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STUDY OF THE EFFECTIVENESS OF ANTIVIRAL DRUGS IN THE TREATMENT OF CHRONIC VIRAL DISEASES OF THE LIVER

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Abstract

This disease has been looked at as a pressing problem all over the world until recently due to prolonged latency in most cases, virulence at high levels, the severity of the complications that occur, and the infection of drugs that have sufficient effectiveness in Da-fly the virus. As a complication in chronic hepatitis C, liver cirrhosis and hepatocellular carcinoma often develop. According to the opinions of many authors, 25% of people with chronic hepatitis C may develop liver cirrhosis and 1-5% of them develop hepatocellular carcinoma. Every year, 4-5% of patients diagnosed with liver cirrhosis develop Hepato-cellulular carcinoma, and therefore every year in the world 200 000 - 300 000 Ta mortality is observed.

Keywords: Hepatitis v, Ig M, IG G, IFA, morbidity.

Laboratory diagnostics of hepatitis V is carried out through the IFA method by detecting serum HBsAg, HBeAg, antitel (IG M and Ig G anti HBcAg, Ig G anti HBeAg, IG G anti HBsAg), as well as by detecting hepatitis v infection DNA from kondan, other biological fluids or organ tissues of the body in the pzr Method [2].

HbsAg is considered the most important marker of infection, and it is detected in acute viral hepatitis v blood infestation, starting from 2 – 5 weeks of age to the recovery period (lifelong in the chronic form of the disease). The circulatory period of HbsAg in the blood is 70-80 days on average [3].

Hepatitis v DNA is detected from SI blood plasma by the pzr method. The number of viruses in the blood increases very quickly during the period of stagnation of the disease and reaches its maximum in the acute phase of the disease. Of viruses. Circulations in the blood for 5-6 months are considered an unpleasant prognostic sign, which means that a chronic form of the disease has developed.

The quantitative indicator of viral DNA Si is important in predicting the effectiveness of antiviral treatment. If the viral concentration is less than 105 PCs/ML, the treatment is effectively tolerated, otherwise it is required to use a different treatment scheme [5, 7].

Serological tests for VGD are performed only in patients with hepatitis V, which means that HbsAg is detected in their blood. Markers expressing vgd damage are RNA VGD, IG M±IG G anti HDVs. Antibodies are detected by the IFA method, while viral RNA Si is detected by the pzr method.

In the case of superinfection, RNA HDV may not be detected in the acute phase of the disease. During this period, IG M anti HDV, combined with IG G anti HDV, is detected at higher titers compared to co-infection. IG M ± IG G is the diagnostic marker of svg D to have a consistently high amount of anti HDV [18].

In the IFA method of detecting viral hepatitis C, it is important to identify antibodies against viral proteins [3].

Method 2 is a pzr method that allows detection of viral RNA si. This method is considered the only one that proves the presence of a living virus in the body and has the ability to detect viral RNAs in the mine in Weeks 2-3 of viral damage. The detection of viral RNA Si is the "gold" standard for diagnosing hepatitis C. Currently, through the pzr method, qualitative, quantitative and genotypic indicators of the hepatitis C virus are determined. The sensitivity level of the method is 10-50 PCs/ML. Determination of the genotypic belonging of the hepatitis C virus is carried out before starting an antiviral treatment and is considered necessary to correctly select an antiviral drug and determine the duration of Drug Administration [1]. Through the pzr method, viral RNA s can be detected not only in the blood, but also from liver tissue. This method makes it possible to determine whether there is a role of the virus in the development of GTSK in the case when serum anti-viral or viral RNA Si is not detected [5].

An increase in ALT levels in chronic hepatitis has also been considered clinically an indicator of liver damage and has been studied in most studies. In one such study conducted, the increase in the amount of Alt was divided into 3 levels : Level 1 is at the norm limit, Level 2 is above the norm limit (up to 3 times) and Level 3 is higher (more than 3 times). ALT levels were found in 22 patients (48.9%) at the norm limit, 16 patients (35.6%) at Level 2 of the norm, and 7 patients (15.5%) at Level 3. From this it can be concluded that patients with SVG s are often more likely to have cases of ALT levels within normal or norm limits [7]

During similar investigations, Bacon B. R. and other authors (2002y.) by SVG s patients had normal blood ALT levels in 30% of patients tested independently of gender and age, while 40% of patients had normal levels up to 2 times higher than the normal upper limit [3].

