

zation (ideally 2 weeks before surgery) may be helpful in giant pelvic pseudotumors. Surgical resection is considered only for symptomatic pseudotumors, and microinvasive endoscopic surgical approaches are preferred.

### **Conclusion**

This case highlights the diagnostic and therapeutic challenges associated with hemophilic pseudotumor, especially in patients with large masses and with extensive bone destruction. Incidence of case like this are increased with increased longevity. Specially currence of complications affecting the osseous system. Here we studied one of the more serious bone complications where hemophilic hemotoma mimicked like a tumor. Sometimes we can find true tumors that mimic hemophilic pseudo tumors too. Diagnosing such pseudo tumor differs from diagnosing a cancerous tumor, and there is high potential for misdiagnosis thus resulting in severe bleeding and fatal consequences. Instead, diagnosing a pseudotumor usually involves taking a history, conducting a physical exam and performing an imaging study, such as a CT scan or magnetic resonance imaging (MRI). Early diagnosis is crucial for evaluation and for proper surgical planning. Replacement therapy is often the first therapeutic approach; however, surgery is the most effective and the only definitive treatment even though it may be associated with higher rates of complications. The main limitation of hemophilic pseudotumors is we have a low degree of evidence (case reports, case series etc). However, it cannot be forgotten that this is a very infrequent and potentially serious injury.

### **LITERATURE**

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**UDC [616.98:578.834.1]:616.2-036.11**

**COVID 19-EFFECT ON PULMONARY SYSTEM. ACUTE RESPIRATORY DISTRESS SYNDROME. COMPARISON BETWEEN H1N1 AND SARS CoV19**

***Zeeshan Ahmad***

**Scientific supervisor: Dr. Pervez Ansari MBBS MD (internal medicine)**

**Kota, Rajasthan, India**

**Senior lecturer of the department A. N. Kovalchuk**

**Educational Establishment**

**«Gomel State Medical University»**

**Gomel, Republic of Belarus**

### **Introduction**

The research was conducted on 406 patients in total, during their admission in covid 19 ward and record data of H1N1 patients in the department of internal medicine at Govt. Medical Hospital KOTA Rajasthan India.

We did an analysis based research on in the department 406 patients infected by SARS CoV 19.

We analyzed history record data of 213 patients infected by H1N1 virus.

Research conducted in Govt. Public Hospital Kota including patients from Saluja and Pillai Rajasthan, India [1].

During the characteristics comparison of H1N1 and COVID 19 we found some dramatic data. Every analysis was done twice in this study to remove the bias that was present due to asymptomatic COVID-19 patients diagnosed as result of aggressive screening and contact tracing. We compared all positive patients, 406 COVID-19 with 213 H1N1 patients, followed by symptomatic COVID-19 and H1N1 patients (162 vs 213). The separate analyses did not show substantial differences, except for the P values and in two variables, which will be enumerated later. The following results will focus on the comparison of symptomatic patient.

Both infection is responsible for ARDS (acute respiratory distress syndrome).

**Key word:** ARDS (acute respiratory distress syndrome) occurs when fluid builds up in the tiny, elastic air sacs (alveoli) in your lungs. The fluid keeps your lungs from filling with enough air, which means less oxygen reaches your bloodstream. This deprives your organs of the oxygen they need to function.

#### **Goal**

The greatest concern of physicians around the world is caused by the effect of COVID-19 on the pulmonary system, since they often lead to acute conditions requiring emergency medical care, and, as a result, lead to persistent disorders of internal organs and even death. We have conducted a database research on patients with COVID-19 and patients with H1N1 virus to find out which infection is causing more mortality.

#### **Material and Methods of research**

All hospitalized patients in the region of Kota city Rajasthan India, with laboratory confirmed COVID-19 were included in the study. We obtained the medical records and compiled data of patients admitted in the isolation wards of New Medical College Hospital, Kota and associated hospitals from 5th February 2022 to 2nd March 2022. Patients still admitted in the isolation wards were omitted from the study to remove any possible bias in outcome. COVID-19 was diagnosed on the basis of the WHO interim guidance. A confirmed case of COVID-19 was defined as a positive result by real-time reverse transcriptase-polymerase-chain reaction (RT-PCR) assay of nasal and pharyngeal swab specimens. Only laboratory-confirmed cases were included in the analysis.

