The Peerian Journal
Open Access | Peer Reviewed
Volume 9, August, 2022.
Website: www.peerianjournal.com
ISSN (E): 2788-0303
Email: editor@peerianjournal.com

Bronchial asthma is one of the main problems of modern medicine

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Abstract: Bronchial asthma is an independent disease based on chronic inflammation of the respiratory tract, accompanied by changes in the sensitivity and reactivity of the bronchi and manifested by an attack of suffocation, asthmatic status or, in the absence of such, symptoms of respiratory discomfort (prismatic cough, distant wheezing and shortness of breath), reversible bronchial obstruction against a background of hereditary predisposition to allergic diseases outside pulmonary signs of allergy, blood eosinophilia or eosinophilia in sputum.

Keywords: allergic bronchial asthma, etiology, laboratory diagnostics, modern methods of therapy.

Relevance: In many countries of the world, bronchial asthma attracts more and more attention of the medical community every year. Statistics show, in fact, that there is an increase in the incidence and mortality associated with asthma in the world, despite the distinct successes in the awareness of this disease and the increasing production of anti-asthma drugs. In the world, more than 100 million people suffer from bronchial asthma. The prevalence of bronchial asthma ranges from 3 to 8%. Within 30% of patients with bronchial asthma rarely use anti—asthmatic drugs, another 30% use them regularly, 20-25% suffer from a severe form of the disease and have to resort to taking several anti-asthmatic drugs, 8-10% suffer from a disabling form of the disease. [1]. Difficulties in the diagnosis and treatment of bronchial asthma have acquired international significance and prompted efforts to develop coordinated actions to address them.
Materials and methods of research: In the Cyberleninka databases, the MSD keyword handbook, a search was conducted among English and Russian-language works published in the period from 2015 to the present time.
Results of the study: Allergic bronchial asthma is the most easily recognized phenotype, in which bronchial asthma usually begins in childhood, is associated with the presence of other allergic diseases such as atopic dermatitis, allergic rhinitis, food allergies in the patient or relatives. This phenotype is characterized by eosinophilic inflammation of the respiratory tract. Patients with allergic bronchial asthma usually respond well to therapy with inhaled glucocorticosteroids. An important role in the occurrence of bronchial asthma is played by exogenous specific factors that cause the inflammatory process in the respiratory tract — "inducers". These include inhaled

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allergens: tick waste products, household dust, plant pollen, animal hair, as well as medications (for example, aspirin), a variety of high-molecular and low-molecular organic and inorganic substances. A special group includes contributing factors that increase the likelihood of developing asthma when exposed to inducers: low birth weight, respiratory viral infections, active and passive smoking. A significant role also belongs to the factors that belong to the group of provoking triggers. They exacerbate the course of the disease, leading to an increase in the process of inflammation or provoking the occurrence of acute obstruction of the respiratory tract with the help of immunological and non-immunological mechanisms. The provoking factors are different in different patients, often combined or replaced during the course of the disease in the same patient. In a sensitized organism, the trigger role can be played by the above allergens or professional agents, respiratory viral infections, food products (in particular, preservatives contained in them), medicines. In addition, physical exertion and hyperventilation, meteorological factors, increased emotional tension, beta-blockers, gastrointestinal reflux, pregnancy can exacerbate the course of asthma and contribute to the appearance of obstructive symptoms. [2].

Diagnosis of bronchial asthma:

— detailed allergological history;
— conducting skin tests with allergens in the remission phase (injection, scarification, intradermal, inhalation);
— radioimmunosorbent test for detection of antigen-specific IgE antibodies;
— detection of sputum and blood eosinophilia, Curschmann spirals, Charcot—Leiden crystals, bronchial epithelium in sputum;
— bronchoscopy;
— x-ray examination;
— carrying out functional pharmacological tests with b-adrenostimulants, M-cholinoblockers. [3].

Treatment. Pharmaceuticals for the treatment of bronchial asthma are divided into drugs that control the course of the disease (supportive therapy) and emergency medications (to relieve symptoms). Medications for maintenance therapy are taken daily and for a long time, since due to their anti-inflammatory effect they provide control over the clinical manifestations of bronchial asthma. Medications to relieve symptoms are taken according to need, these medications act quickly, eliminate bronchospasm and stop its manifestations. Drugs for the treatment of bronchial asthma can be administered in different ways – by inhalation, oral or injection. The main advantage of the inhalation method of administration is the ability to deliver drugs directly into the respiratory tract, which allows you to achieve a higher local concentration of the drug and significantly reduces the risk of systemic side effects.

