigger factors (*Chlamydia trachomatis*, *Yersinia enterocolitica*, *Campylobacter jejuni*) in reactive arthritis.

Material and methods

To achieve the goal of the study and solve the tasks set, the following methods were used: epidemiological, clinical and laboratory, functional and statistical research methods.

The majority of 120 patients with ReA included in the prospective analysis were aged 31-40, i.e. 45.8%. 58.3% of them were men. According to the information in the anamnesis of the disease, the average age of the patients when the first clinical manifestation of this disease occurred was 30.1 \pm 4.5 years. The average period between the appearance of the first clinical signs of ReA and the diagnosis of this disease was 3.7 \pm 1.8 months.

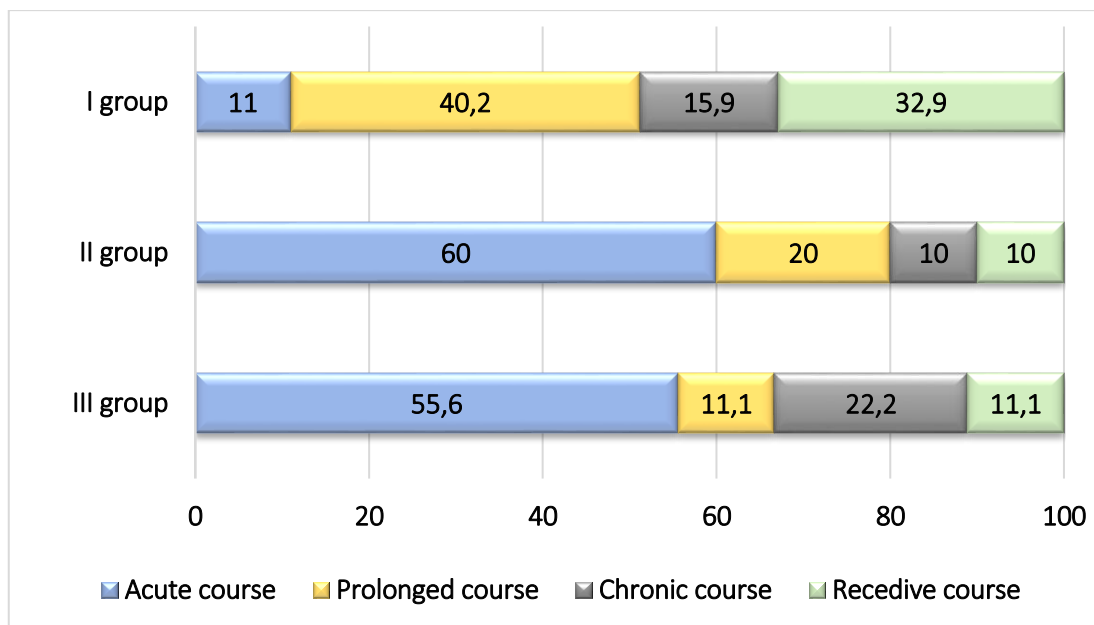
Result and discussion

Analysis of the clinical picture and joint syndrome of patients with ReA in the follow-up showed that they have a number of specific manifestations according to the trigger factors that cause the disease, that is, its clinical forms.

The clinical course of ReA was different in three groups divided according to etiological factors. It can be seen from Figure 3.5 that in group I, i.e. urogenital form of the disease (*Chlamydia trachomatis*), protracted course prevailed and it reliably differed from others, i.e. it was found in 33 (40.2%; $r < 0.05$) patients. In addition, recurrence of ReA in this group was found in 27 (32.9%; $r < 0.05$) patients.

On the other hand, the acute course of the disease prevailed in the postenterocolitic form of the disease and differed reliably ($r < 0.05$) from the urogenital form. As can be seen from the information presented in Figure 3.5, it was found in 60% of cases in group II (*Yersinia enterocolitica*) and in 55.6% of cases in group III (*Campylobacter jejuni*). There were no statistically significant differences between the groups regarding the chronic course of the disease.

According to the analysis of joint syndrome, there were certain differences between the groups. As shown in Figure 3.9, group II and III patients had more damage to one joint, that is, monoarthritis, while oligoarthritis prevailed in group I and accounted for 67.1%. In addition, the clinical and X-ray appearance of spondylitis in the urogenital form of ReA was detected in 68.3% of patients, and this indicator was significantly ($r < 0.05$) different from the other two groups. On the other hand, dactylitis was almost twice as common in group II and III patients compared to group I. At this point, it should be said that in 100% of cases, synovitis of various degrees was observed in all group patients, and it was isolated and sometimes accompanied by peri-arthritis in the form of bursitis or tendinitis.



Picture 1. Clinical course of reactive arthritis according to trigger factors.

Table 1. Clinical presentation of patients with ReA

Features	I group (n=82)		II group (n=20)		III group (n=18)	
	Abs.	%	Abs.	%	Abs.	%
<i>Joints syndrome</i>						
Monoarthritis	6	7,3	11	55	9	50
Oligoarthritis	55	67,1	7	35	7	38,9
Polyarthritis	21	25,6	2	10	2	11,1
Sacroiliitis	73	89,0	17	85	11	61,1
Spondylitis	56	68,3	3	15	3	16,7
Dactylitis	10	12,2	4	20	4	22,2
Functional insufficiency of joints						
I class	17	20,7	12	60	9	50
II class	39	47,6	5	25	7	38,9
III class	26	31,7	3	15	2	11,1
Joint indices and laboratory indicators						
Duration of morning sickness, minutes	31,3±5,9*#		19,1±2,1		17,3±5,5	
Pain, VASh, mm	79,5±12,8		67,5±12,8		53,5±11,4	
Number of painful joints	8,2±3,7*#		4,1±0,7		4,1±0,7	
Number of swollen joints	5,6±0,6*#		2,5±2,6		2,1±0,9	
C-reactive protein, mg/l	19,8±3,9#		12,8±1,9		11,8±1,7	
EC, mm/s	25,3±3,9		18,3±3,6		19,3±5,5	

Note. * and # – $r < 0.05$, where statistically reliable differences between indicators in the study: * - $r < 0.05$ between groups I and II; # - between groups I and III.

In fact, according to the results presented in Figure 1, the duration of morning numbness observed in the joints and the number of inflamed joints, as well as the indicators of the acute phase of inflammation in patients of group I, were reliably differentiated and obvious compared to other groups, which had an effect on the degree of limitation of the functional possibilities of the joints. In this case, II and III degrees of functional insufficiency of the joints made up 40% of the patients of the II group, 50% of the patients of the III group, and 79.3% of the patients of the I group.

Conclusion

Therefore, the functional activity of the joints is related to the specific structural changes, that is, the disturbances that are formed due to the inflammatory process.

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