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Реферати

СОВРЕМЕННЫЕ ПОДХОДЫ К ЛЕЧЕНИЮ БОЛЬНЫХ С ГНОЙНО-НЕКРОТИЧЕСКИМИ ПОРАЖЕНИЯМИ СИНДРОМА ДИАБЕТИЧЕСКОЙ СТОПЫ

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Количество больных сахарным диабетом во всем мире увеличивается с геометрической прогрессией, а значит и растет количество осложнений. Синдром диабетической стопы является лидером среди причин, которые приводят к ранней инвалидизации пациентов. Поэтому поиск новых лечебных тактик является постоянным процессом, мотивирует хирургов и в свою очередь открывает новые возможности в лечении различных форм гнойно-некротических процессов у больных с сахарным диабетом. Терапия отрицательным давлением выступает как одна из самых перспективных на сегодня. А ряд проведенных рандомизированных клинических исследований уже сегодня доказали ее эффективность на практике. Применение вакуумной терапии как составного компонента комбинированного лечения гнойно-некротических поражений синдрома диабетической стопы позволяет значительно ускорить реконвалесценцию и существенно уменьшить процент высоких ампутаций в будущем.

Ключевые слова: сахарный диабет, синдром диабетической стопы, раневой процесс, вакуумная терапия ран.
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MODERN APPROACHES TO TREATMENT OF PATIENTS WITH PURULO-NECROTIC LESIONS OF DIABETIC FOOT SYNDROME

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The number of patients with diabetes mellitus worldwide increases with geometric progression, which means that % of complications increases as well. Diabetic foot syndrome is the leading cause of early disability of patients. Therefore, the search for new therapeutic tactics is a constant process that motivates surgeons and in turn opens new opportunities in the treatment of various forms of purulent-necrotic processes in patients with diabetes mellitus. Therapy with negative pressure is one of the most promising nowadays. A number of conducted randomized clinical trials have already proved its effectiveness in practice. The use of vacuum therapy as an integral component of the combined treatment of purulent-necrotic lesions in diabetic foot syndrome can significantly accelerate reconvalescence and reduce % of high amputations in the future.

Key words: diabetes mellitus, diabetic foot syndrome, wound process, vaccum therapy of wounds.
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COMMUNICATION AND INTERPERSONAL SKILLS IN PRACTICE OF PEDIATRIC DENTISTRY

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This article aims at analyzing the main approaches and principles of professional communication between pediatric dentists and their patients. Communication skills are one of the major competences in the pediatric clinical practice. Dealing with children of all ages, the dentist have to take into account the level of child's development, to choose or to design a special approach to each of the patients, to demonstrate child-friendly and encouraging attitude. The ability to involve the parents into trust relationship and to build up cooperation is one of determinant factors in reaching successful treatment outcomes.

Key words: children, pediatric dentist, communicative competence, communication.

Communication skills are considered as one of the major competences for dental professionals, both in their own right and for underpinning other domains of patient-centred care. Effective verbal communication is essential for successful dental treatment: it contributes to establishing a trusting relationship with the child patient and engages in the cooperation in the provision of oral health care. All pediatric dentists agree as to the importance of verbal communication in making the child's exposure to

dentistry more pleasant and acceptable. Wurster et al. have shown that a child's behavior depends on the communication pattern of the dentist [9]. Thus, communication can be regarded as a main part of the clinical activity of pediatric dentistry and its effectiveness can considerably influence the treatment outcomes.

The **purpose** of the present study is elucidating and analysing the main principles and characteristics of the paediatric dentist-patient touch points.

The communicative competence of dental professionals includes the awareness of: types and functions of communication and interaction; types of characters and temperaments of children, as well as their behavioural patterns; age characteristics of children's behavioural pattern and factors influencing their behaviour; techniques of controlling the children behaviour (behavioural-management techniques); rules and forms of behavioural etiquette; rules and forms of speech etiquette; psychological techniques and methods of persuading and influencing people; ability to watch people while communicating with them and draw right conclusions about their personality traits and emotional state; ability to choose right role model and to follow the example of your role model. ability to evoke trust by demonstrating care, compassion and kindness [3].

The first step initiating the provision of dental care starts with getting into contact with the patient. This is the step of making first impression and laying the foundations of further interpersonal interaction. Good communicative skills are essential for pediatric dentists as they have to deal not only with small patients, but to build up and keep the relations with their parents who are often biased against all doctor's actions and recommendations. It is necessary to stress that many parents today attempt to "become a friend" to their child and lose the ability to set boundaries [8] that should be taken into consideration by medical professionals. The first impression of a child about a doctor will considerably predetermine their relationship, compliance to curative and preventive treatment including taking medication, keeping on diet, regimen, and performing other oral care routine. In other words, child's behavior may range from cooperative to apprehensive to defiant, and vice versa. As a barrier to accessing dental care, dental anxiety in children may be a consequence of the child's stage of personality development, parental dental anxieties or the parent's fears and wishes to deny her child any distress or anxiety. Thus, children and their parents should be aware that the doctors do want and can help them. Mutual understanding between the doctors, the small patients and their parent predetermines not only making correct diagnosis but the successful treatment outcomes.

