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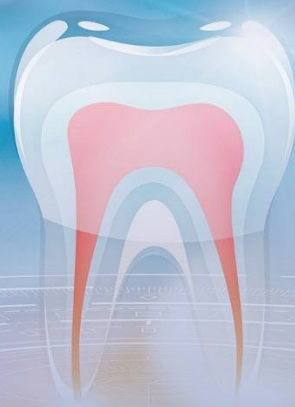
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IMPROVING DENTAL CARE WITH AN INDIVIDUAL APPROACH IN COMPREHENSIVE TREATMENT OF PATIENTS WITH BONE TUBERCULOSIS OF MAXILLOFACIAL LOCALIZATION

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ANNOTATION

Tuberculosis of the maxillofacial bones remains an urgent medical and social problem, despite the achieved successes in combating tuberculosis in general. According to the World Health Organization, approximately 10 million new tuberculosis cases are registered annually worldwide, of which 15-20% account for extrapulmonary forms. Among extrapulmonary localizations, bone and joint tuberculosis ranks third after lymph node and urogenital system tuberculosis, comprising 10-15% of all extrapulmonary forms. Moreover, the lesion of maxillofacial bones occurs in 0.5-2% of bone and joint tuberculosis cases, which creates significant diagnostic and therapeutic challenges for dentists and maxillofacial surgeons.

Keywords: tuberculosis of maxillofacial bones, personalized dental care, interdisciplinary approach, tuberculous osteomyelitis, diagnostic algorithms, surgical treatment, rehabilitation.

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СОВЕРШЕНСТВОВАНИЕ СТОМАТОЛОГИЧЕСКОЙ ПОМОЩИ С ПРИМЕНЕНИЕМ ИНДИВИДУАЛЬНОГО ПОДХОДА ПРИ КОМПЛЕКСНОМ ЛЕЧЕНИИ БОЛЬНЫХ С КОСТНЫМ ТУБЕРКУЛЕЗОМ ЧЕЛЮСТНО-ЛИЦЕВОЙ ЛОКАЛИЗАЦИИ

АННОТАЦИЯ

Туберкулез костей челюстно-лицевой области остается актуальной медико-социальной проблемой, несмотря на достигнутые успехи в борьбе с туберкулезом в целом. По данным Всемирной организации здравоохранения, ежегодно в мире регистрируется около 10 млн новых случаев туберкулеза, из которых 15-20% приходится на внелегочные формы. Среди внелегочных локализаций туберкулеза костно-суставная форма занимает третье место после туберкулеза лимфатических узлов и мочеполовой системы, составляя 10-15% всех внелегочных форм. При этом поражение костей челюстно-лицевой области встречается в 0,5-2% случаев костно-суставного туберкулеза, что создает значительные диагностические и лечебные трудности для стоматологов и челюстно-лицевых хирургов.

Ключевые слова: туберкулез костей челюстно-лицевой области, персонифицированная стоматологическая помощь, междисциплинарный подход, туберкулезный остеомиелит, диагностические алгоритмы, хирургическое лечение, реабилитация.

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YUZ-JAG' SOHASI SUYAK TUBERKULYOZI BILAN OG'RIGAN BEMORLARNI KOMPLEKS DAVOLASHDA INDIVIDUAL YONDASHUVNI QO'LLASH ORQALI STOMATOLOGIK YORDAMNI TAKOMILLASHTIRISH

ANNOTATSIYA

Yuz-jag' sohasi suyaklari tuberkulyozi, umuman olganda silga qarshi kurashda erishilgan yutuqlarga qaramay, dolzarb tibbiy-ijtimoiy muammo bo'lib qolmoqda. Jahon sog'liqni saqlash tashkiloti ma'lumotlariga ko'ra, dunyoda har yili 10 millionga yaqin yangi sil kasalligi qayd etiladi, ularning 15-20 foizi o'pkadan tashqari shakllarga to'g'ri keladi. Silning o'pkadan tashqari joylashuvlari orasida suyak-bo'g'im shakli limfa tugunlari va siydik-tanosil tizimi silidan keyin uchinchi o'rinda turadi va barcha o'pkadan tashqari shakllarning 10-15 foizini tashkil qiladi. Bunda yuz-jag' sohasi suyaklarining zararlanishi suyak-bo'g'im silining 0,5-2 foiz holatlarida uchraydi, bu esa stomatologlar va yuz-jag' jarrohlari uchun tashxis qo'yish va davolashda sezilarli qiyinchiliklar tug'diradi.

