3. Integrate prostate health education in university curricula.

Bridging the knowledge gap in young populations could significantly reduce future disease burden and improve early detection, in line with global guidelines (Rawla, 2019; WHO, 2022; ACS, 2023) [1–4].

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CLINICAL CHARACTERISTIC PATIENTS WITH ULCERATIVE COLITIS

Introduction

Ulcerative colitis (UC) is an idiopathic inflammatory condition of the colon that results in diffuse friability and superficial erosions on the colonic wall and associated bleeding. It is the most common form of inflammatory bowel disease worldwide. Characteristically, it involves inflammation restricted to the mucosa and submucosa of the colon. Typically, the disease starts in the rectum and extends proximally in a continuous manner [1].

It is also important to consider disease extent when planning treatment in UC, as this may affect the optimal route of Drug administration. This is typically defined according to disease involving the rectum only [proctitis], disease distal to the Splenic flexure [left-sided UC], or disease extending proximal to the splenic flexure [extensive UC] [2].

Goal

The purpose of this study is to analyze the clinical characteristic patients with ulcerative colitis.

Material and methods of research

A cross-sectional, single-center study involving 25 patients with Ulcerative Colitis was conducted at the gastroenterology department of Gomel State Clinical Hospital No. 3 in January 2026. This study aimed to understand the clinical presentations and complications associated with Ulcerative Colitis in the hospitalized population of Gomel. Through this detailed analysis, we sought to identify patterns and insights that could enhance the management and treatment of Ulcerative Colitis in similar clinical settings.

25 people of different age groups of Belarus has participated in this study, of which 3 participants belonged to 20–30 age group, 12 participants were from 30–50 age group and 10 participants were from 50–70 age group. Among them 60% were Male and 40% were female.

The results of the research and their discussion

Results and their discussion of the main complications of Ulcerative colitis:

Intestinal manifestation:

Bloody diarrhea was observed in 17 patients (68%). Mucus in the stool was present in 10 patients (40%). Increased stool frequency was reported in 17 patients (68%). Tenesmus was noted in 5 patients (20%), abdominal pain in 9 patients (36%), and rectal bleeding in 6 patients (24%).

Extra intestinal manifestation:

Arthritis was observed in 7 patients (28%). Erythema was noted in 1 patient (4%), episcleritis in 1 patient (4%), anemia in 10 patients (40%), oral ulcers in 1 patient (4%), and conjunctivitis in 1 patient (4%).

The findings from our studies are presented below in table 1.

Table 1 – Manifestation ulcerative colitis

Intestinal manifestation		Extra intestinal manifestation	
Subcategory	N° of Patients	Subcategory	N° of Patients
Bloody diarrhea	17	Arthritis	7
Mucus in stool	10	Erythema	1
Increased stool frequency	17	Episcleritis	1
Tenesmus	5	Oral ulcers	1
abdominalpain	9	Anaemia	10
Rectal bleeding	6	Conjunctivitis	1

In our clinical experience, assessing the severity of ulcerative colitis is fundamental to management. We classify it as mild, moderate, or severe based on a combination of the patient's symptom burden (stool frequency, bleeding) and endoscopic mucosal appearance. This stratification is not merely descriptive; it directly dictates our therapeutic strategy, predicts risks of hospitalization and colectomy, and reflects the significant impairment in a patient's quality of life. Ultimately, accurately defining severity guides every step from initial treatment to long-term monitoring for complications like colorectal cancer.

Table 2 – A comprehensive summary of severity assessment findings patients with ulcerative colitis

Severity	Number of patients
Mild	13 (52%)
Moderate	9 (36%)
Severe	3 (12%)

Most patients had mild severity (52%). Severy patients (12%) had a lot complications and need more intensive care [3, 4].

Conclusions

The clinical spectrum of ulcerative colitis, defined by its variable symptom burden, is fundamentally governed by disease severity. Accurate and dynamic assessment of severity is not a mere academic exercise but the cornerstone of clinical management. It directly informs therapeutic strategy to achieve mucosal healing, mitigates the risk of both acute and long-term complications including hospitalization, colectomy, and colorectal neoplasia and ultimately aims to improve the patient's quality of life. A nuanced understanding of this interplay between symptoms, severity, and complications is therefore essential for optimizing individualized care and improving long-term prognoses in ulcerative colitis. To translate this understanding into practice, we advocate for:

1. Stratify Management by Severity, Not Just Symptoms.

Use validated indices (Partial Mayo Score, endoscopic findings) at every visit to formally categorize disease activity. Treatment intensity and monitoring frequency should be dictated by the patient's highest documented severity, as this predicts complication risk.

2. Treat to an Objective Target.

Aim for clinical and endoscopic remission (mucosal healing). Utilizing fecal calprotectin and scheduled sigmoidoscopy to guide therapy reduces long-term risks of hospitalization, colectomy, and colorectal neoplasia.

3. Establish a Structured Surveillance Protocol.

For patients with a history of extensive, moderate to severe colitis, implement a disciplined schedule for dysplasia surveillance

4. Educate Patients on Complication Red Flags

Proactively teach patients to recognize and urgently report symptoms indicating severe flare (high fever, profuse bleeding, severe pain) or complication (worsening pain, distension suggesting toxic megacolon). This enables rapid intervention.

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GESTATIONAL DIABETES AND ITS RISK FACTORS

Introduction

Gestational diabetes mellitus (GDM) is characterized by high blood sugar levels that first appear or are identified while a woman is pregnant (GDM) is often divided into two classes: (GDM) of class A1, which depends on diet, and (GDM) of class A2, which requires pharmacological treatment of hyperglycaemia [1]. The benefits of diagnosing GDM have been known for a long time; numerous studies have shown that the prevention and treatment of GDM reduces the risk of adverse pregnancy outcomes and that women with GDM are at high risk of developing type 2 diabetes mellitus in the postpartum period [2, 3]. Due to the strikingly high perinatal mortality rate among pregnant women with diabetes, treatment strategies for GDM have continued to change over the past few decades. Treatment strategies for GDM have changed over time, starting with the World Health Organization (WHO) changing glucose thresholds and the adoption of comprehensive criteria by the International Association of Diabetes and Pregnancy Groups (IADPSG) in 2013 [3, 4]. Risk factors for developing gestational diabetes are key points that can reduce risks during pregnancy [5].