Krylevska S. I. TREATMENT OF THE PATIENT WITH ARTERIAL HYPERTENSION AND DIABETES MELLITUS II

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In normotensive people, the prevalence of diabetes is 2-2.5 times lower than in patients with arterial hypertension. Comorbidity of diabetes and hypertension doubles the risk of developing diabetic nephropathy and retinopathy, insults. Reduction of systolic blood pressure every 10 mm Hg reduces mortality from diabetes complications by 15%. It is necessary to reduce arterial pressure in patients with diabetes up to 130/80 mm Hg or below. Optimum is the lower pressure that each patient tolerates well.

According to European Society of Cardiology (ESC) and European Society of Hypertension (ESH) it is recommended to use antyhypertensive drugs of the 1st row for the treatment of patients with diabetes mellitus and hypertension: diuretics, Angiotensin II receptor blockers (ARBs), beta-blocker, Calcium channel blockers (CCB), angiotensin-converting-enzyme inhibitor (ACE inhibitor), and also use a combination of any drugs of the 1st row.

Calcium channel blocker and Angiotensin-converting-enzyme inhibitor have a specific nephroprotect effect. Treatment of angiotensin convertingenzyme inhibitors in the stage of apparent proteinuria reduces the rate of progression of microalbuminuria by 3 times, in severe nephropathy reduces the risk of terminal chronic renal insufficiency by more than 20%.

In patients with hypertension with diabetes, the use of beta-blockers is a complex and important issue. The high effectiveness of these drugs has been proven in multicenter studies. But the undeniable fact is that beta-blockers have an adverse effect on glucose metabolism: increased insulin resistance, disorders of glycolysis and gluconeogenesis, increased Glycated hemoglobin (HbA1c) and glucose in the blood. The incidence of diabetes in patients with hypertension, which received other drugs in 1-series lower than in patients who received betablockers. Studies have shown that beta-blockers have a detrimental effect on the incidence of diabetes, but they reduce the risk of developing complications. Diuretics may also increase tissue resistance to insulin. This can have clinical implications such as increased incidence of diabetes. So, we must carefully consider the treatment of patients with diuretics and beta-blockers. Therefore, despite the undoubted benefit of treatment with beta-blockers and diuretics for hypertension and diabetes, we must use them with caution. In patients with high risk of complications, the benefit of using beta-blockers and diuretics far exceeds the negative effect they make on glucose metabolism. In patients with mild arterial hypertension, having an initial stage of diabetes, the choice of the drug for the treatment of hypertension may play an important role for the further development of diabetes. It is better not to use drugs that have a negative effect on the sensitivity of tissues to insulin in such patients. The exception is betablockers with vasodilating properties (carvedilol, nebivalol). The peculiarity of beta-blockers with vasodilating properties does not have a negative effect on glucose metabolism.

The treatment of patients with arterial hypertension with concomitant diabetes requires consideration of the individual risk of development of complexity and the differentiated tactic depending on it. For people with a very high risk of complications, the priority goal is to lower blood pressure. It is possible to apply any preparations of the first row, which at a particular patient effectively lower blood pressure and do not cause side effects. In patients with moderate risk of complications it is expedient to use a metabolically neutral drug: angiotensin-converting-enzyme inhibitor (ACE inhibitor), Calcium channel blockers (CCB), Angiotensin II receptor blockers (ARBs). If patients have a high risk of complications, it is advisable to use metabolically neutral drugs: angiotensin-converting-enzyme inhibitor (ACE inhibitor), Calcium channel blockers (CCB), Angiotensin II receptor blockers (ARBs).

Glucose control is an important component of treating such patients. Lowering the level of glycemia contributes to a decrease in the frequency of microvascular complications (retinopathy, nephropathy, neuropathy), although it has no significant effect on the frequency of macrovascular complications (stroke, myocardial infarction, atherosclerotic lesions of peripheral arteries). The purpose of the treatment is to normalize the plasma glucose and reduce the glycosylated hemoglobin (HbA1c) to less than 7.5%.

Consequently, it can be concluded that glycemic control, glycosylated hemoglobin, and well-founded appointment of antihypertensive therapy, taking into account the risk of complications, are of fundamental importance in the treatment of patients with comorbidity (arterial hypertension and diabetes). Antihypertensive therapy for diabetics should be considered taking into account the renoprotective effects of the ACE inhibitor, ARBs. If it is not possible to use the ACE inhibitor, ARBs, then cardiolective beta-blockers or nondihydropyridine Calcium channel blockers should be preferred.

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Vegetative-vascular dystonia is a multifactorial, interdisciplinary disease that is associated with impaired neurohumoral and endocrine regulation of the tone of the cardiovascular system, respiratory system, and the gastrointestinal tract. As a rule, many mental, neurological and somatic desorders accompanied by vegetative dysfunction (depression, ischemic heart