Kalit so'zlar: yuz-jag' sohasi suyaklari tuberkulyozi, shaxsga yo'naltirilgan stomatologik yordam, fanlararo yondashuv, tuberkulyoz osteomieliti, diagnostika algoritmlari, jarrohlik yo'li bilan davolash, reabilitatsiya.

Introduction. Tuberculosis of the bones of the maxillofacial region remains an urgent medical and social problem, despite the successes achieved in the fight against tuberculosis in general [1, 2]. According to the World Health Organization, about 10 million new cases of tuberculosis are registered annually in the world, of which 15-20% are in extrapulmonary forms [3]. Among the extrapulmonary localizations of tuberculosis, the osteoarticular form ranks third after tuberculosis of the lymph nodes and genitourinary system, accounting for 10-15% of all extrapulmonary forms [4]. At the same time, bone damage in the maxillofacial region occurs in 0.5-2% of cases of osteoarticular tuberculosis, which creates significant diagnostic and therapeutic difficulties for dentists and maxillofacial surgeons [5, 6].

Over the past decade, there has been a change in the structure of clinical forms of tuberculosis with an increase in the proportion of extrapulmonary localizations, including damage to the bones of the maxillofacial region. This is due to both improved diagnostic methods and an increase in the drug resistance of *Mycobacterium tuberculosis*, migration processes and changes in the immunological reactivity of the population.

The problem is particularly relevant due to the difficulties of early diagnosis of tuberculosis of the maxillofacial region, due to the nonspecific clinical manifestations, similarities with other inflammatory and destructive processes in the jaw bones, as well as insufficient vigilance of dentists regarding the tuberculosis etiology of the disease. According to various authors, diagnostic errors in tuberculosis of the maxillofacial region range from 30% to 80%, which leads to a late start of specific therapy and a worsening of the prognosis of the disease.

The organization of dental care for patients with tuberculosis of the bones of the maxillofacial region is characterized by fragmentation and lack of a unified approach [7]. Existing diagnostic and treatment algorithms often do not take into account the peculiarities of the course of the tuberculosis process, do not ensure continuity between different specialists, and do not provide for a personalized approach to the comprehensive treatment and rehabilitation of this category of patients [8].

Modern approaches to the treatment of tuberculosis of the bones of the maxillofacial region are based on a combination of specific anti-tuberculosis chemotherapy and surgical treatment [9]. However, the issues of preoperative preparation, choosing the optimal amount and timing of surgical intervention, postoperative management and rehabilitation of these patients remain insufficiently developed. Of particular importance is the problem of rehabilitation of patients after surgical treatment of tuberculosis of the maxillofacial region, including orthopedic treatment, restoration of chewing function, aesthetic rehabilitation and social adaptation. The lack of an integrated approach to rehabilitation of this category of patients leads to a significant decrease in the quality of life, functional and aesthetic disorders, as well as social maladaptation [10].

In modern conditions, the development of a personalized approach to the complex treatment of patients with tuberculosis of the bones of the maxillofacial region, taking into account the clinical and morphological features of the disease, the nature of the drug sensitivity of *Mycobacterium tuberculosis*, the immunological status of the patient and concomitant pathology, is of particular relevance [11]. This approach should ensure maximum effectiveness of treatment with minimal risk of complications and recurrence of the disease.

Thus, the urgency of the problem of optimizing dental care and developing a personalized approach in the complex treatment of patients with tuberculosis of the bones of the maxillofacial region is determined by the significant prevalence of the disease, difficulties in diagnosis, the lack of a unified approach to the treatment and rehabilitation of this category of patients, as well as the need to improve the effectiveness and quality of medical care.

The purpose of the study: to develop and evaluate the effectiveness of a comprehensive model for optimizing dental care based on a personalized approach to the diagnosis, treatment and rehabilitation of patients with tuberculosis of the bones of the maxillofacial region.

Research materials and methods: The study included 142 patients with tuberculosis of the bones of the maxillofacial region who were treated at the Republican Specialized Scientific and Practical Center of Phthisiology and Pulmonology and at the Department of Maxillofacial Surgery of the Samarkand State Medical University Clinic in the period from 2022 to 2025. The criteria for inclusion in the study were: age over 18 years, verified diagnosis of tuberculosis of the bones of the maxillofacial region, absence of severe concomitant pathology that prevents comprehensive treatment, informed consent of the patient to participate in the study. The exclusion criteria were: age under 18 years, pregnancy and lactation, the presence of malignant neoplasms, decompensated somatic diseases, and the patient's refusal to participate in the study.

