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DIAGNOSTIC TEST FOR CHILDREN'S PSYCHOPATHICITY PCL-MYV

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Abstract. The introduction notes the difficulties and limitations in the diagnosis of child psychopathy, especially as part of an expert approach that requires a thorough study of the patient's entire previous life. The second part of the article is devoted to the available tests, questionnaires and diagnostic scales and the difficulties of their use for children are noted. The third part of the article is devoted to neuropsychological methods for diagnosing psychiatry in children and the difference in the perception of emotionally charged samples in healthy and psychopathic children is noted. The fourth part considers the world's most famous tool for diagnosing psychopathy in children as part of an expert approach – a List of psychopathic traits – a youthful version of R. Hare and K. Kiehl and highlights its shortcomings when it is extended to younger, pre-adolescent age of the subjects. The fifth part is devoted to the PCL-MYV test, which is proposed for the diagnosis of psychopathy in children before any physical signs of puberty appear (6-12 years) as part of an expert approach and the rules for working with it. This tool, as well as the Youthful version of the Psychopathy Checkist, is designed to be completed by specially trained professionals.

Keywords: psychopathy, list of psychopathic traits, phenomenological approach, expert approach.

1. Introduction

The field of child psychopathies, despite a sufficient number of printed sources on this topic, is still a relatively poorly researched area both as part of child psychiatry and as part of psychiatry of borderline states. In our opinion, this situation is primarily associated with the difficulty of distinguishing states related to the field of psychopathies of childhood from other mental states, especially taking into account the fact that, as shown in our previous article (Datskovsky I., 2019 [**B**]), the very concept of psychopathy is ambiguous and there are two significantly different approaches to diagnosis, operating with the same name for the condition – psychopathy.

In addition, it is quite reasonable that in childhood a diagnosis of psychopathy is not made at all due to the inseparability of congenital (nuclear) psychopathy, early brain injury (trauma, intoxication) and the results of the psycho-traumatic (psychopathic?) influence of the environment and upbringing at an early age, although a number of cases described in the literature clearly indicate the diagnosis. This is due to the uncertainty of the correctness of such a serious diagnosis, which lays a heavy imprint on a person's entire life, since there are many cases of becoming a normative person growing out of a child who manifested many symptoms of psychopathy in childhood. Even the compromise diagnosis of F60 in the ICD-10 ("Specific personality disorders") is generally not given to children, even as comorbid ones, and the diagnosis of accentuations of character accepted in the Russian literature (A.E. Lichko, 2016), by definition, describes preclinical conditions. That is, on the one hand, there is a well-founded fear of overdiagnosis of psychopathy. On the other hand, "as the signs of social distress become more persistent, we no longer have the luxury of ignoring psychopathy in certain children." (R. Hare, 2007).

In this text, we will continue to call psychopathies by psychopathies (from ancient Greek ψυχή (psychi "spirit; soul; consciousness; character" + from Greek παθος (pathos) "suffering, pain, illness" – a suffering soul, however, it is not noticed that psychopaths noticeably suffer from their psychopathy, from their temperament, but the environment of psychopaths suffers from their psychopathy very significantly), although in the modern trend of replacing medical terms that have penetrated into general speech and carry a negative, sometimes offensive connotation in it, this term is being replaced by more neutral "personality disorder", (to be distinguished from personality changes), although there is no tendency to return to the old, rather accurate terms "moral dullness", "emotional underdevelopment".

The main objective of this article is the development of a test for the diagnosis of child

psychopathicity as part of an expert approach to the diagnosis of psychopathies (Datskovsky I., 2019 [**B**]) in the age group of the school stage of psychophysical development from 6 to 12 years old for taking appropriate adequate measures of both socio-pedagogical and medical spectra.

2. Psychological tests, questionnaires, scales

Since the end of the 19th century, various numerous tests and questionnaires, in addition to differently structured (clinical) interviews, are one of the main methods of studying the psyche. These methods have proven themselves very well, the number of tests is multiplying exponentially, the Internet has led to an explosive increase in the number of such tests, however, not all of them are sufficiently well tested (or not tested at all) and adapted to the tasks they are designed to solve and to the target population group, for which they should especially show the properties of validity and reliability. There are texts both universal, designed to solve many problems of general and clinical psychology, and more specific tests that solve the problems of specific differential diagnosis. Simple and short screening tests and questionnaires have the least specificity.

