Conclusions. Our study indicates that multipotent mesenchymal stromal cells might be promising therapeutic agents for the treatment of neuroinflammatory diseases associated with astro- and microglial activation.

PROBLEMS OF DIFFERENTIAL DIAGNOSTICS FOCUS DISSEMINATION OF THE LUNG TUBERCULOSIS IN PATIENTS WITH HIV INFECTION

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Introductions. Diseases with dissemination in the lungs are a serious problem in the diagnosis and differential diagnosis for doctors of various specialties, in the structure of lung diseases make up about 20%. Although about 200 diseases are accompanied by dissemination in the lungs, it is advisable to distinguish the most common in two separate groups in patients with HIV-positive status and HIV-negative status.

Aim. Analyzing the current literature on the diagnosis and differential diagnosis of diseases with pulmonary dissemination, in particular disseminated tuberculosis in patients with HIV infection.

Results and discussion. Disseminated processes in the lungs (DPL) are heterogeneous in etiology, pathogenesis, clinical symptoms, morphological criteria, a group of diseases. Common is X-ray disseminated lung tissue dissemination syndrome (PDS). By etiology, infectious, non-infectious, tumor, systemic diseases of the connective tissue are distinguished. About 85% of cases of lung pathology with HIV-negative status are due to:

- disseminated tuberculosis (DTB);
- pulmonary small cell cancer;
- idiopathic interstitial pneumonia;
- septic bacterial pneumonia;
- sarcoidosis.

The most common causes of DPL in patients with HIV-positive status include:

- DTB;
- pneumocystis pneumonia;
- cytomegalovirus pneumonia;
- pulmonary cryptococcosis and other fungal pneumonia;
- septic bacterial pneumonia;
- generalized Kaposi's sarcoma.

Compliance with a certain sequence is optimal in conducting differential diagnosis of DPL and determining the most likely diagnosis:

- determination of the HIV status of the patient
- assessment of history and clinical symptoms;
- isolation of the leading clinical syndrome;
- the presence of a leading radiological syndrome (pulmonary dissemination) after conducting a radiography and spiral computed tomography of the chest (SCT CO);
- the presence and nature of damage to the intrathoracic lymph nodes (ILN);
- assessment beyond thoracic lesions, including instrumental imaging techniques.

The basic diagnostic methods for DPL include: radiation (X-ray, SCT CO), fibrobronchoscopy (broncho-alveolar lavage, brush biopsy), bacteriological examination (non-specific microflora, fungi, Mycobacterium tuberculosis (MTB), non-tuberculous mycobacteria; molecular genetic methods chain reaction), biopsy (transbronchial lung biopsy, surgical biopsy).

When comparing the manifestations of PDS after imaging by radiation methods and a possible etiology of the disease, the following should be considered:

- the presence of focal shadows in the lungs suggests the need to exclude DTB, carcinomatosis, sarcoidosis;
- lymphogenous foci (along the lymphatic lymphatic outflow structures) - DTB, carcinomatosis, sarcoidosis;
- hematogenous foci (along the vessels) - DTB, carcinomatosis;
- changes in interstitium (without foci), pulmonary pattern in case of damage, disorganization of the connective tissue matrix of lung tissue - interstitial lung diseases of various etiologies, lung damage in diffuse diseases of the connective tissue;
- cysts with langerhans cell histiocytosis;
- combined forms of dissemination with the predominance of one of them (chronic DTB, pneumoconiosis, sarcoidosis).

In the subacute DTB, dissemination is mainly represented by polymorphic foci with a tendency to fuse foci and the formation of small destruction of lung tissue. In SCT, metastatic cancer is visualized as large focal dissemination with minor changes in the surrounding structures. In the mediastinal form of sarcoidosis, an increase in ILN is combined with a pronounced compaction of interstitium in the basal parts of the lungs and focal dissemination. In idiopathic interstitial pneumonia, diffuse interstitial fibrosis and “cell lung” are determined after SCT.

The presence of a typical dissemination does not allow to determine the diagnosis of a particular disease. DTB cannot be delivered without reliable criteria. A morphological study of biopsy specimens is indicated for carcinomatosis. With idiopathic pulmonary fibrosis, a biopsy is not performed. In SCT, fibrotic changes mainly prevail in the basal and cortical parts of the lungs, diffuse reticular changes in the type of “cell lung” are determined.

