SPECIFIC FEATURES OF THE DEVELOPMENT OF CHRONIC KIDNEY DISEASE IN ADOLESCENTS

Olimova Gulhayo Shamsher qizi
Bukhara State Medical Institute, Bukhara, Uzbekistan

Chronic kidney disease (CKD)-considered one of the global medical, economic and social pressing problems that can negatively affect the health of the population and the economic condition of the country, occurs in almost 15% of the population of developed countries, and the resulting CKD is characterized by a high incidence of disability and death among patients.

The development of CKD is age-related, and its prevalence among children aged 14-18 is twice as high as in the age group 10-13, and almost 3 times higher than in children aged 0-5. According to the National Register of Japan and the dialysis and transplantation register (ANZDATA) of Australia, New Zealand, each year the incidence of SBY is 22 per 1 million children Group, with a higher risk of its occurrence in Indigenous children than in the rest of the children's population. The average rate of renal replacement therapy in children aged 17 years is 9 cases per 1 million children worldwide, while the prevalence rate is 65 cases. That being said, the incidence and prevalence of CKD in the United States has been reported to be high, possibly due to the earlier onset of renal replacement therapy compared to other developed countries and the higher glomerular filtration rate (GFR).

When determining the prognosis of CKD, the following factors should be taken into account: the cause of CKD, indicators of GFR and albuminuria, other risk factors and accompanying diseases. According to the recommendations of CDIGO (2012), albuminuria indicators for CKD are determined by the release of albumin per day-accordingly, 3 levels of albuminuria are determined: I. Normal or slightly elevated — up to 30 mg albuminuria II. Moderately raised-30-300 mg III. Significantly increased-more than 300 mg. The risk of developing CKD in children depends on the degree of GFR disorder and the severity of albuminuria. With a normal or initial decrease in GFR, normal and increased albuminuria levels, the risk of developing stage I-II of CKD is low, with a moderate and significant decrease in GFR, with a moderate and sharp increase in albuminuria, the risk of developing the same CKD stage increases and becomes higher. With moderate to severe declines in KFT and moderate to severe increases in albuminuria, the risk of developing CKD in stages III-V of CKD increases to above-average and very high levels, respectively.

Diagnosis of CKD in adolescents is based on disease history data (proteinuria duration, presence of arterial hypertension (AH), delayed physical development, kidney disease, kidney transplant), familial anamnesis (renal, urinary tract congenital anomalies, hereditary nephropathies, systemic diseases of connective tissue), objective examination (body weight deficiency, skeletal deformity, anemia, decreased auditory acuity, etc.), clinical and laboratory examination (protein in clinical and biochemical analysis of blood and urine, albumin, creatinine, electrolytes, ratio of albumin\creatinine in urine, red blood cells and urinary cylinders in urine, GFR), nephrobiopsia, ultrasound, computer, magnetic resonance imaging, angiography, as well as isotopic diagnostic methods are detected. Depending on the disease causing the permanent death of nephrons, CKD can be detected in the early (phase I—II) and late (phase III—V) stages. GFR is an indispensable indicator of the functional state of the kidneys.

Thus, CKD is a serious medico-social problem and requires measures to reduce the risk of its development, early diagnosis and etiotropic treatment of the underlying disease, identify, prevent and treat systemic complications of kidney dysfunction, significantly affecting the health of people on all continents and the economic condition of the country.