The patients were divided into two groups: the main group (72 patients), which used the model we developed for optimizing dental care based on a personalized approach, and the control group (70 patients), who received treatment according to a standard protocol. The groups were comparable in age, gender, clinical forms of tuberculosis, and the nature of drug sensitivity of *Mycobacterium tuberculosis* ($p > 0.05$).

The age of the patients ranged from 19 to 68 years, with an average age of 42.3 ± 11.7 years. The ratio of men and women was approximately the same: 73 (51.4%) men and 69 (48.6%) women. According to the localization of the tuberculosis process, damage to the lower jaw prevailed – 87 (61.3%) cases, damage to the upper jaw was observed in 42 (29.6%) patients, combined damage to the upper and lower jaws – in 13 (9.1%) patients. All patients underwent a comprehensive examination, including general clinical, laboratory and instrumental methods.

The clinical examination included the collection of anamnesis, assessment of the general condition, external examination, examination of the maxillofacial region, assessment of the condition of teeth and periodontitis, detection of fistulous passages, determination of the condition of regional lymph nodes. Laboratory methods included general and biochemical blood tests, bacteriological examination of the discharge from the fistula to determine the drug sensitivity of mycobacterium tuberculosis, molecular genetic methods (PCR, GeneXpert MTB/RIF), immunological tests (quantiferon test, T-SPOT.TB).

Instrumental examination methods included radiography of the jaws in various projections, orthopantomography, computed tomography (CT) of the maxillofacial region, and, if necessary, magnetic resonance imaging (MRI). Histological examination of biopsy and surgical material was performed in all patients to verify the diagnosis using standard staining techniques (hematoxylin-eosin, according to Zil-Nielsen) and immunohistochemical methods.

The model we developed for optimizing dental care for patients with tuberculosis of the bones of the maxillofacial region included the following components:

1. An improved algorithm for early diagnosis based on a comprehensive assessment of clinical, radiological, laboratory and molecular genetic data.

2. A personalized approach to preoperative preparation, taking into account the nature of the drug sensitivity of Mycobacterium tuberculosis, the clinical and morphological form of the disease and the immunological status of the patient.

3. Differentiated choice of the volume and timing of surgical intervention depending on the localization and prevalence of the tuberculosis process, the degree of bone tissue destruction and the effectiveness of preoperative chemotherapy.

4. An integrated approach to postoperative management, including early rehabilitation, prevention of relapses and complications, taking into account the individual characteristics of the patient.

5. Multi-stage rehabilitation aimed at restoring functional and aesthetic defects, with the development of individualized programs for each patient.

Comprehensive rehabilitation of patients after surgical treatment of tuberculosis of the maxillofacial region included the following stages:

1. The early rehabilitation stage (1-3 months after surgery) is mainly medical rehabilitation aimed at wound healing, prevention of complications, prevention of contractures, and restoration of motor functions.

2. The main rehabilitation stage (4-6 months) is comprehensive medical and social rehabilitation, including orthopedic treatment, psychological correction, and social adaptation.

3. The supportive stage (7-12 months or more) is mainly social and professional rehabilitation with supportive medical measures.

The effectiveness of the treatment was assessed on the basis of clinical, radiological, laboratory data and the results of bacteriological examination. Follow-up examinations were performed 1, 3, 6, 12, and 24 months after completion of treatment. The SF-36 and OHIP-14 questionnaires were used to assess the quality of life, the chewing functional assessment scale was used to assess functional results, and a visual analog scale was used for aesthetic results.

Statistical analysis was carried out using the SPSS 25.0 program. To compare quantitative indicators in groups, the

Student's t-test and the Mann-Whitney U-test were used, for qualitative indicators, the χ^2 criterion and the Fisher exact criterion. The differences at $p < 0.05$ were considered statistically significant.

