rare disease difficult to diagnose. Patients with this syndrome need lifelong medical and psychological support. Timely diagnosis and treatment, as well as effective care will help improve their quality of life.

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A CLINICAL CASE OF ELIMINATION OF OBSTRUCTIVE JAUNDICE CAUSED BY *ASCARIS LUMBRICOIDES*

The article presents a clinical case of elimination of obstructive jaundice caused by Ascaris lumbricoides. The patient was admitted with a clinic of obstructive jaundice, presumably caused by choledocholithiasis against the background of a long history of cholelithiasis, chronic calculous cholecystitis. After two attempts of lithoextraction in the lumen of the common bile duct, a round parasite was detected, which extracted and sent for laboratory was testing, where the diagnosis of ascariasis was confirmed. The clinic of obstructive jaundice was dropped out.

Keywords: ascariasis, obstructive jaundice.

Introduction. Ascariasis is one of the most common helminthiases, according to WHO, more than 1.4 billion people are infected with ascariasis in the world. Every year, up to 100 thousand people die from ascariasis and its complications [1]. At the same time, ascariasis rarely gives surgical complications. We applied the principles of writing a systematic review of PRISMA to evaluate the statistics of surgical complications of ascariasis. In the Pubmed database over the past 10 years, 33 publications were found for the keywords "ascariasis", "Ascaris lumbricoides" and "surgical complications", while only one publication is a meta-analysis, the rest were clinical observations of various rare complications. 3 meta-analyses and 336 studies since 1998 were found in the Cochrane database for the keywords "ascariasis", "Ascaris lumbricoides", and "surgical complications". At the same time, less than ten studies are devoted to the systematic study of surgical complications and there is not a single meta-analysis on this issue, and the existing studies are devoted to intestinal obstruction, as the most common complication, the rest of the complications are described in the form of clinical cases. Most surgical complications are caused by a large number of nematodes in the intestinal lumen, which is the fate of third world countries, where there are poor social and living conditions, a high risk of massive contamination by the fecal-oral route [1]. The most common surgical complication of ascariasis is intestinal obstruction [1, 2]. Other complications are published in the literature as clinical cases due to their rarity, such as acute appendicitis due to obstruction of the lumen of the appendix by a parasite [3], perforation of the small intestine [4], as well as complications from the hepatopancreatobiliary system, such as acute pancreatitis, obstructive jaundice and hepaticolithiasis [5, 6].

We considered it necessary to present a clinical example of the treatment of a rare complication of ascariasis, obstructive jaundice, in an adult patient who denies a typical history of STH infection.

A 67-year-old patient was hospitalized in the Department of Surgery of the City Hospital No. 5, Barnaul, with complaints of heaviness and periodic pain in the right hypochondrium and epigastrium for two days. Social and living conditions are satisfactory, he lives in an apartment building with a central sewerage system. Contact with unwashed food from the ground, water not from the sewer denies. In histo-

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ry for many years suffers from cholelithiasis, chronic calculous cholecystitis. When contacting the clinic at the place of residence, an ultrasound examination of the abdominal cavity, magnetic resonance imaging with intravenous contrast was performed, which revealed signs of biliary hypertension, choledocholithiasis, calculi of the left hepatic duct. After further examination, she was sent to the Department of Surgery for treatment.

On admission, the patient's condition was satisfactory. Skin and mucous membranes of physiological color. Pulse - 78 beats per minute, BP-132/84 mm Hg. Art. Tongue moist, not coated. The abdomen is soft, symmetrical, participates in the act of breathing, not swollen, soft, painless. The size of the liver according to Kurlov is 9*8*6 cm. The gallbladder and spleen are not palpated. Peritoneal symptoms are negative. Pasternatsky's symptom is negative. Stool is dyed. Urine is light. Laboratory examination in the scope of the general blood test, taking markers of bilirubinemia, cytolysis, cholestasis, renal dysfunction, electrolytes and blood amylase, general urinalysis, coagulogram did not reveal any violations.