In patients with HIV infection, pulmonary dissemination often occurs when the blood count of CD4 + lymphocytes decreases to 200 cells / μl or lower. The most significant infectious pathogens in this category of patients are MTB, non-tuberculous mycobacteria and pneumocysts (90% of all secondary infectious diseases with lung damage). Atypical pneumonia caused by fungi and viruses is about 10%.

The simultaneous presence of 2 infections with lung damage is possible, which creates additional difficulties in diagnosis.

The clinical course of disseminated pulmonary tuberculosis (DPT) in HIV-infected patients is notable for its severity of intoxication. The persistent fever 38-39^{o}C is resistant to antibacterial drugs with a wide spectrum of action. On the x-ray at a certain stage of the development of the disease in the lungs, changes may not be detected, the "mesh" nature of the pulmonary pattern and basal lymphadenopathy are visualized. At this stage of the development of the disease, small focal dissemination in the lungs can be detected by SCT CO.

Unlike SARS in the late stages of HIV infection, dyspnea is not characteristic of DPT patients with HIV infection. Its presence during dissemination in the lung tissue against the diagnosis of DPT, although with the simultaneous presence of DPT and pneumocystis pneumonia, pronounced shortness of breath is observed.

Radiation imaging in patients with DPT with HIV infection has the following features. A more pronounced increase in pulmonary pattern, a frequent increase in ILN in the roots of the lungs are determined, lesions are usually localized in the lower lobes of the lungs and the middle lobe of the right lung, the upper lobes are less likely to be affected. Often in the lungs, it is not miliary dissemination that is detected, but diffuse drain infiltrates, such as broncholobular caseous pneumonia.

In a generalized course with damage to the internal organs, mycobacteria is often complicated by toxic toxic shock with multiple organ failure of organs and systems, tuberculous meningitis or meningoencephalitis occurs.

Conclusions. More often, problems of differential diagnosis of DTB arise in the stage of secondary diseases with a decrease in CD + lymphocytes to 200 cells / μl and below. A significant increase in the number of cases of disseminated and extrapulmonary forms of tuberculosis with a tendency to a decrease in the number of patients with the presence of lung decay cavities is characteristic. Difficulties in diagnosis are caused in this category by a decrease in the number of positive results of sputum microscopy on MTB and culture on culture media.

At the same time, most of these patients have mycobacteria, which makes it possible to identify the pathogen during blood cultures. The polymerase chain reaction in the study of blood and urine is highly sensitive and specific.

ПОШИРЕНІСТЬ ДЕЯКИХ ФАКТОРІВ РИЗИКУ РОЗВИТКУ НЕСТАБІЛЬНОЇ СТЕНОКАРДІЇ У КУРЦІВ ЗАЛЕЖНО ВІД СТАТІ

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Вступ. Куріння є хворобою, яка визначається в Міжнародній класифікації хвороб як психічний розлад або розлад поведінки, пов'язаний із вживанням тютюну. Останніми роками особливу увагу дослідників і практичних кардіологів привертають пацієнтки жіночої статі через істотне збільшення серед них поширеності нестабільної стенокардії (НС), відмінності у причинах її виникнення та особливостях перебігу. Куріння з кожним роком охоплює все більше число людей, призводить до значних медико-соціальних втрат, економічних збитків і смертності, причому основною причиною смерті є гостра серцево-судинна патологія. За останні 30 років кількість жінок-курців в Україні зросла втричі, що певною мірою пояснює сучасну несприятливу динаміку серцево-судинної захворюваності і летальності в жіночій популяції. Навіть неінтенсивне куріння (до 4 сигарет на день) збільшує ризик ішемічної хвороби серця (ІХС) у жінок удвічі. Жінки-курці мають у 7 разів більший, ніж некурці, ризик перенести інфаркт міокарда, особливо в молодому віці, що пов'язано, як з більшою інтенсивністю атеросклерозу в коронарних артеріях, так і частішою дестабілізацією цього процесу. Незважаючи на те, що у чоловіків і жінок фактори ризику ІХС аналогічні, певні чинники ризику у жінок