Nevertheless, in the area under consideration (child psychopathy), there are numerous sensitive points in comparison with the ability to make or refute other diagnoses. “Assessing and predicting which children will become psychopaths is a difficult task. Some consider that scientists should not even make such attempts, because if a similar diagnosis is made to children, it can become a stigma for them for life. Moreover, such stigmatization can be a self-fulfilling prophecy. According to others, if parents are told that their child is a psychopath, this may further alienate them from their child... Scientists working in this field go to all sorts of tricks, just not to use the term *psychopathy* when discussing children. Most often they speak of traits of *callousness and indifference*." (K. Kiehl, 2015).

Varieties of questionnaires are used to solve this problem. Among the universal tests, the first are questionnaires TAT (Thematic Apperception Test – a projective psychodiagnostic technique developed in the 1930s. The purpose of this technique was to study the driving forces of the personality – internal conflicts, drives, interests and motives. After the Second World War, the test became widely used by psychoanalysts and clinicians to work with disorders in the emotional sphere of patients) and MMPI (Minnesota Multiphasic Personality Inventory – a personality questionnaire developed in the late 30s – early 40s at the University of Minnesota, the most studied and one of the most popular psychodiagnostic techniques, designed to study individual characteristics and mental states of a person. MMPI is widely used in clinical practice. This technique was based on a quantitative comparison of the responses of representatives of the normative group with typical responses of patients, whose picture of clinical disorders clearly demonstrated the predominance of one or another syndromic complex: hypochondria, depression, hysteria, psychopathy, psychasthenia, paranoia, schizophrenia, hypomania. There are Russian-language adaptations of MMPI: MMPI technique modified by F.B. Berezin et al. and SMIL (standard methodology for the study of personality) modified by L.N. Sobchik).

However, universal questionnaires are fundamentally nonspecific, therefore, for a more accurate diagnosis of child psychopathy, more specific questionnaires have been developed and continue to be developed and tested. One of the widespread questionnaires in Russia for the diagnosis of character accentuations and psychopathies in adolescence is the Pathocharacterological Diagnostic Questionnaire for adolescents, PDQ, developed by A.E. Lichko (Ivanov N.Ya., Lichko A.E., 1995).

In Canada and the United States, more recently, a notable range of questionnaires that are specific to assessing the traits of callousness and indifference in children have been developed.

The first and most common self-report tool for assessing callousness and indifference traits in children is the Childhood Psychopathy Scale (CPS), developed by Dr. Don Lyman of Purdue University. It includes questions about the children's relationship with others, about what is important to them, whether they are very angry, etc. The University of New Orleans has developed several scales for assessing the traits of callousness and indifference for parents and teachers, including the Antisocial Process Screening Device (APSD). In parallel, Dr. Frick developed the Inventory of Callous-Unemotional Traits (ICU) with options for parents, teachers and the child (there are also options for preschool and primary school children). Hare's Psychopathy Checklist: Youth Version (PCL: YV); Youthful Psychopathic Traits Inventory (YPI); Child Problematic Traits Inventory (CPTI) may also be named.

Research has even shown that traits of callousness and indifference in boys aged 7-12 predict their psychopathic score at age 19 (for example, Burke J. D., Loeber R. & Lahey B. B. Adolescent Conduct Disorder and Interpersonal Callousness as Predictors of Psychopathy in Young Adults. [Research Support, N.I.H., Extramural]. Journal of Clinical Child Adolescent Psychology, no. 36 (3), 2007, pp. 334–346 and also Lynam D. R., Caspi A., Moffit T. E., Loeber R. & Stouthamer-Loeber M. Longitudinal Evidence that Psychopathy Scores in Early Adolescence Predict Adult Psychopathy. Journal of Abnormal Psychology, no. 116 (1), 2007, pp. 155–165).

However, such questionnaires have their drawbacks and limitations. Moreover, some drawbacks are exacerbated when trying to assess the features of callousness and indifference in young children. Thus, many children at risk, whose callousness and indifferent traits we want to assess, are simply unable to read or listen to questions and answer them on the CPS, MMPI or other questionnaires.

