control group (non-atopics suffering from functional dyspepsia, chronic gastritis, functional biliary disorders).

Atopy at all the main group patients was confirmed by the elevated serum total IgE detected by the electro-chemiluminescence quantitative determination method. All the patients of the main and control groups had undergone CTACK and TARC detection using the enzyme-linked immunosorbent quantitative determination method.

Association between IgE total, CTACK, TARC and AD phenotypes was determined by the Spearman rank-order correlation (R). For detecting the risks associated with onset of AD different phenotypes we had determined odds ratio (OR) with 95% confidence interval (CI) by application of ROC-analysis.

All the data was validated by p-value ($p < 0.05$).

There is a significant association between serum total IgE and CTACK with AD as mono-nosology – $R = 0.385$ and $R = 0.341$ ($p < 0.01$) and with AD combined with SARC and/or PAR – $R = 0.718$ and $R = 0.397$ ($p < 0.01$). Risk of onset of AD as mono-nosology is significantly associated with serum IgE > 173 IU/ml – OR =

8.98 [95% CI 2.53, 31.86], $p < 0.001$ and CTACK ≥ 3658.5 pg/ml – OR = 5.64 [95% CI 1.56, 20.32], $p < 0.01$. Risk of AD combined with SARC and/or PAR onset is significantly associated with serum CTACK ≥ 4308.8 pg/ml – OR = 7.40 [95% CI 2.30, 23.76], $p < 0.001$. Risk of progression of AD as mono-nosology into AD combined with SARC and/or PAR is significantly associated with total serum IgE ≥ 1000 IU/ml – OR = 16.0 [95% CI 2.68, 95.44], $p < 0.001$.

Serum IgE total and CTACK are significantly associated with the studied AD phenotypes.

Risk of AD as a mono-nosology onset is significantly associated with serum total IgE ≥ 173 IU/ml and CTACK ≥ 3658.5 pg/ml, AD combined with SARC and/or PAR – serum CTACK ≥ 4308.8 pg/ml.

Risk of progression of AD as mono-nosology into AD combined with SARC and/or PAR is significantly associated with serum total IgE ≥ 1000 IU/ml.

There is no significant association between serum TARC and the risk of AD phenotypes onset.

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THE LONG-TERM MONITORING AND ANALYSIS OF OUTCOMES OF DIFFERENT APPROACHES TO THE MANAGEMENT OF CHRONIC SPONTANEOUS IN ADOLESCENTS

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Second-generation of H1-antihistamines (H1-AH) is the main therapy for the chronic spontaneous urticaria (CSU). Omalisumab (Oma) is the only biological, approved for the severe H1-AH resistant CSU in adolescents over

12 years.

Aim: to evaluate different approaches to severe CSU therapy in adolescents and assess achieving of disease control in 3 y period.

Methods The long-term prospective observation study of 34 children with severe CSU (55% boys, average age 13 y o (min 3; max 17,0), the duration of disease – 33 mo (min 3;

max 144); UAS7 – 18 points (min 16; max 24,0) was conducted. All patients received H1-AH for minimum 3 mo.

Patients were randomized in 2 groups. 17 patients of the 1st group were added with Oma to therapy: 55,6% girls, average age – 15 y (min 12,0; max 17,0); disease duration was 45,2 mo (min 3,0; max 144,0), the average total IgE level – 348,2 IU/mL (min 0,8; max 2041,0); the average UAS7 at debut –

17,2 points (min 16; max 24). The course of Oma therapy was 6 mo, 300 mg/mo subcutaneously.

17 patients of the 2 nd group maintained alone H1-AH therapy: 64,7% boys, average age – 10,8 y (min 3,0; max 15,0); disease duration was 20,5 (min 3; max 72) mo, the average total IgE level -182 IU/mL (min 20; max 1050);

UAS7 at debut – 18 (min 16; max 28) points.

The efficacy of therapy assessed by urticaria activity score for the 7 days (UAS7).

Results in the 1st group of patients in 6 mo of Oma therapy UAS7 was 1,6 (min 0; max 20) points, $p < 0,05$. After 3 y of the course Oma therapy UAS7 was 4,5 points, $p < 0,05$.

In the 2 nd group of patients, who received alone H1-AH, in 6 mo UAS7 remained at the same level – 18 points ($p < 0,05$). The average UAS7 in 3 y was 12 (min 0; max 26) points ($p < 0,05$).

Thus, in patients receiving Oma UAS7 significantly decreased after 6 mo.

The UAS7 level in the Oma group indicates a greater proportion of children who have achieved disease control. The proportion of children, who have achieved remission during 3 y (UAS7=0): in Oma group 52,9%, in H1-AH – 29,4% ($p = 0,163$).

Conclusion Our results indicate the efficacy of Oma in adolescents with

CSU: rapid relief of urticaria symptoms and a greater proportion of adolescents who have achieved disease control, compared with therapy alone H1-AH.

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STEVENS-JOHNSON SYNDROME

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Stevens-Johnson syndrome (SJS) is a severe mucocutaneous reaction characterized by extensive necrosis and separation of the epidermis. The mucous membranes are affected in over 90% of patients, usually in two or more different sites. The incidence ranges from 2 to 7 cases per million people per year. Medication use is a leading trigger of Stevens-Johnson syndrome in both adults and children, followed by Mycoplasma pneumoniae infection. The disease begins with flu-like symptoms and fever, followed by the onset of mucocutaneous and skin changes. The diagnosis is based on clinical and histological findings in a patient with a history of previous medication exposure or febrile illness.

A 10-year-old boy presented with fever, cough, and dyspnoea. He was examined ten days before the admission and prescribed with antibiotic.

Physical examination shows dehydration and light dyspnoea, along with mild diffuse bulbar injection of both eyes, and moderate oedema and hyperaemia of the tonsils and pharyngeal mucosa. There was no skin rash. Auscultation of lungs