The main drugs for the treatment of bronchial asthma include:

A. Anti–inflammatory drugs.

I. Glucocorticosteroids:

- systemic glucocorticosteroids;
– inhaled glucocorticosteroids;
– "liquid" glucocorticosteroids.

Glucocorticosteroids are more active among anti–inflammatory drugs. Under the action of glucocorticosteroids, the number (as a result of activation of apoptosis) of the main inflammatory cells of the respiratory tract decreases and the synthesis of inflammatory mediators and allergies

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by these cells is inhibited. Systemic glucocorticosteroids have long been used to treat patients with bronchial asthma. They are divided into several groups.
By chemical composition:
– prednisolone group (prednisone, prednisolone, metipred);
– triamsinolone group (triamsinolone, berlicort, polcortolone).
By duration of action:
– short (hydrocortisone);
– of medium duration (prednisone, methylprednisolone);
– of long duration (triamcinolone, dexamethasone, betamethasone).
They are prescribed parenterally or orally as symptomatic agents for an attack of bronchial asthma in case of ineffectiveness of β2-agonists. Systemic glucocorticosteroids are not recommended for long-term use, due to the presence of equally effective and safer drugs in the arsenal of therapists and due to severe systemic side effects of systemic drugs.
II. Antileukotriene drugs are anti–inflammatory drugs that have recently become widely used in clinical practice. They reduce the effect of leukotrienes, which is not manifested by a pronounced expansion of the bronchi and a weak anti-inflammatory effect. Depending on the mechanism of action, there are:
a) antagonists of cysteinyl leukotriene receptors of the 1st subtype - montelukast (singular), pranlukast;
b) inhibitors of leukotriene synthesis – zileutone, inhibiting enzyme 5-lipoxygenase.
iii. Stabilizers of mast cell membranes.
The main drugs: cromoline sodium (intal) and nedokromil sodium (tailed). Drugs of this group are prescribed to children, people with mild bronchial asthma.
B. Broncholytic drugs.
I. β2-agonists:
– short-acting fast;
– long-lasting fast action;
– long slow action.
II. Anticholinergic drugs.
III. Methylxanthine preparations. [4].
Prevention of bronchial asthma includes: primary prevention – a complex of medical and non-medical measures aimed at preventing the disease for people at risk and preventing the formation of IgE antibodies in them. The tactics of primary prevention of AD are focused on the prenatal and perinatal periods. In the prenatal period, it is necessary to exclude smoking and exposure to tobacco smoke, especially during pregnancy. It is also necessary to exclude active and passive smoking in the workplace. Postnatal activities include breastfeeding up to 4-6 months. Early contact with cats and dogs prevents the development of allergies. As preventive measures, it is recommended to exclude smoke from the premises, reduce the effect of household pollutants, reduce exposure to inhaled allergens in the first years of life in children with a high risk of atopy (house dust, animal cockroaches). Secondary prevention is a complex of medical, social, sanitary–hygienic, psychological measures aimed at early detection and prevention of exacerbations, complications and chronization of asthma and allergies, life restrictions that cause maladaptation of patients in society, reduced working capacity, including disability and premature

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mortality from asthma and allergies. With the existing sensitization to house dust mites, epideomal allergens of animals, cockroaches, professional pest, it is necessary to eliminate their effects. In addition to early termination of contact with causally significant allergens, the main measures are allergen-specific immunotherapy and preventive pharmacotherapy.Tertiary prevention is a complex of psychological, pedagogical, and social measures aimed at eliminating or compensating for life limitations, restoring lost functions in order to possibly restore social and professional status more completely. Tertiary prevention involves the proper treatment of existing asthma and allergies. Elimination of culpable allergens is a necessary component of asthma control and reduces the frequency of exacerbations of allergic diseases and asthma. The aim of asthma pharmacotherapy should be the inflammatory process.

Conclusions: Despite the fact that bronchial asthma is still a disease that cannot be cured, it can and should be effectively controlled. Against the background of proper lifestyle modification, adequately selected (in the early stages of the disease) treatment, patients with bronchial asthma can lead an active lifestyle, work, play sports and all types of activity characteristic of healthy people. It is necessary to approach your health reasonably, taking into account the achievements of modern medical science.

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