Results: Analysis of diagnostic results showed that in the main group, due to the use of an improved diagnostic algorithm, the time for diagnosis decreased from 5.8 ± 2.3 to 2.1 ± 0.9 months ($p < 0.001$), the frequency of diagnostic errors decreased from 37.1% to 9.7% ($p < 0.001$), which allowed early initiation of specific treatment. A personalized approach to choosing preoperative chemotherapy regimens, taking into account the drug sensitivity of mycobacterium tuberculosis, made it possible to achieve higher efficiency of preoperative preparation in the study group: complete clinical improvement in the study group was observed in 69.4% of patients, in the control group - in 41.4% ($p < 0.001$); partial improvement - in 23.6% and 38.6%, respectively ($p = 0.042$); no effect was observed in 7.0% in the main group and in 20.0% in the control group ($p = 0.017$).

Due to a differentiated approach to choosing the volume and timing of surgical intervention in the main group, the incidence of intraoperative complications was reduced from 14.3% to 5.6% ($p = 0.019$), postoperative complications from 25.7% to 11.1% ($p = 0.012$), and the average duration of surgery was reduced from 165.3 ± 38.4 to 127.6 ± 31.7 minutes ($p < 0.01$) and intraoperative blood loss from 387.2 ± 89.3 to 264.5 ± 67.8 ml ($p < 0.01$).

An integrated approach to postoperative management and rehabilitation ensured earlier restoration of the functions of the maxillofacial region in the main group. The recovery of chewing function 6 months after surgery in the main group was $74.8 \pm 8.2\%$ of normal, in the control group - $58.3 \pm 9.5\%$ ($p < 0.001$); after 12 months - $86.3 \pm 7.9\%$ and $69.5 \pm 10.2\%$, respectively ($p < 0.001$). Aesthetic results on a visual analog scale 12 months after surgery in the main group were assessed as good in 68.1% of patients, satisfactory in 23.6%, unsatisfactory in 8.3%; in the control group - 37.1%, 42.9% and 20.0%, respectively ($p < 0.001$). The recurrence rate of tuberculosis in the maxillofacial region during 24 months of follow-up in the main group was 5.6% (4 patients), in the control group - 18.6% (13 patients) ($p = 0.008$). The duration of TB therapy in the main group decreased from 13.7 ± 2.8 to 10.2 ± 1.9 months ($p < 0.001$), the frequency of side effects of chemotherapy decreased from 35.7% to 22.2% ($p = 0.034$).

The quality of life of patients 12 months after completion of treatment in the main group increased from 37.2 ± 9.4 to 73.5 ± 12.6 points ($p < 0.001$) for the physical component of health (PCS), and from 34.8 ± 10.2 to 76.9 ± 11.8 points ($p < 0.001$) for the psychological component (MCS). In the control group, the dynamics of these indicators was significantly less pronounced: PCS - from 36.9 ± 9.8 to 56.7 ± 11.3 points ($p < 0.01$), MCS - from 35.2 ± 9.5 to 61.3 ± 12.4 points ($p < 0.01$). The differences between the groups in both indicators were statistically significant ($p < 0.001$). Social readaptation in the main group was more successful: the restoration of social ties was noted in 84.7% of patients, in the control group - in 60.0% ($p < 0.001$); employment among patients of working age in the main group was 79.2%, in the control group - 53.8% ($p = 0.004$).

Conclusions: The study showed the high effectiveness of the developed comprehensive model for optimizing dental care and a personalized approach to the treatment of patients with tuberculosis of the bones of the maxillofacial region. The use of an improved diagnostic algorithm has significantly reduced the time for diagnosis and the frequency of diagnostic errors, which ensured an early start of specific therapy and improved prognosis

of the disease. A personalized approach to preoperative preparation, taking into account the clinical and morphological features of the tuberculosis process, the drug sensitivity of mycobacteria and the immunological status of the patient, made it possible to achieve higher efficiency of preoperative chemotherapy and better preparation of patients for surgical treatment. A differentiated approach to the choice of the volume and timing of surgical intervention contributed to a reduction in the frequency of intra- and postoperative complications, a reduction in the duration of surgery and intraoperative blood loss. Comprehensive rehabilitation of patients after surgical treatment, including medical, psychological, social and

professional components, ensured a more complete restoration of the functional and aesthetic characteristics of the maxillofacial region, a significant improvement in the quality of life and successful social rehabilitation of patients. A personalized approach to postoperative management and recurrence prevention has helped to reduce the frequency of tuberculosis recurrence and reduce the duration of TB therapy.

The proposed model for optimizing dental care for patients with tuberculosis of the bones of the maxillofacial region can be recommended for implementation in practical healthcare in order to increase the effectiveness of diagnosis, treatment and rehabilitation of this category of patients.

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