#### **Complications**

If you have ARDS, you can develop other medical problems while in the hospital. The most common problems are:

**Blood clots.** Lying still in the hospital while you're on a ventilator can increase your risk of developing blood clots, particularly in the deep veins in your legs. If a clot forms in your leg, a portion of it can break off and travel to one or both of your lungs (pulmonary embolism) — where it blocks blood flow.

**Collapsed lung (pneumothorax).** In most ARDS cases, a breathing machine called a ventilator is used to increase oxygen in the body and force fluid out of the lungs. However, the pressure and air volume of the A ventilator can force gas to go through a small hole in the very outside of a lung and cause that lung to collapse.

**Infections.** Because the ventilator is attached directly to a tube inserted in your windpipe, this makes it much easier for germs to infect and further injure your lungs.

**Scarring (pulmonary fibrosis).** Scarring and thickening of the tissue between the air sacs can occur within a few weeks after the onset of ARDS. This stiffens your lungs, making it even more difficult for oxygen to flow from the air sacs into your bloodstream.

**Breathing problems.** Many people with ARDS recover most of their lung function within several months to two years, but others may have breathing problems for the rest of their lives. Even people who do well usually have shortness of breath and fatigue and may need supplemental oxygen at home for a few months.

*Depression.* Most ARDS survivors also report going through a period of depression, which is treatable.

### **The results of the research and their discussion**

Despite being taken from different time periods, both viral diseases showed certain parallels as well as marked differences. Increased prevalence in male population and abnormalities found on chest X-rays were some of the similarities. At the same time, poor baseline clinical status, multi organ involvement, increased complications, requirement of life support, and finally mortality were startlingly high in H1N1, whereas constitutional symptoms, cardiac complications, and ARDS less responsive to standard management were associated with COVID-19. showed a higher reproductive number in COVID-19 the value is subjective to change keeping in mind the dynamic state of the pandemic. A specific treatment of the ongoing pandemic is still awaited but antivirals, anticoagulants, and antibiotics along with supportive management have helped to control the disease a bit. Vaccine development is quintessential as are social distancing norms at this critical hour to fully curtail the infection. Research with better logistics and a larger sample size from multiple centers are needed for the same.

Symptoms	SARS CoV-19 virus patients (406)	H1N1 virus patients(213)
Fever	89	64
Cough	94	73
Sputum production	30	13
Hemoptysis	2	8
Dyspnea	19	28
Fatigue	10	5
GI symptoms	12	10
Myalgia	27	1
CNS/PNS involvement	4	1
Olfactory	2	0
Cutaneous manifestation	7	0

SARS-CoV2, severe acute respiratory syndrome-coronavirus; CNS, central nervous system; COVID-19, coronavirus disease GI,gastrointestinal; H1N1, influenza A virus subtype H1N1 (A/H1N1); PNS, peripheral nervous system. Rest all patients were asymptomatic.

### **Conclusions**

A major difference was seen in critically ill patients. The frequency of complications and deaths were definitely more in H1N1, but the course was predictable with higher sequential organ failure scores at admission. Increased requirement of vasopressors, ventilator support in case of development of ARDS was also commonly seen in H1N1. What made even the small number of cases of ARDS and deaths in COVID-19 daunting was the unpredictable nature and poor response to the standard protocol. A higher PaO<sub>2</sub>/FiO<sub>2</sub> level in the setting of ARDS and poor response to customary management have made the situation worse. Though risk factors such as extremes of age, comorbidities, and pregnancy have been stated for both, it is less commonly observed with COVID-19.

We have observed that symptoms such as fever, cough and dyspnea are more predominant in H1N1 patients when compared to patients with COVID-19. Moreover, symptoms such as CNS and PNS involvement, myalgia, olfactory cutaneous manifestations and pleural effusion have been more predominant in COVID-19 patients when compared to H1N1 patients.

H1N1 virus patients We have found Fever 33 %, Cough 37 %, Myalgia 1 %, Dyspnea 22 %, Other symptoms 8 %.

SARS CoV-19 virus patients We have found Fever 30 %, Myalgia 10 %, Dyspnea 6 %, CNS PNS involvement 10 %, Cough 32 %, Other symptoms 12 %.

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