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e-mail: liverpool@sci-conf.com.ua

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**PROBLEMS OF EARLY IDENTIFICATION OF TUBERCULOSIS IN
PRIMARY HEALTH**

Yevstihnieiev Ihor Volodymyrovych

c. m. s., assistant

State Institution «Dnipropetrovsk

Medical Academy»

Dnipro, Ukraine

Abstract. The article describes the aspects of the interaction of a general practitioner with a TB doctor and doctors of other specialties in the early diagnosis of tuberculosis (TB). The primary practitioner conducts the primary prevention of the disease, first of all, forming risk groups and conducting screening examinations of the population. An important task is to increase the effectiveness of prevention and early diagnosis of TB and motivation for anti-epidemic measures.

Key words: disease, tuberculosis, diagnostics, family (general) doctor, primary health care.

The incidence of TB in developing countries remains high. This is due to many reasons, mainly, with a low level of socioeconomic development, HIV infection, drug multidrug resistance *Mycobacterium tuberculosis* (MBT) [1, p. 3]. The primary role in primary health care for the early detection of TB is assigned to the family doctor (general practitioner). An important task in primary care facilities is to conduct outpatient treatment in patients with TB.

A family doctor takes an active part in recreational activities in TB foci with the participation of a TB doctor and an epidemiologist [2, p.144]. In risk groups, an X-ray examination is performed. For tuberculin diagnostics, modern methods are used, for example, diaskintest in children under 15 years of age. In the dynamics of several test results, children are identified with a negative diaskintest result turning into a

positive one (turn the tuberculin test). These children are examined in primary care facilities or in a hospital.

Test results are important for anti-epidemic measures. For example, if in the same entrance of an apartment building in three children the turn the tuberculin test shows the results of a diaskintest, one can reasonably assume the presence of an epidemiological focus in it with the possible residence of a TB patient with the release of MBT. A family doctor treats patients with TB under the supervision of a TB doctor. Due to contact with TB patients, children from risk groups undergo preventive treatment at the family doctor, a TB specialist carries out its correction once a month. Adolescents are more likely to have TB than younger children.

Family doctors constantly interact with a TB doctor, with doctors of other specialties of primary care, conduct an early diagnosis of pulmonary TB and extrapulmonary localization. Important is not only the alertness of primary care physicians regarding TB, but also the level of knowledge in TB. A study of the perception of TB problem by general practitioners of primary health care was carried out [3, p.41]. The level of knowledge on phthisiology was insufficient, and in 58.8% of doctors the self-esteem of knowledge was overstated.

The TB service should perform organizational, methodological and mobilizing functions in relation to primary health care. Definitely, in modern conditions, the role of a general practitioner of primary health care has increased significantly. The issues of financing, motivation for prevention and early detection of TB remain relevant. Adequate self-esteem of knowledge in phthisiology, increasing theoretical knowledge and improving practical skills are important in the daily activities of a doctor. However, in practical implementation, negative trends are observed.

To reduce the incidence of TB, the role of the family doctor in the early detection of local forms of the disease, patients with bacterial excretion, is important. HIV infection. In the implementation of the tasks assigned to the family doctor, the role of training webinars, seminars, and lectures to increase theoretical knowledge in TB is growing. The emotional attitude of general practitioners to the problem of detecting TB in terms of a threat to their health is also important.

In the study, when assessing the emotional component in the survey, general practitioners were divided into three groups [3, p. 42]:

- 1) A kind of psychological defense unit "TB is somewhere, but cannot be with me." Such a psychological attitude was observed in the analysis of questionnaires in 64% of general practitioners of primary health care;
- 2) Fear of contracting TB was detected in 30% of general practitioners;
- 3) An adequate level of response to the possibility of getting TB while performing their functional duties was determined by questioning in 6% of general practitioners.

Inadequate perception of the problem of TB is revealed, thus, in 94% of general practitioners, which creates problems in training and professional activities. Theoretical training in TB is not enough. An increased self-esteem of knowledge has been established, which reduces the motivation for advanced training in the prevention and diagnosis of TB in accordance with regulatory documents.

Another study assessed the competence of primary care physicians in the prevention and diagnosis of TB [4, p. 2]. The survey using the original questionnaire was conducted among general practitioners, pediatricians, and doctors of other specialties of primary health care. An insufficient level of competence of primary care physicians has been revealed, which must be taken into account when drawing up training programs in TB.

The insufficient level of knowledge of primary care physicians on TB problems correlated with low patient awareness of TB risk factors, preventive measures, and clinical manifestations of the disease.

Another problem is the incomplete history of primary care doctors in patients regarding their epidemiological environment and risk factors for TB. In order to increase the motivation of primary care doctors in carrying out effective preventive measures against TB, it is necessary to increase the effectiveness of the webinars, seminars, conferences, and lectures that are being held.

Increased funding for primary health care institutions, the availability of modern equipment, material incentives for doctors for diligent work are necessary conditions for solving the tasks.

A study was conducted to study the level of knowledge of primary care physicians for extrapulmonary TB [5, p. 76]. Diagnosis of urogenital TB is an important medical problem for both primary care physicians and TB doctors. The development of chronic renal failure and impaired reproductive function in this pathology is an important medical problem. Symptoms of kidney and urinary tract TB are nonspecific, often combined with nonspecific inflammatory diseases. The main problem is the irrational prescription of antibiotic therapy in acute and chronic forms of cystitis and pyelonephritis.

One of the problems is the early detection of pulmonary TB in the presence of acute respiratory infection and during the flu epidemic [6, p. 151]. Pulmonary TB can mask its non-specific clinical symptoms as influenza and other respiratory infections. When performing a diagnostic minimum, the results of triple sputum bacterioscopy on MBT may be negative. If pulmonary dissemination syndrome is detected according to an X-ray examination and if there are a history of social risk factors for TB, it is necessary to expand the diagnostic minimum. Testing for HIV infection is advisable. By agreement with a TB specialist, these patients can be referred to a TB dispensary for sputum testing for MBT by polymerase chain reaction using the GeneXpert kit. Sowing on BACTEC media is also performed. In the presence of risk factors and pulmonary dissemination syndromes, infiltration, focal changes, there is a need to expand the diagnostic minimum with the implementation of multispiral computed tomography in some cases.

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