PECULIARITIES OF THE CLINIC OF EXUDATIVE PLEURISY

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Abstract

Initial symptoms of exudative pleurisy, mechanisms of clinical symptoms, specificity of clinical symptoms, signs of intoxication, influence of fluid volume on the clinic of pleurisy.

Key words: Pleurisy with exudate, fibrinosis, Intoxication, pleural fluid.

Exudative pleurisy. Clinic Exudative pleurisy in most cases begins with the fibrinous (dry) pleuritic symptoms listed above, and later the clinical picture of the disease changes. The body temperature rises to febrile indicators, accompanied by shivering, strong sweating, increasing symptoms of intoxication. In most cases, the temperature has a hectic character.

Some symptoms of intoxication (muscle weakness, drowsiness, numbness, headache, loss of appetite) are usually manifested at a moderate level. But in purulent plcvritis and its empiycma, the symptoms are significantly increased.

As a result of accumulation of exudate and separation of the pleural sheets, sharp pains in the chest decrease sharply or disappear completely. In this case, patients feel heaviness on the affected side and complain of "not fully recovered" lungs. In diffuse inflammation of the pleural sheets, even despite the accumulation of a large amount of exudate, sharp pains in the chest remain. In most cases, pleural friction noise, which is increased during auscultation, is heard at the fluid level in the area where the inflamed pleural sheets are joined. Depending on the level of exudate accumulation, the patient has symptoms of acute respiratory failure and displacement of the trachea and chest cavity. At low physical exertion and at rest, visible panting occurs. When the amount of exudate is not large, panting has the characteristic of tachypnea. Inspiratory wheezing is observed when fluid accumulates in large quantities, and it increases with signs of increased work of the respiratory muscles.

Many patients with exudative pleurisy suffer from a reflex dry painful cough, which is explained by damage to the pleural sheets and displacement of the trachea.

When examining Bcmomi, they try to take a slightly bent or half-sitting position, sometimes lying on the healthy side. This position leads to improvement of blood oxygenation and reduction of shortness of breath (decubitus lateralis position). Shortness of breath. the outbreak is accompanied by the appearance of diffuse "gray"

cyanosis. Cyanosis has a mixed character when there is significant displacement of the chest cavity or in the case of concomitant heart diseases.

On the affected side, there is an increase in the size of the chest and its lag in breathing (Guvcr's symptom). The intercostal spaces are narrowed and there is no tension during breathing (Lilcn symptom). The skin on the affected side is swollen and more wrinkled than the healthy side (Wintrich's symptom). On the affected side, the vibration of the sound in the fluid field decreases sharply.

If the amount of fluid in the pleura exceeds 300-400 ml, it can be determined using simple percussion. In this area, the percussion sound is significantly muffled, when the cksudat layer is thick - a completely muffled sound is heard. In a smaller amount of exudate, a muffled sound is determined above the Ellis-Damuazo line. The highest point of this border is located at the back armpit or shoulder line. From this ycr, it descends along the c line, intersects with the spine behind, and reaches the midlife line at the level of the V rib in front.

In exudative pleurisy, a large amount of fluid is located in the back and sides of the chest. Therefore, in order to assess the volume of fluid in the pleura, it is necessary to carefully check the limit of sound dullness in this area. A bluntness along the mid-spinal line from the front, and when the upper border from the back reaches the middle of the scapula, is determined, and this corresponds to the amount of 2-3 I of pleural fluid.

The difference in the level of the upper border of the exudate in different parts of the lung is explained, first of all, by the direction of displacement and lung compression from the bottom to the top) and back-to-back compression, that is, in the direction towards the root of the lung. In this case, the back-side sections of the lungs move less. Therefore, in this area, the liquid reaches the highest level. When the amount of exudate exceeds 3-4 I, the upper border of the hoarseness is almost horizontal. A zone of compression atelectasis is located in the area of the compressed lung at the upper border of the hump. It consists of a horizontal line passing through the spine, the Ellis-Damuazo line and its upper point, forming the Garland triangle. On percussion, a muffled tympanic sound is heard in this area. If a large amount of exudate accumulates in the plcvra cavity (more than 4 I), a muffled sound is detected on percussion. This corresponds to the projection of the thoracic cavity shifted to the healthy side (Rauxfus-Grocco triangle). This triangle is bounded by the continuation of the spine and the Ellis-Damuazo line. Loss of tympanic sound at the surface of Traube's space is an early physical sign of left-sided fluid accumulation. On auscultation in the area of muffled percussive sound, weak breathing is significantly reduced or is not heard at all. In the Garland triangle. i.e. weak bronchial breathing, sometimes creasing is detected in the area of compression atelectasis projection of the back chest wall. In some cases, a pleural friction noise is heard at the upper limit of the liquid, which means that the

inflammation has spread to its sheets.

