

Principles of Rational Dispensary Follow-up and Prevention of Chronic Gastritis in School-age Children

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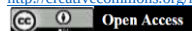
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ABSTRACT

Chronic gastroduodenal pathology in children remains an important pediatric problem because of its high prevalence, age-related variability of clinical manifestations, recurrent course, risk of complications, and need for long-term monitoring. To systematize the principles of rational dispensary follow-up and prevention of chronic gastritis in school-age children, with emphasis on diagnostic surveillance, individualized treatment, rehabilitation, and criteria for evaluating follow-up effectiveness. A narrative analytical review was performed using the pediatric gastroenterology textbooks, practical manuals, scientific publications, and regulatory documents cited in the manuscript. The material was grouped according to the main components of dispensary care: clinical assessment, laboratory and instrumental diagnostics, frequency of specialist examinations, treatment and anti-relapse measures, dietary and lifestyle interventions, rehabilitation, and criteria for removal from dispensary registration. Rational follow-up is based on continuity of care, individualization, systematic monitoring, and coordination between primary care, specialist, hospital, rehabilitation, and sanatorium services. During the first year after registration, general-practitioner assessment is recommended every three months, followed by twice-yearly monitoring, while key laboratory and instrumental examinations are generally performed annually or as clinically indicated. Preventive management includes nutritional correction, lifestyle modification, treatment of clinically significant gastroduodenal dysfunction and Helicobacter pylori infection when present, anti-relapse measures, physical rehabilitation, and health education. A structured, continuous, and individualized dispensary approach may reduce recurrence risk, improve rehabilitation, and support timely transition of children with chronic gastritis from active follow-up to routine observation.

1. Introduction

Chronic gastroduodenal pathology (CGDP) in children has attracted increasing attention because of its high prevalence, polymorphic clinical presentation, recurrent course, possible development of complications, and the need for prolonged follow-up after inpatient or outpatient treatment [1,2,10]. Chronic gastritis, chronic duodenitis, and chronic gastroduodenitis are characterized by inflammatory and dystrophic changes of the gastric and/or duodenal mucosa accompanied by disturbances of secretory, motor, and endocrine functions.

The clinical picture of chronic gastritis in children is age-dependent and varies according to the localization and activity of the inflammatory process. Pain, dyspeptic, and asthenovegetative syndromes are commonly described. Pain may be associated with food intake, while nausea, vomiting, belching, epigastric discomfort, and local tenderness may accompany the disease [1,4,5]. Because the symptoms are not always specific, rational follow-up requires a combination of clinical assessment, laboratory testing, and instrumental verification.

Dispensary follow-up is an active form of dynamic health monitoring aimed at early identification of disease, registration and observation of patients, comprehensive treatment, rehabilitation, prevention of progression and complications, and preservation of normal physical and neuropsychological

development. In children, its effectiveness depends not only on medical therapy but also on continuity between the family polyclinic, hospital, rehabilitation services, school medical personnel, and, where indicated, sanatorium care [5,7].

School age is a particularly important period for such monitoring. Early school age (6-9 years), middle school age (10-14 years), and adolescence are accompanied by changes in growth, neuropsychological development, and hormonal status. These factors can modify the manifestations of digestive disorders and influence the organization of nutrition, physical activity, and preventive care. The physician should therefore assess the child comprehensively, including physical development, neuropsychological status, functional condition of organs and systems, previous illnesses, and relevant risk factors [4,5,6,7].

The aim of this article is to systematize the principles of rational dispensary follow-up and prevention of chronic gastritis in school-age children and to present an integrated framework for diagnosis, monitoring, therapeutic and preventive measures, rehabilitation, and evaluation of follow-up effectiveness.

2. Materials and Methods

This article was structured as a narrative analytical review. The source material consisted of the pediatric gastroenterology textbooks, outpatient pediatric manuals, methodological guidance, scientific publications, pharmacological reference material, and regulatory documents included in the manuscript reference list [1-11]. No new patient cohort, intervention, or primary clinical dataset was introduced during the editorial restructuring of the article.

The available information was analyzed thematically. Content was classified into the following domains: (1) organizational principles of dispensary follow-up; (2) clinical assessment and age-related characteristics; (3) laboratory and instrumental diagnostic methods; (4) frequency of primary-care and specialist examinations; (5) therapeutic and anti-relapse measures; (6) dietary, lifestyle, physical-rehabilitation, and sanatorium interventions; and (7) criteria for evaluating the effectiveness of follow-up and removal from dispensary registration.

