Aim: to investigate the contemporary efficient management or treatment of vertebral pain syndrome in lumboischalgia.

Results. Causes of back pain include mechanical back pain, degenerative discs and facet,joints, prolapsed discs, spinal stenosis, referred pain, psychogenic pain and miscellaneous causes. The treatment for vertebral pain syndrome depends on the severity of the pain and how it affects the general well-being of the patient. Initially the pain will be relieved with a conservative treatment that will also help to reduce inflammation and relax the back muscles. A raised leg position with hip and knee joints bent 90°, lessens the pain in the nerve root. The patient should avoid prolonged bed rest and remain mobile. Pain relievers such as paracetamoland anti-inflammatory agents including non steroidal anti-inflammatory drugs such as ibuprofen, diclofenac, naproxen, etc help to relieve the discomfort. Again the use of a combination drug such as athrotec (diclofenac and misoprostol) for patients with risk of developing stomach ulcers. Using of mild opiods such as tramadol is recommended if patient is not responding to other treatment options. Physiotherapy, massage, cryotherapy and back training support this process and prevent a recurrence of the lumboischialgia. If these measures do not help, or if additionally, a numbness and / or paralysis occur, surgical procedures are to be considered.

Conclusion: It can hence be concluded that vertebral pain syndrome in lumboischalgia is pain located in the lumbar region which radiates through the leg and sometimes to the foot. This can be managed and treated very well using pain relievers, anti-inflammatory agents including NSAIDs, mild opiods like tramadol. Pain relief can also be attained from physiotherapy, massage and back training to improve mobility. If all these are not effective then surgery may be applied.

Feldman D.A., Mykhaylov V.B.

STUDY OF PSYCHO-EMOTIONAL DISORDERS IN PEOPLE AND DISPLACED RESIDENTS FROM ATO ZONE

Kharkiv National Medical University, Kharkiv, Ukraine
Department of psychiatry, narcology and medical psychology
Scientific supervisor: professor Kozhyna A.M.

Introduction. Still several years ago Ukrainian school-children, students, majority of Ukraine's citizens knew about war only from books, films and reciting's of the older generation. Nobody could even think that in XXI century any war might come into our house and that we would get known about armed hostilities firsthand. As of today some new single population is continuously appearing and these people are affected by psychogenic factors that contribute to development of such mental disorders in them, as posttraumatic stress disorder and adjustment disorder which, in accordance with statistical data, develop in 25.0 to 80.0 % individuals harmed as a result of those or other emergency situations. As far as is known the spectrum of potential mental disorders connected with their experience of life-threatening situations is rather big. For rendering of psychological and psychiatrical help to people and displaced residents from ATO (anti-terrorist operation) zone an important thing is knowledge about consequences of armed hostilities on the state of mental health that is an actuality of this investigation.

Aim: To study developmental peculiarities of psycho-emotional disorders in individuals of the displaced residents from ATO zone.

Materials and methods. With the help of clinical and psycho-diagnostic (Hamilton Depression Rating Scale, State-Trait Anxiety Inventory, life quality scale) methods, 30 persons (15 men and 15 women) were investigated.

Results. Principal patho-psychological syndromes diagnosed in the persons of displaced residents from ATO zone: astheno-depressive (75.9 %), astheno-distressing (82.5 %), astheno-phobic (13.2 %), astheno-hypochondriacal (3.3 %). Results of the psycho-diagnostic investigations showed up that in men the indices of a reactive alarm (average score – 37.7 ± 3.0) were higher than the indices of a trait anxiety (average score – 32.6 ± 2.9). In women the indices of a trait anxiety (average score – 38.6 ± 2.9) were higher than the indices of a reactive alarm (average score – 34.7 ± 3.0). An average score on the Hamilton Anxiety Rating Scale in men: 17.0 ± 2.3 points, in women: 18.0 ± 2.3 points. On the life quality scale, investigation of the individuals did not reveal any substantial differences among men and women. In the lowest level the scales were evaluated as follows: 'Psychoemotional State', 'Interpersonal Interaction' and 'Overall Comprehension of the Life Quality'.

Conclusion. Therefore in the majority of people having left ATO zone one can observe psychoemotional disorders of various expression grades which need further correction in conditions of specialized medical institutions.

Gasan A.A., Batalina E.A.

CADASIL SYNDROME DIAGNOSTIC CRITERIA

Kharkiv National Medical University, Kharkiv, Ukraine
Department of neurology №1

Introduction: Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy – CADASIL syndrome – is a genetically determined disease, which is characterized by recurrent subcortical ischemic stroke, migraine with aura, subcortical dementia, mood disorders such as depression and anxiety. The cause of CADASIL syndrome is suspected mutation in Notch3 gene on the 19^{th} chromosome, which induced the development of arteriopathy with progressive occlusion of small perforating vessels of brain white matter and chronic hypoperfusion. Currently there is no single point of view on the pathogenesis of CADASIL. Therefore, the diagnosis of this pathology is based only on the already acquired knowledge and assumptions.

Aim: To identify the criteria for diagnosis of CADASIL syndrome.

Materials and methods. A review and analysis of publications and scientific literature in this area.

Results. In order to establish a definite diagnosis the conform to the requirements of probable CADASIL and identification of genetic mutations and/or arteriopathy with typical granular osmiophilic inclusions in biopsy of the skin/muscle/peripheral nerves are required. Diagnostic criteria for probable CADASIL are the disease onset age younger than 50 years old and at least 2 of the following clinical symptoms: severe migraine attacks (often hemiplegic and basilar); "silent" heart attacks and subcortical strokes; subcortical dementia; slowly rising asthenic and depressive syndromes; absence of cardiovascular risk factors; evidence of autosomal dominant inheritance; atypical lesion of cerebral hemispheres white matter and absence of cortical infarcts on MRI. Confirmation of CADASIL syndrome is finding Notch3 gene on chromosome 19g12 regulating angiogenesis. A simpler method is a