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ХАРКІВСЬКИЙ НАЦІОНАЛЬНИЙ МЕДИЧНИЙ УНІВЕРСИТЕТ
КАФЕДРА ВНУТРІШНЬОЇ МЕДИЦИНИ №1**

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СТУДЕНТІВ ТА ЛІКАРІВ-ІНТЕРНІВ, ПРОВЕДЕНИХ НА БАЗІ
КАФЕДРИ ВНУТРІШНЬОЇ МЕДИЦИНИ №1**

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ERLIHYOSIS BRIEF HISTORY OPENING SKETCH

Ahmed Reeda, I.I.Zelena

Ehrlichiosis infection is a transmissible infectious disease of people and mammals caused by obligated intracellular pathogens - the bacteria of the genus *Ehrlichia*, respectively, are characterized by the development of the syndrome general infectious intoxication and specific cell experience mesodermal origin. Erylichiosis is a typical natural focal zoonosis and transmitted through the bite of infected ixodic ticks (Ixodidae), among which *Ixodes*, *Amblyomma*, *Dermacentor*, *Rhipicephalus* has the main role of both vectors and reservoirs pathogens. Since opening in 1925, the first representative of the family *Ehrlichia* - *E. ruminantium* (ex - *Cowdria ruminantium*) and before 1986 *erlychiae* also known as pathogens of transmissible diseases of animals.

The impetus for in-depth studies of these microorganisms served the case of mass death of dogs in Algeria in 1935. Animal studies allowed scientists Donatien A., Lestoquard F. in 1935 to describe a new species *rickettsia canis* (now *E. sanis*) is a typical species. Classification and nomenclature *Erlichi* also constantly changed due to the discovery of new species and their genetic variants. The first case of human erlichosis is presence specific morulas in leukocytes of a patient on the background of an unknown fever etiology, thrombocytopenia, azotemia, hypoxemia, described by K. Maeda and sang in 1986 in the USA. Further research by other scientists from using electron microscopic, immunological and molecular genetic (sequencing gene 16S rRNA) methods gave rise to the basis to describe in 1991 a new species of *E. chaffeensis* - the causative agent of EI, which is the main etiologic agent of MEL in the USA. In the current day International Statistical Classification of Diseases and Related Health Problems of the Tenth Revision (ICD-10), adopted on Forty-third World Health Assembly (1992) no separate sections for registration of AI and EI. In the MCD-10 the heading is excluded: *Rickettsiosis "Rickettius induced by Ehrlichia sennetsu"* (A 79.8).

Despite more than a century of biological research experience the properties of anaplasma and erylichia, this group of microorganisms and today is relatively little known. Therefore, their taxonomy (classification, nomenclature, identification criteria) is constantly changing. Today representatives the genus *Ehrlichia* is part of the Bacteria, a type of Proteobacteria, of the class α (Alpha) Proteobacteria, order Rickettsiales, All representatives of four genera are obligate intracellular proteobacteria, which multiply in the specialized vacuoles of eukaryotic cells. Family *Ehrlichia* has five species. *E. chaffeensis* - the dominant pathogen EI (MEL)

In the US, *E. muris* is a dominant MEL agent in Europe, Asia, Japan.

GAUCHER DISEASE AS A POSSIBLE CAUSE OF HEPATOSPLENOMEGALY IN ADULTS

Akewusola A., Prosolenko K.O.

Gaucher disease (GD) is one of the most common forms of hereditary fermentopathy, united in the lysosomal storage diseases group, which is based on the deficiency of the lysosomal enzyme β -D-glucosidase (glucocerebrosidase), responsible for lipoprotein catabolism.

The frequency of GD in the general population is 1: 40000 - 1: 70000. In the population of Ashkenazi Jews (those from Eastern Europe), the prevalence of this disease is higher and reaches 1: 450.

GD is inherited by the autosomal recessive type. Depending on the clinical course, three types of HGs are distinguished: type I - non-neuronopathic (most common), type II - infantile or acute neuronopathic, type III - subacute neuropathic.

Type I GD has a chronic duration. The clinical picture is characterized by a progressive increase in parenchymal organs (liver and spleen), pancytopenia, and pathology of the tubular bones of the skeleton. Characteristic features are: hepatosplenomegaly, bone pain (bone crisis), pathological fractures, disorders of joint mobility, often due to aseptic necrosis, hemorrhagic syndrome, delayed physical and sexual development, asthenic syndrome.

Permanent and earliest symptom of the disease is splenomegaly. The size of the spleen can exceed the norm by 5-80 times. Spleen has a dense consistency. As the splenomegaly progresses in the spleen, infarctions and fibrotic changes that often have no clinical manifestations can develop.