The synthesis focused on practical application in school-age children and on the role of the general practitioner in coordinating continuity of care. Recommendations were presented in a structured form while preserving the clinical and organizational content of the cited sources. Therapeutic measures were summarized by treatment category rather than reproduced as individualized prescriptions, because drug selection and dosing must depend on the child's clinical condition and medical supervision.

3. Results

3.1. Core principles and organization of dispensary follow-up

The reviewed sources identify continuity and staged care, an individualized approach, systematic and continuous observation, use of scientifically substantiated and standardized approaches, and improvement of organizational measures in pediatric care as the central principles of rational dispensary follow-up. The general practitioner plays a coordinating role and should combine disease-oriented assessment with evaluation of physical and neuropsychological development, resistance of the organism, functional status of organs and systems, and the child's health group.

The main components of follow-up in children with chronic gastroduodenal pathology include active identification of early disease, comprehensive clinical examination, dynamic monitoring, outpatient therapy, referral or hospitalization when indicated, dietary measures, rehabilitation, and sanatorium-resort treatment in selected cases. School medical personnel and family polyclinic specialists should cooperate during scheduled examinations, particularly when chronic digestive pathology is already known or suspected [4,5,6,7].

3.2. Clinical and diagnostic monitoring

Clinical assessment begins with a detailed medical history and evaluation of complaints, followed by physical examination using inspection, palpation, percussion, and auscultation. Particular attention is required for the relationship between abdominal pain and food intake, dyspeptic complaints, epigastric or umbilical tenderness, nutritional habits, previous illnesses, and age-related developmental characteristics.

Basic laboratory monitoring may include complete blood count, urinalysis, stool analysis, fecal occult blood testing, and biochemical blood testing. Additional testing is selected according to clinical indications. *Helicobacter pylori* infection may be assessed by invasive or non-invasive methods, while specific autoantibodies to gastric parietal cells and pepsinogen I may be considered when autoimmune gastritis is suspected. Esophagogastroduodenoscopy (EGD) with morphological examination of gastric tissue is described as a principal method for diagnostic verification and allows biopsy-based evaluation where needed.

Table 1. Suggested schedule of dispensary monitoring described in the source material

Monitoring component	Suggested frequency	Purpose
General-practitioner examination	Every 3 months during the first year; thereafter twice yearly	Clinical status, recurrence, development, treatment and prevention plan
Otolaryngologist and dentist	Twice yearly	Detection and management of chronic foci of infection
EGD	Approximately once yearly or as clinically indicated	Endoscopic verification and follow-up of mucosal changes
Complete blood count, urinalysis, stool examination/coprogram	Approximately once yearly or as clinically indicated	General laboratory surveillance and differential assessment
Assessment of gastric secretory function	Approximately once yearly where clinically justified	Characterization of secretory disturbances
Other specialist/laboratory examinations	As indicated	Individualized assessment of comorbidities, complications, and diagnostic uncertainty

3.3. Therapeutic and preventive measures

Therapeutic and preventive measures should be individualized according to the clinical form of chronic gastritis, severity and phase of disease, associated motor and secretory disturbances, presence of *Helicobacter pylori* infection, and the child's general condition. Outpatient management is appropriate for many patients, whereas hospitalization is reserved for severe exacerbation, complications, or situations in which differential diagnosis is difficult.

The reviewed material supports a comprehensive approach combining lifestyle modification, age-appropriate nutrition, pharmacotherapy when indicated, and correction of relevant functional disturbances [3,7]. In hypersecretory conditions, acid-suppressive or antacid therapy may be considered according to clinical indications. Prokinetic therapy can be used when gastroduodenal motility disorders contribute to dyspeptic complaints, while antispasmodic or other symptomatic approaches may be used for pain under medical supervision. Enzyme preparations should not be used routinely in the absence of clear evidence of exocrine pancreatic insufficiency [3,8,11].

When *H. pylori*-associated disease is confirmed, eradication therapy should be selected according to the applicable pediatric clinical recommendations. The source material also emphasizes anti-relapse care, correction of stressful and adverse behavioral factors, appropriate sleep and activity patterns, and

rational psychotherapy or specialist support when neurovegetative or emotional factors aggravate symptoms.

Dietary management should be individualized and should emphasize regular meals, avoidance of foods that consistently provoke symptoms, and adequate intake of vitamins, minerals, and other essential nutrients. The school environment is relevant because school-age children spend a substantial part of the day outside the home; therefore, coordination of appropriate school meals and health education is part of preventive care.