Fazilov V.X. and in the course of studies conducted by hammuallifs, testing of alt enzyme activity in the blood of patients with SVG s through dynamic Ravish (1 time in 2-3 months for 12 months) found that only 3.7% of 168 patients consistently showed normal levels of the enzyme, or no more than 1.5 times above the norm threshold. In 23.9% of patients, high rates of ALT in constant ravation have been observed (up to 1.5 - 12 times higher than the upper norm limit). In a large percentage of patients (72.4%), it has been observed that the amount of the enzyme increases wave-wise from normal to 1.5 times and above [4]. As a result of massive damage to liver cells, an increase in the amount of AST, in addition to which the mitochondrial enzyme is cisobed, is also observed. Low ALT levels do not always indicate a healthy liver. Many factors influence the amount of this indicator. Examples of such factors include hemochromatosis, vitamin V6 deficiency, development of JTS, blockage of intracellular alt production under the influence of toxins. It should also be mentioned that not all damaged liver cells produce Alt [1]. The viral load in the body is also considered to be of great importance in the change in the level of liver damage and biochemical indicators of blood. In patients with low viral load, transaminases and ggtp up to 3 times increase in blood biochemical indicators have been observed. No changes were observed between the oxyls in the blood and their fractions. In 6 patients in this group, Alt and AST levels were observed to be 3-5 times higher than the norm upper limit, with moderate increases in total bilirubin, fibrinogen, PTI, mild dysproteinemia – a slight decrease in albumin levels, and a slow increase in α2 - i γ-globulins levels. In patients with high and very high viral load, moderate activity of blood biochemical indicators was observed (in 8 patients), while in the rest of the patients (in 7) this rate was at a high level. In patients with high biochemical activity observed, 10 N of the amount of transaminases, GGTP 5 n, an increase in the amount of bilirubin with an unconnected fraction predominance(71.8 ± 5.1 mkmol/L), an increase in the amount of fibrinogen (5.9 ± 0.3 g/l), a decrease in the prothrombin index (71 ± 1.4%), a significant degree of dysproteinemia was observed [9]. Liver fibrosis (JF) is considered one of the unpleasant consequences of chronic diffuse diseases of the liver of various etiologies, and its detection at an early time is considered important for the backwardness of liver changes and the choice of optimal treatment tactics [4].

The study of JF in patients with chronic diffuse liver disease (JSDK) is considered necessary for the following conditions: 1) clearly developed JF affects the effectiveness of the course of treatment and increases the duration of the treatment process, and requires an increase in the dose of drugs used in the treatment [5]; 2) determination of the fibrosis stage makes it possible to determine the]; 3) non-alcoholic steatogepatitis makes it possible to ososize the drugs given by detecting JF in identified patients [6]; 4)

the development of re-JF against the background of treatment serves as the main criterion of the treatment process, and this condition is actively studied in the process of clinical studies of new drug drugs. [5]; 5) patients with pronounced liver fibrosis are considered to be patients in the high risk group for the development of JTS and GTSK [8]. In modern hepatological practice, there are invasive and noninvasive methods used to detect JF. Invasive diagnosis consists of performing a liver puncture biopsy (JPB). This method is held in hospital conditions, being considered the "gold standard" in determining JF. There are a number of contraindications to the process of detecting JF in this way, and there is a risk that the process will be complicated until death [8, 10.]. In addition according to many authors the data obtained as a result of morphological examination of liver tissue can in some cases be considered suspect and cannot be sufficient to establish treatment tactics [14,6.]. To give JF noninvasive baxo, 2 different i.e. instrumental (liver elastography) and serological (using Fibro-Aktitest, Fibromax and Steatoscrin diagnostic panels) methods are diluted. Hepatic Elastography is a noninvasive verification method that informs about vibrasion impulses and changes in the elastic composition of the liver through their analysis in computers, the progression of JF in the process of re-examinations in dynamics [99, 97, 108]. Liver elastography is performed through the FibroScan apparatus. The noninvasive serological assessment of JF is a Fibrotest-method analysis that exhibits 5 biochemical indicators in itself: α2-macroglobulin, haptoglobin, apolipoprotein A1, gammagglutamintranspep-tidase, and total bilirubin, and they are thought to be linked via discriminant function. From the biochemical data obtained , the level of JF is determined by an index obtained based on mathematical analyzes, taking into account the age, gender, height and body weight of the patient [10.].

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