Communication is a complex process that is performed through the use of various mutually understood signs and rules. In some cases, attention is focused on what is said; in other situations, how is said seems to be much more important. For example, good control of some voice parameters as speaking rate and intonation can enhance the effect of encouraging or condemning the child's behavior [2].

Non-verbal communication of the pediatric dentist at the stage of making contact is more important than verbal communication. At the level of verbal interaction, different doctors usually use identical typical vocabulary, but nonverbally, be means of intonations, gestures, and facial expression, they can convey completely different messages that demonstrate a particula attitude towards children of all ages and their problems. While communicating with the patient, the dentist should gradually shorten the physical distance: at some point of the conversation, he can lean closer to the child or touch his / her hand, avoiding sharp movements and rough touches. This gives the child a sense of warmth and friendly support. Non-verbal communication is an essential skill; non-verbal information is the most meaningful for the small patients that they can perceive and respond to when seeing the dentist for the first time [7].

Making and keeping eye contact is important part of interaction a swell. A child who avoids looking straight the doctor in the eye, as a rule, feel uneasy and anxious and is unready to cooperate. The first doctor's asking "Look at me!" can help to make eye contact and initiate communication [2].

When communicating with children and their parents, the pediatric dentists should adhere to a number of principles [5] in order to choose the most appropriate behavioral options and apt behavioral management techniques.

The first principle emphasizes that the younger children the more special attention and attitude they need. The initial clinical encounter sets the tone for all other interactions throughout the visit. At first acquaintance the dentists should address first rather a child than his/ her parents. It is recommended to greet the child at the level of his / her eye (to bend forward to the child) that by itself is a positive nonverbal sign for the child, but avoid approaching too close. Dentists can greet little patients with a node and a friendly smile. When speaking, dentists should not use words unclear or hardly understandable for children. The first point of communication with preschoolers is often facilitated if you start conversation with soft friendly tone so that children feel more comfortable and relaxed. Quite often, children can

answer whispering. If a child is at the age of 4-5, it is very important for the doctor to find a common language with him /her in such a way that to get true information about complaints, symptoms and to discuss the treatment options using the language clear, positive, and understandable for the child. It is very beneficial to use pictures and drawings to explain or illustrate some medical problems.

The second important principle of effective communication is conciseness, i.e. all doctor's comments and replies should be brief. It is necessary to ask permission to examine both the children and their parents. The doctor or dental assistant should be extremely clear and convincing in explaining what will happen or what will be done – anxiety can be vastly reduced if the child knows what to expect. The doctor should be friendly, but insistent on performing examination and some procedures when necessary. If possible, the word "no" should be avoided, because for children this word is a call to confrontation.

Praise is the third essential principle in pediatrics used to reinforce cooperative behavior. All people demonstrate better response to positive words. Therefore, it is important for dentists to demonstrate sincere friendly attitude towards their small patients and reward them for displaying any desirable behavior. It is much easier to keep patients calm and open to cooperation providing positive reinforcement. As useful tricks dentists can direct children's attention on clothes, shoes, fashionable hair style or elements of child-friendly environment.

To date, several patterns of doctor-patient interactions have been reported [1].

Paternalistic (sacred) pattern. The foundations of the model were laid down in the hippocratic era. According to this pattern, the doctor appears as a wizard, caring father and even a god who, at his own discretion, guides the life of a person (patient). The patient is regarded as a child, who blindly and unconditionally trusts the doctor and is not responsible for his or her own health. Deontological principles enshrined in the Oath of the Doctor may be considered as the patient's safety guarantor. Otherwise, if there is no such guarantee, the patient will never risk consult the doctor. Therefore, the basic moral principle, which expresses the tradition of sacred type, proclaims: "Do not harm patients by providing care ".

Technical pattern. One of the ambiguous consequences of the rapid development of biomedical technologies is the emergence of a doctor-scientist or doctor-researcher. According to this pattern, the responsibility for the treatment outcome is shared equally between the physician and the patient. Within this approach the doctor often acts as a scientist whose main task is to eliminate (repair) the problem in the patient's body and the process of eliminating the "breakage" is self-sufficient in terms of scientific knowledge and involves a pronounced impartiality of the doctor. The ethical incorrectness of such attitude towards the patient as relation to the faulty mechanism here is completely compensated by the patient's responsibility for the final decision-making.

Cooperation pattern. The doctor and the patient work jointly towards the same end in fighting against the disease. Patient's social status, age, education do not influence the cooperation at all. The only part of some hypocrisy seems the fact that the doctor does not feel the suffering of the patient, with all the consequences of the psychological and moral problems that might arise.

