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II МІЖНАРОДНА НАУКОВО-ПРАКТИЧНА КОНФЕРЕНЦІЯ «ТЕРАПЕВТИЧНІ ЧИТАННЯ: СУЧАСНІ АСПЕКТИ ДІАГНОСТИКИ ТА ЛІКУВАННЯ ЗАХВОРЮВАНЬ ВНУТРІШНІХ ОРГАНІВ» (ПРИСВЯЧЕНА ПАМ'ЯТІ АКАДЕМІКА НАМН УКРАЇНИ Є.М.НЕЙКА)

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INDEXES OF FATTY ACID METABOLISM AS A PREDICTORS OF HIGH RISK OF MYOCARDIAL INFARCTION FOR THE TRANSCARPATHIAN REGION RESIDENTS WITH OVERWEIGHT

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Background: One of the most important tasks of the healthcare is searching of markers for the prognosis of development and early detection of the most common diseases that contribute to the implementation of preventive medicine. Diagnostic value of low density lipoprotein (LDL) and high density lipoprotein (HDL) are well known during a long time and include in protocols of diagnostic of myocardial infarction (MI), but the early determining of fatty acid on subclinical stages of disease when changes are still reversible, can become the key to early diagnosis and prognosis of MI.

Target: Can the indexes of fatty acid metabolism in patients with overweight used as predictors of high risk of MI developing.

Method: We examined 141 persons, including 99 patients who seeking help to outpatient department and 42 patients in the acute phase of MI, who were hospitalized in the intensive care unit of Transcarpathian Regional clinical cardiology dispenser. In the studied groups we determined Pearson correlation coefficient and made stepwise regression analysis. In the surveyed persons evaluated age, gender, body mass index, lipid spectrum indixes and fatty acid composition of blood, which was determined by analytical gas chromatograph.

Results: The level of arachidonic acid in patients with obesity and MI was not statistically different (223.2 ± 16.9 and 203.1 mcg/ml respectively p□0.05), while in healthy people and people who are overweight this level was significantly lower (159.3±15.3 and 150.2±12.1 mcg/ml, $p<0.01$). In obese patients, unlike patients with MI middle level of anti-inflammatory polyunsaturated fatty acid (PUFA) are significantly greater (127.1±9.6 mcg/ml and 54±6.1 mcg/ml in patients with MI, $p<0.01$).

Conclusions: In obesity patients predictor of coronary blood flow disorders can be considered a progressive increase of arachidonic acid concentration on the background of ώ3-PUFA decrease. This knowledge will allow primary care doctors identified groups of overweight patients, who have a high risk of MI.

PHENOTYPE-BASED MANAGEMENT IN CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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Actuality. Chronic obstructive pulmonary disease (COPD) is a heterogeneous disease of the lungs with systemic manifestations that affect the phenotypic expression of the disease, its course and outcomes. COPD associated with significant morbidity and mortality globally. According to the latest World Health Organization (WHO) update, it causes the death of ≥ 2,9 million people annually and in 2013, was the 12th cause of global years of life lost.

Aim of the investigation was to explore the modern clinical phenotypes of COPD.

Materials and methods. We have analyzed COPD guidelines in different countries on the subject of identification of disease phenotypes.

Results. The Global Initiative for Chronic Obstructive Lung Disease (GOLD) has proposed a new approach to risk assessment, including evaluation of symptoms, health status, exacerbation rate, and severity of airflow limitation. This approach is a tentative move towards personalised treatment for patients with COPD. However, no mention of the concept of clinical phenotypes is included.

Clinical phenotype is a single or combination of disease attributes that describe differences between individuals with COPD as they relate to clinically meaningful outcomes like symptoms, exacerbations, response to therapy, rate of disease progression, or death. The concept of phenotypes emerged again, and the traditional concept of "blue bloaters" and "pink puffers", abandoned in the past, is now being replaced by a variety of different phenotypes. The goal of COPD phenotyping is to be able to classify patients into distinct subgroups according to prognosis and response to therapy in order to better select the appropriate therapy that can optimize clinically meaningful outcomes for patients.

In 2012, the Spanish guidelines of COPD (GesEPOC) identified four different phenotypes: the non exacerbator phenotype, the exacerbator phenotype with emphysema or with chronic bronchitis and the asthma-COPD overlap syndrome (ACOS). The phenotypic approach to treatment has been followed by other European guidelines such as the Czech Republic, the Finnish, the Russian or the Swedish ones. Czech guidelines also include the COPD-bronchiectasis and the pulmonary cachexia (Koblizek V., Chlumsky J., Zindr V. et al., 2013).