Another disadvantage of self-reporting in psychology is that it requires patient cooperation. It is very easy to spoil the results if the patient lies (consciously or unconsciously), answers questions at random, or simply refuses to fill in the questionnaires.

This greatly limits the usefulness of questionnaires when the patient is hostile or unable to cooperate with the psychologist. In addition, in the field of research on psychopathies, especially in childhood and adolescence, a negative feature of conventional psychological approaches has been revealed. It lies in the fact that, on the one hand, tests and questionnaires filled in by children (if the children are not angry, agree to cooperate and know how to read or at least listen and answer clearly), questionnaires filled in by parents (if the parents are adequate in their assessments and do not specifically give false answers, for example, when their child is threatened with isolation in special pedagogical systems) about the same children and, on the other hand, a professional expert assessment of objective materials and independent assessments about this child and a focused clinical interview to fill in the Expert Youth Version of the Psychopathy Checklist (PCL: YV – R. Hare, 2007) give very different assessments of the psychopathic properties of the child. Finally, and perhaps the most important flaw in self-report questionnaires for assessing callousness and indifference is that children with these traits may simply not be able to talk about their emotional world in detail. They do not understand themselves, and this can prevent the researcher from assessing these traits in them. Therefore, the main emphasis in the diagnosis of psychopathy or psychopathic temperament has to be done precisely on the expert assessment of a specialist.

3. Neuropsychological methods

"In addition to using tests, questionnaires, scales, and other tools to measure callousness and indifference, psychologists and neuropsychologists have developed tasks or games to study the brain systems associated with these symptoms. One such task or game used by researchers is a task of making *an emotional lexical decision*. It actually kind of reminds of spelling dictation. Chains of letters quickly appear on the computer screen, and the subject must decide whether the letters constitute a real word, or it is gibberish or a word written with a mistake. When letters form an emotional word (“hate,” “kill,” “die”), people react faster than to a neutral word (“chair”, “table”, “hand”). Emotional word processing employs a brain system that makes us recognize them very quickly. Today, it has been fairly reliably found that, unlike ordinary people, psychopaths do not respond to emotional words faster than neutral ones. This proved that psychopaths "know the words, but not the melody." In other words, psychopaths know the meaning of the words “love”, “hate”, “murder”, but they *do not feel* the affective influence conveyed by these words.” (K. Kiehl, 2015).

After these discoveries, studies have shown that children and adolescents with traits of callousness and indifference are worse at solving emotional vocabulary and other similar tasks. The use of many studies and tasks developed in recent years suggests that children and adolescents with callousness and indifference (as well as adults with psychopathy in terms of an expert approach) are characterized by deficiencies in the quality and speed of processing emotional stimuli.

However, the methods of neuropsychology, just like traditional test methods, provide researchers and doctors with only indirect tools for assessing the psychopathic characteristics of children and adolescents and, when applied, require the active participation of the subjects.

4. Expert approach

In section 3 "Phenomenological approach" of the article (Datskovsky I., 2019 [**B**]), we have already indicated that the issue of child psychopathy was already raised by P.B. Gannushkin (1933). However, it remained (and in many respects remains today) within the framework of an approach based on clinical-descriptive criteria, which remain both subjective and eclectic. Today, the presence of child psychopathy (and early accentuations of character) is widely recognized, the corresponding chapters (within the framework of the phenomenological approach) are included in many child psychiatry books (V.V. Kovalev (1979), I.V. Makarov (2019), B.V. Voronkov (2017) and many others), however, we believe that the real breakthrough in the diagnosis of child psychopathy is precisely the expert approach (Datskovsky I., 2019 [**B**]) and the objective diagnostic methods that have been further brought to clinical use, especially those that do not require the active participation of the child under study. At the same time, other characterological deviations in the state and thinking of a child (and an adult), considered in the framework of the phenomenological approach to psychopathies, are not denied in any way. Consider the expert approach to the diagnosis of child psychopathy proposed by Dr. K. Kiehl (2015) and propose a modified tool that is more suitable for younger children (6-12 years old).

