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OPTIMIZATION OF DIAGNOSTICS OF PATIENTS WITH VOCAL CORD PARALYSIS WITH A DIFFERENTIATED APPROACH TO THEIR MANAGEMENT TACTICS

Abdumutalipov Ulugbek Shuxrat ugli

Andijan State Medical Institute,Department of Otorhinolaryngology

Abstract: Vocal string loss of motion is a condition that influences the voice and ability to gulp of patients. Opportune and precise analysis of this condition is critical to deciding the suitable treatment plan and the executive's methodology. As of now, analytic techniques and the board strategies for vocal line loss of motion change altogether between patients. This heterogeneity presents difficulties and cutoff points ideal consideration. In this manner, there is a need to upgrade diagnostics and execute a more normalized at this point separated way to deal with patient administration. This article will investigate the qualities of vocal vocal cord paralysis.

Keywords: Vocal cord paralysis, surgery treatments, conditions, medicine, voice changes.

Introduction: The board of pediatric two-sided vocal line paralysis (BVCP) is a questionable and testing subject. It might address an extreme obstructive condition normally connected with respiratory misery, and, in such condition, tracheostomy has been viewed as the highest quality level for quite a while. Numerous careful choices have been depicted and used to expand the glottic space in BVCP, with progressing examination of less obtrusive methods. The test and latest thing in our area of expertise and in many major pediatric focuses is to stay away from tracheotomy through an early treatment. Numerous methods presented somewhat recently diminished the quantity of tracheotomies and expanded the decannulation rate. Vocal rope loss of motion (VCP) is the second most normal innate laryngeal abnormality in pediatric age (10-15%).

One-sided VCP and two-sided VCP vary in clinical show, etiology, and treatment. Two-sided vocal line loss of motion (BVCP) can be described by stridor, respiratory trouble, suprasternal, and chest withdrawals, rest apneas, and inability to flourish, and it addresses up to 62% of all pediatric VCPs. Rather gentle stridor, yearning, and rough and raspy voice are by and large reminiscent of one-sided vocal rope loss of motion (UVCP).

VCP results from laryngeal innervation issues, back glottic stenosis, or cricoarytenoid joint's (Caj's) obsession. All the motility peculiarities of the larynx are depicted with the expression "laryngeal fixed status."

A conscious laryngeal endoscopy is the fundamental test for determination of the loss of motion, and a total aviation route endoscopy under broad sedation is constantly prescribed to reject other aviation route related pathologies and to separate the loss of motion from vocal string obsession (cricoarytenoid joint ankylosis, back glottic stenosis). Around 45% of the instances of inborn BVCP have other aviation route illnesses, and the most widely recognized are laryngomalacia, subglottic stenosis, and tracheomalacia.

In babies and kids, VCP has basically neurological, horrible (birth injury), and iatrogenic (post-careful confusions) etiology. A X-ray is frequently expected to assess the focal sensory system. In around 33% of the neurological cases, Arnold-Chiari II contortion is available with attendant

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hydrocephalus and myelomeningocele. Besides, an enormous number of BVCPs are idiopathic and as indicated by the writing, unconstrained recuperation of vocal line motility is conceivable inside 1 or 2 years over the 66% of patients.

The treatment's decision has numerous factors; specifically, critical intubation might be expected in the event of serious respiratory pain to guarantee a protected aviation route. Situation of a tracheostomy can be expected to sit tight for an unconstrained recuperation or the helpful decision.

Somewhat recently, the chance of an early treatment staying away from tracheotomy has been thought of, specifically with the proposition of negligibly intrusive medicines with conservation of the vocal folds, for example, endoscopic arytenoid snatching lateropexy or front back cricoid split.

The best timing of careful mediation isn't normalized, and it is by and large examined one case at a time case. Examining the etiology of loss of motion is pivotal to foreseeing the conceivable outcomes of recuperation and the planning of treatment. Other significant prognostic factors are presence of comorbidities, related aviation route infections, age of the patients, and seriousness of the clinical condition.

A few surgeries to work on the glottic respiratory space have been proposed throughout the long term, both endoscopic and open a medical procedure, yet a standard therapy has not been laid out.