The exacerbator phenotype is defined as COPD patients who present with two or more moderate or severe exacerbations a year requiring anti-inflammatory treatment.

The emphysema phenotype includes COPD patients with confirmed diagnosis of emphysema, who have dyspnea and exercise intolerance as predominant symptoms. Severe emphysema is associated with a poor prognosis as it is a predictor for a greater annual fall in forced expiratory volume in 1 sec (FEV_1). Patients with this phenotype tend to present with a lower body mass index. The emphysema phenotype usually has fewer exacerbations than the chronic bronchitis phenotype.

The chronic bronchitis phenotype is defined as COPD patients who present with chronic cough and sputum production for 3 months a year for 2 consecutive years. Bronchial hypersecretion in COPD has been associated with greater airway inflammation and greater risk for respiratory infection, which can explain why patients with chronic bronchitis have a greater frequency of exacerbations.

The diagnosis of mixed COPD phenotype is made when 2 major criteria or 1 major and 2 minor criteria are met. The major criteria include very positive bronchodilator test (increase in FEV_1 $\geq$15% and $\geq$400 ml), eosinophilia in sputum and personal history of asthma. Minor criteria include high total IgE, personal history of atopy and positive bronchodilator test (increase in FEV_1 $\geq$12% and $\geq$200 ml) on two or more occasions.

Therapeutic approaches depend on the patient phenotype. For example, the exacerbator phenotype with chronic bronchitis should receive other anti-inflammatories, such as phosphodiesterase-4 inhibitors, mucolytics at high doses or long-term macrolides in selected cases in addition to inhaled corticosteroids (ICS). Patients with ACOS phenotype

show an enhanced response to ICS. Special attention should be paid to comorbidities, and their control optimized.

Conclusion. The identification of clinical phenotypes of COPD reflects the heterogeneity of the disease and helps clinicians to select the most suitable treatment for their patients.

THE INFLUENCE OF ENDOGENOUS INTOXICATION FOR MAIN HEMODYNAMIC PARAMETERS IN PATIENTS WITH Q-MYOCARDIAL INFARCTION

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The aim of this study was to exam of endogenous intoxication level in patients with STEMI and arterial hypertension (AH) and its influence for main hemodynamic parameters.

Material and Methods. We observed of 130 patients with STEMI which were divided into two groups: with essential AH (70 persons) and without AH (60 persons). 30 apparently healthy persons were included into control group.

Resting heart rate (HR), systolic (SBP) and diastolic blood pressure (DBP) were measured due current recommendations. Echocardiography was performed at baseline. The endogenous intoxication was evaluated by method of sorption ability of erythrocytes. P values of 0.05 or less were considered statistically significant. All the statistical analyses were carried out via Statistica 12.0 (StatSoft, Tulsa, OK, USA). The study was performed in accordance with the Helsinki Declaration and Good Clinical Practice Guideline. The study was approved by the local ethics committee and written informed consent was obtained from all patients.

Results. The average age of all observed patients with STEMI was (64,96±12,94) years. Among all patients 78 persons (60.0 %) were males.

No differences between HR were observed in both groups: (80.73±2.95) bpm – in patients without AH and (79.39±1.43) bpm – in patients with essential AH (p=0.65). But we founded of blood pressure inequality: SBP was (125.0±1.58) mm Hg and (161.69±2.91) mm Hg relatively (p<0.001), and DBP – (81.12±2.39) mm Hg or (94.60±1.60) mm Hg (p<0.001).

The level of endogenous intoxication measured by sorption ability of erythrocytes (SAE) method was similar in STEMI patients with or without AH, but was higher than in control group - (24,56±0,58) % (p<0,01).

No differences in Echocardiography parameters were observed in both groups patients with STEMI.

The moderate correlation between SAE and resting HR was established in patients with STEMI and without essential AH: r=0.40, p=0.012.

In STEMI patients without AH we observed the moderate direct correlation between SAE and some Echocardiography parameters (see table 5): EDS (r_s = 0.55, p<0.001), ESS (r_s = 0.52, p<0.001), EDV (r_s = 0.50, p<0.001), ESV (r_s = 0.53, p<0.001) and LVEF (r_s = 0.40, p=0.012).

Conclusion. STEMI is accomplished by endogenous intoxication. This phenomenon