K. Kiehl (2015) provides a corresponding Psychopathy Checklist for children and adolescents, which is a modification of R. Hare's Psychopathy Checklist (2007) for adults. The traits and behavior inherent in this disorder (child psychopathy) are assessed by an expert (trained specifically for such an assessment of the data by a specialist) using this checklist based on collecting as much information as possible about the child's previous life (anamnesis vitae). Just as when using the adult version of the questionnaire, for each item the expert gives the child a score from the series 0, 1, 2, and children who scored 30 or more points are considered psychopathic.

"List of Psychopathic Traits for Children and Adolescents:

1) Introducing oneself in society (external)
2) Exaggerated sense of self-esteem (internal)
3) Desire for arousal
4) Pathological deceit
5) Manipulation for personal gain
6) Lack of remorse
7) Affective flattening
8) Callousness/lack of empathy
9) *Parasitic orientation*
10) Anger
11) ***Impersonal sexual relations***
12) Early behavioral problems
13) Lack of goals
14) Impulsivity
15) Irresponsibility
16) Failure to take responsibility

17) Unstable interpersonal relationships

18) Major infractions

19) Serious violations of the conditions of release

20) *Variety of criminal activities*".

Since in this paper we are discussing children between the ages of 6 and 12, a number of features cited by Dr. K. Kiehl is irrelevant or requires a change in the wording for this age group (and often for a group of older children). We have marked these characteristics in Dr. K. Kiehl's Checklist in *underlined italics*. However, among these signs there are two, which, although infrequently, appear in the examined children and very clearly (obligatory) indicate the presence of psychopathy. We marked these features in ***highlighted underlined italics***, and in the proposed test, we highlighted them in a separate group of features (table 2).

5. Psychopathy Checklist – Modified Youth Version (PCL-MYV)

Often, the problems of psychopathic development of the child's character become noticeable to parents and educators, as a rule, from 3-4 years old (and sometimes even earlier), but it is obvious that it is impossible to diagnose such a difficult diagnosis based on only recently noticed problems. And a child of primary school age (from 6-7 years old) is already a fairly mature personality with clearly distinguishable character traits that can already be diagnostically analyzed, although the actual diagnosis of psychopathy cannot be made even before any physical signs of puberty appear, or even until late adolescence (for avoidance of labeling, when the diagnosis can greatly interfere with the child's socialization and thereby turn out to be a self-fulfilling prophecy). However, even the diagnosis "established" by the points scored in the pre-pubertal age should be recorded only in documents that are closed from outsiders (except for a professional-specialist) and explained to parents in Aesopian language, with euphemisms in the form of recommendations for correctional, educational and, if this is indicated, for medical measures.

For the needs of early diagnosis of child psychopathy (in terms of an expert approach), we have clarified the Psychopathy Checklist for children and adolescents (in fact, by proposing PCL-MYV – Psychopathy Checklist – Modified Youth Version), removing irrelevant items and adding items that are absent in the original Checklist, but important from our point of view, or changing the wording of some items from the Checklist of R. Hare – K. Kiehl.

In addition, we have made the scoring a little more difficult. Although this list is in no way a test or a questionnaire for a small patient and it is also not a questionnaire for the environment of the child being checked (parents, educators, teachers, neighbors, etc.), but is a professional tool of a trained professional psychologist or psychiatrist, nevertheless, if you use the method of R. Hare – K. Kiehl, to give a score of 2 points, you need to have a very vivid picture of this deviation, which is often very difficult to collect, given the limited materials on the characteristics of the behavior of a small patient, and a score of 1 point is often does not give a sufficiently adequate characterization of the child. Therefore, we mitigated the difficulty of assessing a particular characteristic of a child by introducing not a three-position (0-1-2), but a four-position assessment (0 (absent) – 1 (present in a mild form) – 2 (present in a highly developed form) – 3 (striking feature of the child's personality)). We understand that in most cases it will not be easy to give a score of 3 for most characteristics (as well as a score of 2 in the R. Hare – K. Kiehl approach), therefore, we left the main scoring at the level of the third column (the characteristic is in a very developed form), giving the relatively rare characteristics that received a point in the fourth column to slightly increase the total score and thereby slightly strengthening the validity of the psychopathic diagnosis.