Table 2. Main components of preventive and rehabilitative management

Component	Practical focus	Expected role in follow-up
Lifestyle modification	Reduction of stress, nervous overload, excessive physical strain; age-appropriate daily regimen	May reduce symptom-provoking factors and support stable remission
Nutrition	Regular, balanced meals; avoidance of individually provocative, excessively spicy, fried, or fatty foods	Supports symptom control and adequate growth
Etiologic therapy	Management of confirmed <i>H. pylori</i> infection and other identified causes	Targets clinically relevant disease mechanisms
Symptomatic/functional therapy	Individualized acid suppression, antacid, prokinetic, antispasmodic, or other therapy when indicated	Controls pain and dyspeptic manifestations
Physical rehabilitation/physiotherapy	Selected according to phase of disease and general condition	Supports recovery and gradual return to normal activity
Sanatorium-resort care	Considered in selected children during stable periods	Rehabilitation and anti-relapse support
School and family participation	Health education, nutrition, observation of symptoms, adherence to follow-up visits	Improves continuity and adherence

3.4. Evaluation of follow-up effectiveness

The effectiveness of dispensary follow-up is judged primarily by clinical stability, absence or reduction of exacerbations, improvement of functional status, and normalization or favorable dynamics of endoscopic and morphological findings. Decisions about reducing the intensity of follow-up or removing a child from dispensary registration should be made jointly by the general practitioner and the relevant specialist.

The source material describes removal from active dispensary registration after a sustained period without exacerbations and in the absence of significant endoscopic or morphological signs of active gastritis. Because different passages in the source material indicate different observation intervals, the final decision should be individualized and aligned with current institutional protocols. If a child remains under observation, a follow-up plan for the next year should be prepared and the results of annual monitoring should be reviewed by the responsible medical team.

4. Discussion

The synthesis shows that rational dispensary follow-up of children with chronic gastritis is broader than repeated gastroenterological examinations. It is a coordinated system that integrates early detection, verification of diagnosis, risk assessment, treatment, prevention of recurrence, rehabilitation, and supervision of the child's growth and development. This is especially important during school age, when

changes in nutrition, academic workload, emotional stress, physical activity, and puberty may influence symptom expression and adherence to treatment.

A major practical advantage of the staged approach is continuity. Primary care can identify recurrence, monitor growth and general health, organize annual testing, and coordinate referrals, while gastroenterology and other specialists can address diagnostic uncertainty, comorbid conditions, or persistent symptoms. In this model, school medical personnel and the family also become part of the preventive system. Such coordination is consistent with the broader goals of pediatric dispensary care described in the reviewed literature [4,5,7].

The diagnostic component should remain clinically justified. The source material emphasizes EGD and morphological assessment as central tools for verification, but repeated invasive testing should be linked to clinical indications, disease severity, prior findings, and applicable pediatric standards. Similarly, treatment should be individualized rather than based solely on the presence of dyspeptic symptoms. The observation in the source material that enzyme preparations are often prescribed without sufficient evidence of pancreatic insufficiency illustrates the need to avoid unnecessary medication [3,8,11].

The preventive component is equally important. Rational nutrition, reduction of stress and overload, regular medical follow-up, management of chronic infection foci, and appropriate physical rehabilitation can be incorporated into a long-term care plan. For children with confirmed *H. pylori*-associated disease, etiologic therapy represents a key element, whereas in other children the main emphasis may be symptom control, functional correction, and prevention of relapse.

This article has limitations. It is based on a narrative synthesis of the literature and documents included in the original manuscript rather than on a systematic database search or a new clinical dataset. In addition, some cited sources are older and may reflect treatment practices that require comparison with current pediatric gastroenterology guidelines before direct clinical application. Therefore, the article should be interpreted primarily as an organizational and preventive framework for dispensary follow-up rather than as a stand-alone prescribing protocol.

5. Conclusion

Rational dispensary follow-up of school-age children with chronic gastritis should be continuous, individualized, and coordinated across primary care, specialist services, school health services, rehabilitation, and the family. The core elements are timely clinical assessment, appropriate laboratory and instrumental diagnostics, periodic monitoring, individualized treatment, nutritional and lifestyle correction, prevention of relapse, and evaluation of physical and neuropsychological development. A structured follow-up plan allows the physician to detect recurrence early, reduce unnecessary treatment, support rehabilitation, and determine when active dispensary observation can safely be reduced or discontinued. For clinical application, diagnostic and therapeutic choices should be aligned with current pediatric standards and the individual child's condition.

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