Numerous careful choices have been portrayed and used to expand the glottic space in BVCP, with persistent exploration of less obtrusive strategies. In 1946, Woodman distributed a progression of patients treated by arytenoidectomy and stitch lateralization of the vocal cycle performed with the outer posterolateral approach. This method was accounted for with great outcomes additionally by Cohen in 1973 and Narcy in 1990.

Different creators portrayed halfway and all out arytenoidectomy with lateralization of the vocal interaction through the laryngofissure approach, making a midline entry point of the thyroid ligament.

Thornell was one of the firsts to advance endoscopic techniques; he performed endoscopic arytenoidectomy utilizing electrocautery. The advancement of the CO2 laser gave additional opportunities, guaranteeing more noteworthy accuracy, so in 1984 Ossoff et al. portrayed endoscopic CO2 laser back cordotomy and in 1989 Dennis and Kashim endoscopic laser CO2 arytenoidectomy.

In 1993, Crumley proposed a variety of this method: endoscopic laser average arytenoidectomy, protecting piece of the ligament including the vocal cycle, to decrease the results on the voice capability. Terrible voice quality is the super unfavorable impact of the medical procedure for BVCP, specifically after aritenoidectomy and back cordotomy.

The greater part of the writing about the treatment of BVCP is alluded to grown-up patients. One of only a handful of exceptional portraying a progression of pediatric patients looked at consequences of endoscopic versus open arytenoidectomy. The series of 30 patients went through endoscopic or outside arytenoidectomy and lateralization, bringing about a higher decannulation rate for open arytenoidectomy (84%) than the endoscopic arytenoidectomy one (56%).

In 1989, Dennis and Kashima presented laser fractional cordotomy as another endoscopic strategy, which comprised of a three-sided extraction of the back evident vocal overlay and bogus vocal crease to work on the glottic respiratory space. In 2001, Friedman et al. revealed a progression

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of pediatric patients all decannulated after back cordotomy. A joined endoscopic utilization of the two techniques might be shown.

One more technique to further develop the laryngeal respiratory space is the back cricoid split with rib uniting. This medical procedure, principally demonstrated for the therapy of glottic-subglottic stenosis and back glottic stenosis, comprises of a back growth of the interarytenoid space by parting the cricoid plate and putting a rib ligament join, through laryngofissure or utilizing an endoscopic methodology. In 1994, Dark et al. depicted the treatment of three instances of BVFP utilizing this surgery, with great results regarding decannulation (every patient was decannulated), and in 2003, Inglis et al. distributed the outcomes got in a progression of 10 patients who went through this medical procedure through endoscopic method.

For the last option, a great laryngeal and subglottic space openness is vital to performing midline back cricoid cut by CO2 laser and parting and where to put the ligament rib unite luckily molded without connect stitches. As of late, on 2017 again Inglis et al. distributed a survey of their experience about endoscopic back cricoid split during the most recent fifteen years.

They portrayed a progression of 33 patients (32 had tracheostomy) with various pathologies (subglottic stenosis, back glottic stenosis, and two-sided vocal rope fixed status) and a pace of decannulation after this medical procedure of 65.6% (just 28.6% for respective vocal overlap stability). This endoscopic methodology enjoys the benefit of safeguarding the life structures of the vocal folds and, hypothetically, doesn't create issues in the event of unconstrained recuperation of the motility and doesn't block the chance of different medical procedures, yet its prosperity was different for the pathologies treated, with more terrible outcomes in subglottic stenosis joined with vocal rope loss of motion.

Moreover, this medical procedure can be muddled by dysphagia and tracheotomy was considered previously or during the endoscopic back cricoid split to forestall the gamble of respiratory difficulties in the event of dislodgment of the join.

Conclusion: All in all, improvement of diagnostics and improvement of a separated administration approach for patients with vocal string loss of motion is required. Normalizing the demonstrative workup through consolidation of genuine measurements and more reasonable utilization of subordinate testing can further develop precision and proficiency. Also, laying out proof based clinical rules custom fitted for shifting patient profiles can possibly arrange treatment choices while keeping up with adaptability. With these improvements, ideal and predictable consideration for patients with this difficult condition might be understood.

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