It was also noted that some characteristics from the modified children's list of psychic traits are almost always found in children with psychopathic problems and characterize their personality much more clearly than other characteristics. Moreover, such characteristics are absent or poorly expressed in non-psychopathic children. To account for this phenomenon, we introduced the concept of important characteristics (some semblance of obligate symptoms in psychiatry) and ordinary characteristics (some semblance of facultative symptoms in psychiatry), provided that important characteristics received a double number of points (scale 0-2-4-6).

Moreover, there is a third group of characteristics, which includes only two characteristics (in a modified formulation), marked by us in the list of K. Kiehl in ***highlighted underlined italics***. These characteristics (highlighted in Table 2) receive points in the same way as the characteristics in Table 1, but these characteristics were NOT entirely included in the total score when setting the boundary values of points (like the points in the fourth column), but were included in the score points given to this child. This leads to the fact that scores other than zero in this table noticeably shift the result towards the diagnosis of psychopathy.

We do not consider parabolic or more complex scales of increasing points within one PCL-MYV item (for example, instead of a scale of 0-1-2-3 points, introducing a scale of 0-1-3-6 points with an increase in the difference in points when moving up the scale), as to substantiate such an approach, we need a fairly large statistical sample WITH TRACED CATAMNESIS at least up to the upper limit of adolescence (18 years), which we do not have.

We also refrained from highlighting some characteristics that do not strongly affect the child's image into the fourth, one-half, less significant scale with score values of 0-0.5 – 1-1.5 in order not to multiply entities (Occam's razor) without a sufficiently long and massive statistical study on numerous children with psychopathic problems.

Since the collection of full-fledged, complete information about a fairly short life of a young patient is very difficult, we tried to compensate for this problem with more detailed, consisting of a larger number of characteristics than in the original. This also mitigates the influence of each given score on the final diagnostic result.

We shall note that adult psychopaths usually have a history of late (after the age of 5 years) enuresis. However, it is impossible at this stage of diagnosis to accept this symptom as a predictor of psychopathy – according to modern concepts, enuresis can be caused by abnormalities in one of the four neural pathways, but it seems that only one of them, passing through the amygdala, to some extent indicates psychopathic development. Apparently, those suffering from enuresis due to the pathology or underdevelopment of other neural pathways do not become psychopaths, and they often even have late enuresis spontaneously or with some treatment, although later than most children.

We also note that in psychopathy, deviating personality traits should be total, that is, be manifested everywhere and always, in any situation and circumstances. "They should be present almost everywhere – at home, at work, at school, in communication with family, friends and neighbors." (K. Kiehl, 2015). "A teenager with psychopathy discovers his/her type of character in the family and school, with peers and with elders, in school and on vacation, in work and play, in the ordinary and familiar, as well as in the most emergency situations." (A.E. Lichko, 2016). But the opposite is also true: "A tyrant at home and an exemplary student at school, a quiet child under harsh authority and an unbridled bully in an atmosphere of connivance, a fugitive from a home where an oppressive atmosphere reigns or a family is torn apart by contradictions, who can get along well in a good boarding school – they all should not be counted to psychopaths, even if adolescence passes under the sign of impaired adaptation." (A.E. Lichko, 2016).

The test was constructed according to a scheme similar to the scheme of the Modified Detailed Infantilism Test – DIT-M, previously published (Datskovsky I., 2019 [A]).

The proposed revised list of PCL-MYV (Psychopathy Checklist – Modified Youth Version) consists of three tables (scales) and looks as follows:

1. Important characteristics

Item No.	Characteristic	Absent 0 points	Present in mild form 2 points	Present in a highly developed form 4 points	Striking personality trait of a child 6 points
1	Early behavioral problems				
2	Affective flattening				
3	Lack of empathy				
4	Lack of remorse				
5	Callousness				
6	Indifference				
7	Pathological deceit				
8	Aggressiveness				
9	Conflict, numerous fights, often on their own initiative without sufficient reason				
10	Systematic cruelty to animals, insects and even children and adults that does not pass even after many explanations and punishments. Unexplained disappearances and deaths of animals				
11	Intriguery				
12	Seeking arousal to perform inappropriate actions / susceptibility to boredom				
13	Lack of fear				
14	Apparent ineffectiveness of punishments				
	Column scores				
	Total score for important characteristics				

