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RISK FACTORS FOR THE DEVELOPMENT OF AFFECTIVE RESPIRATORY PAROXYSMS IN CHILDREN

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Annotation
Affective-respiratory attacks are episodic occurrences of apnea in children, sometimes accompanied by loss of consciousness and convulsions. ARP occurs in approximately 5% of the population, with an equal distribution between boys and girls. It most often occurs in children aged 6 to 18 months and is usually not seen after 5 years of age. The occurrence of such seizures before 6 months of age is unusual. A positive family history can be identified in 25% of cases. This article is devoted to the risk factor for the development of affective respiratory paroxysms in children

Keywords: affective-respiratory paroxysms, risk factors, prevention.

RelevanceAffective-respiratory paroxysms (ARP) are episodic short-term attacks of respiratory arrest in children that develop with intense emotional arousal. Apnea attacks appear at the peak of crying, severe pain, fright after a blow, a fall. The affect suddenly stops, the child cannot breathe, becomes silent, turns blue or pale, muscle tone drops [1,2]. Sometimes there are convulsions, fainting. According to the literature, there are four types of ARP [1,2,3,4]:

1. The most common one is called simple ARP. Manifested in the form of holding the breath at the end of exhalation. It is usually the result of frustration or trauma. There are no major changes in circulation or oxygenation and respiration occurs spontaneously;
2. Blue type. As a rule, it is caused by anger or frustration, although there are also from pain. The child cries and makes a forced expiration, sometimes there is cyanosis (blue), loss of muscle tone and loss of consciousness. Most children regain consciousness, some fall asleep for an hour or two. The postictal phase is absent. EEG parameters of the brain are normal, without pathology;

3. Pale type. The child turns pale (as opposed to the blue type) and loses consciousness; not crying or crying a little. The post-ictal phase is also absent. EEG is normal;
4. Complicated type. It may simply be a more severe form of the previous two types. An attack of this type begins as "blue" or "pale", and then flows into a semblance of an epileptic seizure. The electroencephalogram outside the attack is mostly normal. Affective-respiratory paroxysms in a child, regardless of when they appear, disappear at the age of 4-6 years and often much earlier. It is now generally accepted that ARP is a paroxysmal condition, which in most cases does not lead to death and other serious consequences [2,3,4].

The purpose of the study is to study the risk factors for the development of ARP in children.

Materials and Methods of the Study

We examined 30 children with ARP, in our study, the alleged risk factors for the development of ARP were studied by interviewing and questioning parents, analyzing outpatient records.

Among the possible risk factors for the development of ARP, we analyzed: genetic, biomedical and psychosocial factors.

Results of the Study

Biomedical factors influencing the development of ARP are divided into factors of antenatal, intranatal and postnatal periods. In the antenatal period, the following were analyzed: extragenital diseases of the mother and pathology of pregnancy. In the intranatal period: protracted, rapid, rapid labor, early rupture of amniotic fluid, a long anhydrous period, surgical interventions, drug stimulation of labor, pathology of the placenta and umbilical cord, large fetus. In the postnatal period: the weight of the child at birth, clinical forms of perinatal CNS damage, neurosonography data , speech development of the child, concomitant neurological and somatic diseases.

In the study group of children with ARP, preeclampsia prevailed from the pathology of pregnancy (19%), complications during childbirth were entanglement of the umbilical cord around the neck (33%), weakness of labor activity (33%).

Perinatal damage to the CNS was detected in 50% of children: the syndrome of increased neuro-reflex excitability occurred in 38% of children and the syndrome of vegetative-visceral dysfunctions in 46% of children.

As a result of our research, concomitant somatic pathology was registered in 90.2% of ARP children. The most frequently observed pathology of the respiratory system, the pathology of the cardiovascular system and the gastrointestinal tract.

In the examined group, in the somatic status of children, ARVI was noted - 11 children (22%), lacunar tonsillitis - 7 children (14%), intestinal infections - 16 children (32%), after which episodes of ARP increased.

Diseases of the respiratory and ENT organs were detected in 48.5% of patients, among which community-acquired bronchopneumonia (37.6% of patients) and acute rhinosinusitis (11.9% of patients).

Among diseases of the gastrointestinal tract in patients with ARP, acute and chronic gastroduodenitis (35.6%), biliary dyskinesia (15.4%) and dysbacteriosis (56.7%) were most often detected.

Analysis of the results of the study showed that out of 23.8% of patients with confirmed pathology of the cardiovascular system, the most common sinus node dysfunction - sinus max and - and bradyarrhythmias in 11.5% of patients, transient atrioventricular (AV) block I degree and (AV) II degree blockade were detected equally often in 12.4% of cases in children of the main groups.

An analysis of the features of speech formation in the examined group (data of a speech therapist's examination on an outpatient chart) showed that most often children had a defect in sound pronunciation. Basically, it was due to insufficiently correct formation of the articulatory base (20%). In all cases, manifestations of dysarthria were the result of perinatal CNS damage. The prevalence of speech disorders in children with ARP was 15%, while the functional nature of the disorders was revealed.

Conclusions

Thus, the factors contributing to the occurrence of ARP in children may be aggravation of the antenatal, intranatal postnatal periods, with an aggravation of the somatic status.

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