In right-sided parapneumonic pleurisy, the chest cavity expands. In this case, the thrust is located at the level of the anterior axillary line. In these cases, significant tachycardia - 120-140 beats per minute. acrocyanosis and other symptoms of heart failure occur. Left-sided exudative pleurisy is accompanied by a rightward shift of the border of relative suffocation of the heart. When the thoracic cavity is significantly shifted, a contraction occurs at the transition of the lower caval vein to the diaphragm, a strong limitation of venous blood return to the heart, a decrease in heart rate, and persistent arterial hypotension develop.

Reabsorption of exudate is usually observed 1-1.5 months after the onset of the disease. After healing, the sheets of the inflamed area remain markedly thickened, and sometimes pleural adhesions are formed.

Laboratory tests. Blood analysis. When inflammation is observed in the plcvra under the influence of infection, the following non-specific signs of the inflammatory syndrome are revealed in the general analysis of blood: a shift of the leukocyte formula to the left, neutrophilic leukocytosis and an increase in ECHT. In severe cases, toxic granular neutrophils, as well as leukemoid reaction cells are detected. Normochromic anemia often develops.

Changes characteristic of the biochemical analysis of blood include significant dysproteinemia, an increase in the amount of albumin, α(and α, globulin).

composition - the amount of C-reactive protein, haptoglobin, seromucoid, sialic acid increases.

Changes in the blood analysis in aseptic pleural fluid, which is not related to infection, are characteristic of the main disease complicated by pleurisy.

Check with Renlgenaid. This method is crucial in diagnosing pleurisy. The rcntgcn symptoms of dry plcvrit are as follows:

- high position of the dome of the diaphragm on the damaged side;

- limitation of the mobility of the posterior border of the lung and the dome of the diaphragm during deep breathing;

- above the diaphragm and ribs - in the area of the sinus of the diaphragm, the clarity of the lung area

decrease

Signs of fluid accumulation in exudative pleurisy include flattening of the acute X-ray costal diaphragm angle along with a curved upper border of the fluid. Due to the increase in the volume of exudate in the pleural cavity, the x-ray image shows the upward movement of the outer corner of the lung and the diaphragm, as well as uniform darkening. The upper border of the tan is often slanted from top to bottom and from outside to inside. When the position of the body changes, the darkening and its upper border changes its shape due to the location of the fluid. A large amount of exudate

fluid in the pleural cavity forms a triangular shadow with an outer upper and inner lower curve when it accumulates significantly in the lower side of the lung. In this case, the dome of the diaphragm is flattened, and the chest area moves to a healthy side.

When there is a small amount of fluid in the pleura (around 100-150 ml), lacrography is used to detect it, that is, an X-ray examination in which the patient lies on his side on the affected side. If there is a free fluid in the pleural space without a limited membrane, a narrow band shadow is visible in front of the wall. When pleural fluid develops on the basis of pleural adhesions. the border of its shadow will be clear and convex. In interlobular pleurisy, the bordered shadow takes an elongated shape. corresponds to the border of the interfragmentary crack.

One of the sensitive methods of determining pleural fluid is UTT and computer tomography of chest organs. Before and after the right puncture, the work is appropriate. Examining the fluid allows to determine the cause of the pathological process (colic, tuberculosis, tumor, etc.).

Examination of pleural fluid is important to diagnose the cause of pleurisy. The examination allows to distinguish the type of pleural fluid (exudate, transudate), the pathological process in it (pus-inflammation, aseptic, tumor, tuberculosis, etc.), the causative agent, and to determine the sensitivity to antibiotics. In order to treat patients with a large amount of fluid and significant shortness of breath, it is necessary to quickly remove the fluid from the pleural space.

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