2. Rarely found important characteristics

Item No.	Characteristic	Absent 0 points	Present in mild form 3 points	Present in a highly developed form 3 points	Striking personality trait of a child 9 points
1	Active sexual behavior beyond age (up to the normal age of puberty)				
2	Major infractions, often with violent behavior				
	Column scores				
	Total score for rarely found important characteristics				

3. Ordinary characteristics

Item No.	Characteristic	Absent 0 points	Present in mild form 1 point	Present in a highly developed form 2 points	Striking personality trait of a child 3 points
1	Pompous introducing of oneself in society for both adults and children (external)				
2	Exaggerated sense of self-esteem (internal)				
3	Loquacity / superficial charm (ability to speak convincingly, fluently, interesting, streamlined)				
4	Manipulation for personal gain				
5	Envy				
6	Anger even for minor reasons, or even for no apparent reason				
7	Impulsiveness				
8	Lack of goals even in normal activities (play, study, etc.)				
9	Lack of idea even about the immediate results of their own actions				
10	Lack of idea about the feasibility and reality of the goal of the performed actions (even without taking into account possible obstacles in achieving the goal)				
11	Lack of both close and more distant plans				
12	Unstable interpersonal relationships (both with adults and in the children's team)				
13	Irresponsibility				
14	Failure to take responsibility				
15	Inability to study regularly, even with good intelligence				
16	Inability to control expenses, excessive and unnecessary spending, debts that are not even planned to be paid				
17	Cheating in games, during tests				
18	Inappropriate behavior against the background of their age group				
19	Non-participation in collective actions (games and other actions), striving for individual activity				
20	Lack of cooperation (separation of functions in collective actions) and lack of understanding of the need to share in games and other actions				
21	Pyromania				

22	Difficulties with abstract concepts: abstract description of objects in mathematics, metaphors, proverbs, fables in the humanities				
23	Impaired learning ability (not school, but life), even from their own experience (not to mention the experience of children from their age group or gleaned from literary or folklore sources)				
24	Imperviousness to moral ideas and rules (including inferences from literary or folklore sources)				
25	Nasty things (verbal (name-calling, curses) and actions), often in an underhand way, without witnesses				
	Column scores				
	Total score for ordinary characteristics				
	Total score for the test				
	Conclusion				

The total score for the third column (the characteristic is present in a highly developed form) for both tables – scales (tables 1 and 3) is 106 points (without points for table 2). Following Dr. R. Hare and K. Kiehl, we will establish the conclusion about the presence of psychopathy at the level of overcoming 75% of the mark, that is, 80 points and above. However, for a more differential diagnosis, we will introduce two more scoring ranges:

- 54-79 points (51-75%) – psychopathic character formation;
- 36-53 points (36-50%) – suspected psychopathic character formation;
- 35 or less points – no psychopathic tendencies.

We shall notice that, since we have proposed the calculation of the sums of points according to the sum of points in the third column, it is theoretically possible that some especially pronounced psychopaths who scored points in the fourth column for several characteristics or received points other than zero according to Table 2 will exceed 106 points. The theoretical maximum is 159 points (167 points taking into account the points in Table 2).

6. Conclusion

Therefore, in this article we have proposed the PCL-MYV test (Psychopathy Checklist – Modified Youth Version), which is a sufficiently distant relative of the Psychopathy Checklist (PCL) for children and adolescents, proposed by R. Hare (2007) and K. Kiehl (2015), but, like it, drawn up in the framework of an expert approach. The proposed test has a completely different, more complex and branched structure in relation to the Psychopathy Checklist (PCL) for children and adolescents and is more focused on children aged 6-12 years (pre-pubertal age).

An attempt is made to introduce the boundaries of various preclinical stages of psychopathy, separating them from the indicators of healthy children, determined by the same test.

Although it is clear to us that the expert and phenomenological approaches to the diagnosis of psychopathies and preclinical psychopathic states are not very compatible with each other, nevertheless, an attempt has been made to draw some analogies in assessing the severity of a psychopathic state between these approaches.