Ultrasound examination of the abdominal organs revealed:

Liver: oblique vertical size of the right lobe 164 mm, craniocaudal size 100 mm, contours are clear, even, the edge is sharp, the structure is fine-grained, heterogeneous, echogenicity is moderately increased. Volumetric formations were not revealed. The diameter of the portal vein is 11 mm, the inferior vena cava is 18 mm. Gallbladder: located in the usual projection, dimensions 120*45 mm, with a constriction in the body and an inflection in the lower third, walls up to 4 mm, increased echogenicity, no calculi, a small amount of sludge in the cavity, calculi are not convincingly located. Intrahepatic ducts are dilated: right lobar up to 8 mm, left lobar up to 10 mm, confluence is preserved, segmental up to 3 mm on the right, up to 4 mm on the left. Hepaticocholedochus is expanded to 15 mm, has a non-straight course, is visualized up to the head of the pancreas. In the lumen of the hepaticocholedochus, formations of increased echogenicity with dimensions of 8.3 * 5 mm and 4 * 4 mm are located, without a clear acoustic track. Pancreas - located in the usual projection, dimensions: Head: 25 mm, body 14.5 mm, tail 23 mm. The contours are fuzzy, even, the structure is heterogeneous, increased echogenicity, the Wirsung duct is not dilated. Spleen: in the usual projection, 110 * 37 mm, the structure is homogeneous, the splenic vein is not dilated. Kidneys: the usual location is the right kidney-112*48 mm, the contours are clear, even. the left kidney is 101*45 mm, the contours are clear and even. The thickness of the parenchyma of the right kidney -14 mm, the left kidney -16 mm. Corticocentral differentiation is not disturbed. Corticomedullary differentiation is not disturbed. The outflow of urine is not disturbed. The ureters are not dilated. In the projection of the adrenal glands, no mass formations were detected. Bladder: empty. The abdominal aorta is not dilated. Retroperitoneal lymph nodes are not located. In the pleural cavities, free fluid is not located. There is no free fluid in the abdominal cavity. Conclusion: Biliary hypertension syndrome, low level of block. Ultrasound signs of choledocholithiasis. Enlargement of the right lobe of the liver. Diffuse-heterogeneous changes in the structure of the liver. Deformation of the gallbladder. Thickening, diffuse changes in the structure of the walls of the gallbladder. Sludge in the gallbladder. Diffuse-heterogeneous changes in the structure of the pancreas.

The patient is exposed to a preliminary diagnosis: Cholelithiasis: choledocholithiasis. Chronic calculous cholecystitis. Mechanical jaundice.

Upon admission, the patient was urgently performed endoscopic retrograde cholangiopancreatography (ERCP), endoscopic papillosphincterotomy (EPST) in order to eliminate choledocholithiasis and stop the clinic of obstructive jaundice. When performing EPST, a big duodenal papilla (BDP) enlarged to 25 * 15 mm, tense, was revealed. At the mouth, there is villous hypertrophy and portioned bile secretion is visualized. An end knife made a dissection of the "roof" of the BDP from the mouth in a typical place with a length of 15 mm. There was an outflow of bile under pressure. Additionally, the "roof" was dissected with a cannulation papillotome up to 25 mm. Visually, the choledochus is not expanded. 30.0 ml tight filling performed. ultravist contrast. Shadows of concrements were not revealed. A biopsy of the BDP due to severe edema and local hemorrhage after EPST was not performed. The postoperative period proceeded without complications. 5 days after ERCP and EPST, the patient underwent videolaparoscopic cholecystectomy to eliminate chronic calculous cholecystitis. The postoperative period proceeded without complications. 7 days after videolaparoscopic cholecystectomy, in order to monitor the condition of the BDP and take a biopsy of the BDP against the background of the changes identified during the previous endoscopic

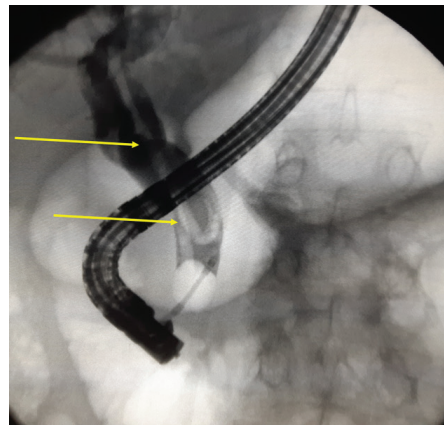

Fig. 1. Endoscopic retrograde cholangiopancreatography. In the lumen of the common bile duct, the shadow of the parasite is visible (showed by yellow figures)

