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FEATURES OF CLINICAL MANIFESTATIONS AND RISK FACTORS OF ATOPIC CHILITISM IN CHILDREN

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ABSTRACT:

The most significant occurrence of atopic cheilitis among the factors of the antenatal and postnatal development of the child turned out to be a history of exudative-catarrhal diathesis. The leading clinical signs of atopic cheilitis are lichenization of the skin of the corners of the mouth, swelling of the lips, small and large plate peeling, deep or multiple small cracks, itching of various intensities.

Keywords: atopic cheilitis, lip architectonics, functional disorders.

RELEVANCE

Atopic cheilitis (AH) - a chronic recurrent inflammation of the red border of the lips occurs in children with atopic dermatitis (AD) [3,4,5]. AD is a chronic allergic disease that develops in persons with a genetic predisposition to atopy, has a recurrent course, age-related clinical manifestations and is characterized by an increased level of total and specific IgE in the blood serum [1,2,6].

In recent years, the incidence has continued to grow steadily. In about one third of children, the clinical picture of blood pressure is characterized by a pronounced cheilitis with a chronic recurrent course [4]. In some cases, the inflammatory process of the red border of the lips becomes the dominant complaint of children with AD or may be its only clinical manifestation [1,3,5]. AH, adversely affects all aspects of the life of children and adolescents, significantly impairs the well-being and activity of patients, complicating their social adaptation [4,5].

The aim of the study was to identify risk factors, as well as to study the clinical features of the course of ACh in children of different ages.

Materials and methods

We observed 66 children with AH, including 22 children with an isolated form and 44 with symptomatic cheilitis against the background of AD. All children were divided into 4 age categories: 10 children - early childhood group - 1-3 years; 18 children - first childhood group - 4-7 years old; 18 children - second childhood - 8-12 years old; 20 children - adolescence - 13-16 years old. 25 healthy children of the same age period made up the control group.

RESEARCH RESULTS AND DISCUSSION:

During a thorough analysis of the data of the family allergological history, 77.05% of children with AH were found to have a hereditary burden. Thus, in 29.79% of children, both parents had an allergic pathology, and in 63.83% of patients, only one of the parents suffered from atopy. Of these, 73.33% of patients had an allergic history burdened on the maternal side, in 26.67% - on the paternal side.In 6.38% of children, parents did not have allergic diseases, but their close relatives suffered from atopic pathologies. In the structure of atopic lesions in the family history of the examined children, allergic reactions to various allergens prevailed: - 57.45% of cases, allergic rhinitis 19.15%, bronchial asthma 12.77% and eczema 6.38%.

Table 1 the results of the assessment of the anamnestic data of antenatal and postnatal development of children with AH and practically healthy children of the control group

Anamnesisdata	Maingroup(N = 66) %	Control group(N = 25) %	d
Gestosis of pregnancy	26,14	9,15	d<0,05
The threat of termination of pregnancy	8,24	6,18	d<0,05
Prematurebirth	10,02	4,00	d<0,05
Cesareansection	12,04	5,01	d<0,05
Diseases of the mother during pregnancy	17,29	6,23	d<0,05
Excessive consumption highly allergenic products with pregnancy	30,89	19,16	d<0,05
Artificialfeeding from 1 month	19,22	9,28	d<0,05
Artificialfeeding from 3 months	23,95	15,47	d<0,05
Early introduction of complementary foods (up to 3 months)	14,55	1,65	d<0,01
Exudative-catarrhaldiathesis	96,12	19,55	d<0,001

Notes: P - reliability of the difference in values between the indicators of children in the main and control groups.

Comparison of the anamnestic data of antenatal development of children of the main and control groups (Table 1) showed that in mothers whose children later suffered from ACh, pregnancy gestosis occurred more often than in mothers of practically healthy children in the control group (26.14% and 9.15 %, respectively, p <0.05).Further analysis of obstetric anamnesis data, the course of pregnancy and childbirth did not reveal statistically significant differences between the examined groups. Evaluating risk factors during the neonatal period and infancy, it was found that children with ACh significantly more often than children in the control group received complementary foods up to 3 months of age (14.75% and 1.54%, respectively).

In addition, in the overwhelming majority of patients with this pathology, 12% of children had exudative-catarrhal diathesis in history, while in the control group, diathesis was observed only in 18.46% of children. This gives grounds with a high degree of reliability (99-99.9%) to assert that the early introduction of complementary foods and the presence of exudative-catarrhal diathesis in the child's anamnesis are significant risk factors for the occurrence of ACh in children.

Further comparative analysis of concomitant diseases and pathological conditions in children of the main and control groups showed that children with ACh are more often diagnosed with food allergies (84.65% and 14.02%, respectively), gastrointestinal diseases (87.62 and 23.21%) , intestinal dysbiosis (90.16% and 10.77%), chronic recurrent herpetic infection of the lips (70.49% and 24.62%).

The high degree of statistical reliability of the difference in indicators relative to the control group indicates their significance as important prerequisites for the development of ACh in children.

The frequency of identifying risk factors in isolated form of ACh and cheilitis against the background of blood pressure did not have a significant difference in indicators acceptable in medical research (p> 0.05).