In addition, the traits of the character and behavior of children are considered, which at a certain stage of ontogenesis may be similar to some psychopathic traits, but require careful attention to themselves in order to avoid unreasonable overdiagnosis of psychopathic states.

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Абстракт. Общая анестезия является методом выбора у пациентов подвергающихся обширным оперативным вмешательствам. Иногда данная анестезия может комбинироваться с эпидуральной анестезией. Однако комбинирование обоих методик имеет множество ограничений и побочных эффектов. Здесь мы предоставляем случай пациентки, у которой была выполнена срединная лапаротомия по поводу острого холецистита осложненного холедохолитиазом и синдромом билиарной гипертензии. Сопутствующая патология: ишемическая болезнь сердца, постинфарктный и атеросклеротический кардиосклероз, атеросклероз аорты и коронарных артерий, Н2А, последствия перенесенного ОНМК. Короновирусная двухсторонняя полисегментарная пневмония, тяжелое течение ДН2.

Интра- и послеоперационное ведение данной пациентки требовало адекватного обезболивания с минимальным количеством наркотических анальгетиков. Адекватная анестезия была достигнута путем комбинирования общей анестезии и интратекального введения низких доз тяжелого бупивакаина и морфина. Данная комбинация позволила снизить количество введенных опиоидов и миорелаксантов во время операции и отказаться то использования наркотических анальгетиков в послеоперационном периоде, что позволило быстрее активизировать пациентку в раннем послеоперационном периоде и избежать осложнений характерных для пациентов с данным коморбидным фоном.

Введение

Общая анестезия – метод анестезии который наиболее часто применяется у пациентов подвергающихся лапаратомным вмешательствам. Однако у пациентов с сопутствующей кардиальной патологией, последствиями перенесенного ОНМК и короновирусной пневмонией желательно применение Fast truck методик и использование меньшего количества опиоидных анальгетиков в послеоперационном периоде. Рутинная комбинация комбинированной анестезии с применением эпидурального обезболивания сопровождается гемодинамическим дисбалансом и требует жесткого контроля показателей свертывании крови при стоянии эпидурального катетера, так при лечении COVID пневмонии требуется введение терапевтических доз гепаринов.

Учитывая заболевание пациентки, сопутствующую патологию, ограничение ресурсов в условии эпидемии COVID 19 была выбрана комбинированная анестезия с использованием интратекального введения низких доз бупивакаина и морфина в виде единичного введения. Используя этот метод мы добились хорошего уровня интра- и послеоперационного обезболивания с минимальным количеством опиоидов, ранней экстубации и активации, возможность раннего перевода в общесоматическое от деление с последующей выпиской из стационара.

Презентация случая

Мы проводили анестезию пациентке, у которой был диагностирован острый калькулезный холецистит, холедохолитиаз, синдром билиарной гипертензии. Пациентке оказывалась помощь в специализированном стационаре т.к. у неу была диагностирована двухсторонняя полисегментарная короновирусная пневмония. Исходное состояние оценивалось как тяжелое ЧД – 28 SpO2 95 с подачей увлажненного кислорода через носовые канюли со скоростью потока, 7л/мин. Содержание кислорода в артериальной крови составило 67 mmHg. Респираторный индекс 250 Среднее АД было несколько выше нормы и колебалось в пределах 95-100 мм рт ст . По данным РКТ грудной клетки от с обеих сторон более выражено слева, по всем легочным полям, больше в нижних отделах перибронхиально и субплеврально определяются участки снижения пневматизации по типу матового стекла. С участками утолщения интерстиция.

Сопутсвующая патология включала ишемическую болезнь сердца, постинфарктный и атеросклеротический кардиосклероз, атеросклероз аорты и коронарных артерий, Н2А, последствия перенесенного ОНМК.

Пациентке была выполнена операция: лапаротомия, холецистэктомия. Реконструктивная операция на желчевыводящих путях, трансдуоденальная папиллосфинктеропластика, дренирование холедоха по Холстеду.

В качестве анестезиологического пособия мы выбрали комбинированную анестезию с использованием интратекального введения низких доз бупивакаина и морфина в виде единичного введения в комбинации с тотальной внутривенной анестезией с ИВЛ.