Pattern of mutual obligations. This model also demonstrates the equal responsibility of the doctor and the patient for the result of treatment. Within the framework of the agreement (both oral and documented agreement) all aspects of "doctor-patient" interaction are specified. The pattern being the most widespread in European countries and the United States enables to avoid doctor's empathy decline that is typical for the technical pattern on the one hand, and on the other hand, to forestall the refusal of patient's personal responsibility for the involvement in the process of treatment that is typical for the sacral pattern. In contract-based relationships, the physician is aware that informed consent of the patient provides his / her freedom to manage own life. When working with children, the paternalistic model seems to be quite reasonable to follow. The emotional lability is known as typical for children that may impede to build up the contact at the dentist's visit and during dental interventions, which are preceded by a feeling of emotional stress and fear [4].

Children operating a limited vocabulary, often experience difficulties in describing the character of pain; they can not identify it ('acute / keen / stinging / sharp', "cutting", "pressing", "aching"). Young children often can not establish cause-effect relations between the events: it is difficult for them to determine whether the pain is associated with eating or the nature of the food they eat, etc. At the dentist's office, children are often frightened and panic, and can mimic the disease, by simulating, for example, complaints, which are typical not for caries, but for its complications. Observing the child's behavior allows the dentist to obtain the necessary additional information to establish the diagnosis [6].

By creating the child-friendly atmosphere and shortening the physical interpersonal distance insensibly, the pediatric dentists get the child prepared for physical contacts during the routing procedures of oral examination (palpation, percussion, probing, etc.). It is important to remember that

that in most cases, small patients demonstrate emotional reactions to the first physical contact with the dentist. To reduce the stressful impact of oral examination, the dentists may try to mask all manipulations through the play and imitation. For instance, the dentist or hygienist can explain and demonstrate all the nuances of proper tooth brushing and flossing, and then offer the child to try to operate by his / herself.

It would be very beneficial for pediatric dentists and dental auxiliaries to introduce some elements of play activity into their practice when dealing with small patients as playing is a natural way of their learning and communicating. The dentists can make the first experience to the dental office positive, unique and memorable by encouraging children's good behavior with special pleasant and meaningful things, useful gifts (pictures, baby toothpaste, a tooth brush, etc).

Conclusion

Communication skills are one of the major competences in the clinical practice of pediatric dentists. Dealing with children of all ages, the dentist have to take into account the level of child's development, to choose or to design a special approach to each of the patients, to demonstrate child-friendly and encouraging attitude. The ability to involve the parents into trust relationship and to build up cooperation is one of determinant factors in reaching successful treatment outcomes. When patients have a positive experience in your practice they will be more inclined to accept a recommended treatment and return for ongoing care.

Prospects of further research: better understanding of behavioral patterns of children with general somatic diseases and identifying the peculiarities in their coming into contact with dentists allow us to develop practical recommendations and the algorithm of action in various cases.

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Реферати

КОМУНІКАТИВНА СТОРОНА ПРОФЕСІЙНОГО СПІЛКУВАННЯ ЛІКАРЯ-СТОМАТОЛОГА НА ДИТЯЧОМУ ПРИЙОМІ

Падалка А.І., Труфанова В.П., Поліщук Т.В., Костенко В.Г., Шешукова О.В.

В статті проаналізовані основні моменти та принципи професійного спілкування лікаря-стоматолога на дитячому прийомі. При лікуванні маленьких пацієнтів особливо вагому роль відіграють комунікативні здібності лікаря-стоматолога. Працюючи з дітьми різного віку, лікарю необхідно враховувати рівень розвитку дитини, спланувати особливий підхід до кожного, не скупитися на заохочення. Здатність встановити довірчі відносини з батьками є дуже важливою для подальшого успішного лікування дитини.

Ключові слова: діти, лікар-стоматолог, комунікативна компетенція, спілкування.

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КОММУНИКАТИВНАЯ СТОРОНА ПРОФЕССИОНАЛЬНОГО ОБЩЕНИЯ ВРАЧА-СТОМАТОЛОГА НА ДЕТСКОМ ПРИЕМЕ

Падалка А.И., Труфанова В.П., Полищук Т.В., Костенко В.Г. Шешукова О.В.

В статье проанализированы основные моменты и принципы профессионального общения врача-стоматолога на детском приеме. При лечении маленьких пациентов особенно важную роль играют коммуникативные способности врача-стоматолога. Работая с детьми раннего возраста, врачу необходимо учитывать уровень развития ребенка, спланировать особенный подход к каждому, не скупиться на похвалу. Способность установить доверительные отношения с родителями очень важна для дальнейшего успешного лечения ребенка.

Ключевые слова: дети, врач-стоматолог, коммуникативная компетенция, общение.

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