On clinical examination, a limited form of blood pressure in the form of an isolated lesion of the red border of the lips (isolated form of AH) was diagnosed in 31.15% of children, including 9 girls and 12 boys. Symptomatic cheilitis against the background of blood pressure was found in 44 children (68.85%), including 26 girls and 18 boys.

Among them, in 41 children (95.24%), cheilitiswas established with disseminated form of blood pressure with localization of lesions on the face, neck, elbow and knee bends, buttocks, and back surfaces of the hands. In 2 patients

(4.76%), symptomatic cheilitis was diagnosed with a limited form of blood pressure. In these children, in addition to the red border of the lips, elements of the lesion were observed in the behind the ear region and on the skin of the forehead.

In 14 patients (33.33%) with symptomatic cheilitis against the background of blood pressure, a mild degree of blood pressure was established (SCORAD index = 16.65 ± 1.59, EASI index = 9.59 ± 1.72). In 23 children (54.76%), the average severity of blood pressure was observed (SCORAD index = 44.94 ± 3.37, EASI index = 32.07 ± 1.3). A severe course of blood pressure was diagnosed in 5 patients, or 11.9% (SCORAD index = 71.3 ± 3.25, EASI index = 56.03 ± 1.65).

The development of ACh in most children (40 patients, or 65.57%) occurred against the background of the chronic phase of childhood (37 children, 92.5%) or adolescent (3 children, 7.5%) forms of blood pressure. In 10 children (16.39%), cheilitis was the only manifestation of atopic lesion from the onset of the disease without involvement of skin areas typical for AD into the pathological process. In 8 children (11.48%), isolated AC was first detected after the acute phase of blood pressure and long-term remission (from 9 months to 1.5-2 years), while the lesions of the skin of typical localization were never diagnosed in the future.

In 2 children (3.28%) of the age group of early childhood, lesions of the red border of the lips and skin of the perioral region were observed against the background of the acute phase of the infant form of blood pressure, followed by the chronicization of the inflammatory process.

According to the anamnesis, the first clinical symptoms of ACh in children with isolated lesions of the red border of the lips appeared at the age of 2 years 7 months. - in 1 child (5.26%), 4-6 years old - in 6 children (31.57%), 7-11 years old - in 9 children (47.37%), 12-14 years old - in 3 children (15.79%). Manifestations of symptomatic cheilitis in children with blood pressure first appeared at the age of 1.5-3 years - in 8 children (9.05%), 4-6 years old - in 18 children (42.86%), 7-11 years old - in 12 children (28.57%), 12-14 years old - 4 children (9.52%).

11 children (57.89%) with an isolated form of ACh and 27 children (64.29%) with cheilitis against the background of AD at the beginning of the acute phase of the disease observed the appearance on the red border of the lips, especially in the corners of the mouth, and in many cases on the skin perioral site - pink erythema with clear boundaries, as well as edema of the lips in 36.84% (7 children) and 57.4% (24 children), respectively. these symptoms were accompanied by itching of varying intensity, intensifying at night.

In 4.76% of children with cheilitis against a background of AD, acute inflammation was accompanied by the formation of lips and perioral areas on the skin, as well as on the red border of microvesicles, which quickly collapsed, exposing oozing zones.

In 42.11% of children with isolated form of ACh and in 30.95% of children with cheilitis against the background of blood pressure, a different course was observed: severe dryness and infiltration of the red border of the lips and skin of the perioral region, the formation of excoriation and small cracks in the corners of the mouth.

With the help of a comparative analysis of the clinical manifestations of the isolated form of ACh and cheilitis against the background of AD, it was found that their course as a whole is of the same type: with approximately the same frequency, lichenization of the skin in the area of the corners of the mouth was found (78.99% and 73.81%, respectively), hyperemia red border (26.32% and 21.43%), multiple small cracks in the area of the outer edge of the red border, in the corners of the mouth and the Klein zone

(36.84% and 38.1%), crusts (36.84% and 30 , 95%) and excoriation (21.65% and 23.8%).In the course of the study, we found some clinical differences in the course of the isolated form of ACh and symptomatic cheilitis against the background of blood pressure, although they did not have a sufficient level of statistical significance (p> 0.05).Thus, large-lamellar peeling in the area of the outer part of the red border of the lips prevailed in children with cheilitis with disseminated blood pressure (33.33% versus 15.79% with isolated cheilitis), while large-lamellar peeling is more common with the formation of whitish scales in the corners of the mouth and along the outer the edges of the red border of the lips were more often manifested in the isolated form of AX (84.21% versus 66.67%). In addition, in patients with an isolated form of ACh, a characteristic feature was the appearance of transparent or grayish-yellow scales along the line of closing the lips, which was observed in 47.57% of cases; this is almost twice as often as in children with cheilitis on the background of AD (28.57%).

CONCLUSIONS:

1. The most significant prerequisites for the occurrence of AH among the factors of antenatal and postnatal development of a child are the presence of exudative-catarrhal diathesis in the anamnesis and early (up to 3 months) introduction6 of complementary foods.
2. Risk factors for the development of ACh in children are the presence of concomitant diseases: pathology of the gastrointestinal tract, food allergies, intestinal dysbiosis, chronic recurrent herpes of the lips, impaired posture and musculoskeletal system, chronic tonsillitis.
3. In 65.57% of cases, the development of ACh began against the background of the chronic phase of childhood (92.5%) and adolescent (7.5%) forms of blood pressure.

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