Fig. 2. Macroscopic view of parasite

Fig. 3. Parasite in neutral formalin

operation, the patient underwent fibrogastroduodenoscopy with taking a biopsy of the BDP. Intraoperatively: from the previously dissected BDP into the lumen of the duodenum, the head of a round, worm-shaped parasite of a whitish color sticks out. A biopsy was taken from the edges of the BDP and a smear-imprint for cytology. A Fogarty-type probe was inserted, 15.0 ml of Ultravist was introduced, ERCP was performed, where in the lumen of the enlarged choledochus there is a convoluted shadow 5-6 mm thick of the parasite, there are no calculi (Figure 1). With a Fogarty-type probe, the parasite was brought down into the lumen of the duodenum, captured by an endoscopic loop, and removed. The parasite is pale brown in color, up to 20-22 cm long, 5-6 mm in diameter (Figure 2). The parasite is immersed in neutral formalin for examination (Figure 3). The outflow of bile is restored. No complications were observed in the postoperative period. The patient was consulted by an infectious disease specialist based on the results of a laboratory study of the parasite, where a female Ascaris lumbricoides was identified. The final clinical diagnosis was made: Ascariasis complicated by obstructive jaundice. GSD: Chronic calculous cholecystitis. 6 days after the operation, the patient was discharged for outpatient observation with recommendations for deworming under the supervision of an infectious disease specialist at the place of residence.

Conclusion. Despite the typical localization in the intestinal lumen, Ascaris lumbricoides nematodes can migrate into the lumen of the bile ducts, causing obstructive jaundice that is difficult to diagnose, especially in combination with other pathologies of the biliary system.

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A CASE OF CONGENITAL MEASLES

Measles is a highly contagious acute viral infectious disease with an airborne and transplacental transmission mechanism caused by an RNA-containing measles virus (genus morbilliviruses, family paramyxoviruses). Vaccination against measles is included in the National Calendar of Preventive Vaccinations of the Russian Federation and is carried out at the age of 12 months, followed by revaccination at 6 years. Immunity after measles is usually lifelong. Post-vaccination immunity is less prolonged: after 10 years, protective antibody titers remain only in 36% of vaccinated. In this regard, in the conditions of an epidemiological outbreak, there is a shift in morbidity to older age groups. Several cases of measles in pregnant women have been described. However, congenital measles is an extremely rare diagnosis. Our article describes a case of congenital measles in a newborn from a 34-year-old woman. At 28 weeks gestation, the woman was diagnosed with pneumonia, then a typical rash appeared. The diagnosis was confirmed by serological method. Thus, the birth occurred in the acute period of the disease. The baby was born prematurely at 28 weeks gestation by Caesarean section. The child's condition at birth was extremely severe. Apgar score is 5/7. The condition of the newborn was extremely severe due to prematurity and multiple pathology. The child was diagnosed with Respiratory distress syndrome of a newborn with respiratory insufficiency of the III degree. On the ninth day of life, a rash appeared. The diagnosis of measles was confirmed by the determination of antibodies to Measilis virus IgM. The course of measles in the exanthemic period was atypical (spotty rash elements on the first day, not characteristic dynamics of rash appearance). However, the presence of perinatal contact, the appearance of rashes made it possible to suspect such a rare diagnosis as congenital measles, and serological diagnostics confirmed this diagnosis. Against the background of the therapy, the patient's condition stabilized on the 7th day of the exanthemic period, the rash regressed. At the age of 1 month and 23 days, the child was discharged home in a satisfactory condition.

Keywords: measles, newborn, pregnancy, congenital pathology, exanthemic infection, prematurity, congenital malformations.

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Methods and materials: the medical history of a newborn with a diagnosis of severe respiratory distress syndrome of a newborn has been analyzed. Respiratory failure of the II degree. Extreme immaturity. Prematurity is 28 weeks. Measles, the period of rashes. Congenital heart defect: aneurysm of the secondary part of the MPP with a defect. FAP. Perinatal CNS lesion of hypoxic-ischemic genesis.

Introduction. The introduction in 1967 of routine vaccination of children against measles with live measles vaccine led to a widespread decrease in the incidence in all age groups. This allowed the world community to set the task of eliminating measles on the planet. In 1998 The WHO Regional Committee for Europe has officially set the goal of eliminating local measles transmission by achieving and maintaining a very high level of coverage (≥95%) with two doses of measles vaccine [1]. Currently, in countries conducting total vaccination against measles, the disease occurs in the form of individual outbreaks and epidemics, involving sev-