Hepatomegaly is observed in 80-90% of patients with type 1 GD. The size of the liver is increased by 2-4 times, which is much less than the degree of enlargement of the spleen. From 30 to 50% of patients have a slight increase in the activity of serum aminotransferases, usually no more than 2 norms. A standard biopsy of the liver always detects Gaucher cells that are contained in the form of aggregates in sinusoids or diffused in all zones and lobes presented in the biopsy.

The standard of modern diagnostics is the biochemical analysis of the activity of glucocerebrosidase in blood leukocytes. Diagnosis is confirmed by reducing the activity of the enzyme to 30% and less than normal. An additional characteristic biochemical marker is the significant increase in the activity of chitotriosidase in serum. Verification of the diagnosis can be done by molecular analysis of the glucocerebrosidase gene: the presence of two mutant alleles confirms the diagnosis of GD.

The presence of numerous Gaucher cells in punctinum and bone marrow trepanobiopates or liver biopsy is an evidence of GD. X-ray of skeletal bones, densitometry and MRI are methods that can detect bone defects.

The treatment of GD is the life-long appointment of substitution enzyme therapy for recombinant glucocerebrosidase (imiglucerase). Another direction in the treatment of GD is subtratradsion therapy, the first representative of which is a drug - miglustat, intended for the treatment of a non-complicated form of GD with the impossibility of substitution enzyme therapy of recombinant glucocerebrosidase.

TREATMENT OF RHEUMATOID ARTHRITIS IN NIGERIA

Boateng Isaac, Andrieieva A.

Introduction: Rheumatoid arthritis (RA) is a chronic, progressive and non-isolated disease whose purpose is to achieve long-term remission in order to improve the quality of life of the patient. The disease is common among the population, about 0.7-1.4% of the population, and 10 years after the onset of the disease, about 85% of working-age patients become disabled. Due to the rapid failure of patients, not only the duration but also the quality of life of patients with rheumatoid arthritis is reduced. Often there are not enough effective and many side effects in the treatment of patients with rheumatoid arthritis with major non-steroidal anti-inflammatory drugs and glucocorticoids.

RA is not uncommon in Nigeria. Fourfold retrospective study of patients presented to the rheumatologic department of the State University of Lagos (LASUTH) in Nigeria. The diagnosis was based on the criteria of the American College of Rheumatology (ACR), or on the classification criteria of the ACR / European League of Rheumatism Association (EULAR) in 2011 for RA.

Of the 1215 patients who were observed with rheumatologic problems, 128 (10.6%) fulfilled the criteria for RA. The ratio of women and men was 6.1: 1. The average age of patients was 41.4 years. PIPJ was mostly affected. The frequency of erythrocyte sedimentation (ESR) and C-reactive proteins (CRP) is mostly elevated. The rheumatoid factor (RF) test was positive in 78 (72.2%). Anticyclic citrulinated peptide antibodies (anti-CCP) were positive in 54 (61.1%). Roentgenograms of hands mainly showed bone erosion and periarticular osteopeniums.

Treatment in Nigeria is carried out using NSAIDs, anti-rheumatic drugs (DMARDs), prednisolone and biologics. Methotrexate is an overwhelming DMARD, if not contraindicated. Systemic glucocorticoids are used in the lowest dose as a temporary (<6 months) additional treatment to reduce pain, edema and structural progression. Intravascular injections of glucocorticoids can be considered. Similarly, regular monitoring of diseases, exercises, smoking stops, weight control and education is conducted.

Conclusion: rheumatoid arthritis in Nigeria is treated in accordance with the recommendations of EULAR. However, statistics on the effectiveness of treatment in Nigeria are not reported. The world continues to develop new drugs. Currently, genetically modified biological products are among the most effective and promising.

DYNAMIC OF THE GLOMERULAR FILTRATION RATE, FETUIN A AND PRO-INFLAMMATORY CYTOKINES AFTER USING OF THE COMPLEX THERAPY IN PATIENTS WITH NONALCOHOLIC FATTY LIVER DISEASE AND RENAL PARENCHYMAL HYPERTENSION

Ekong A.W., Prosolenko K.O.

The role of inflammation is known in pathophysiology of nonalcoholic fatty liver disease (NAFLD) and renal parenchymal hypertension (RPH). Nowadays role

of NAFLD in pathophysiology of CKD especially in patients with hypertension is studying.

The aim of our study was to investigate the basic level and dynamics of the fetuin A, pro-inflammatory cytokines (TNF-alpha and IL-6) and glomerular filtration rate (GFR) after using the complex therapy.

Materials and methods. The study involved 30 patients with NAFLD and stage II, grade 2 RPH (as result of chronic pyelonephritis, chronic kidney disease (CKD) 2-3 stage). There were examined 10 men (33,3%) and 20 females (66,7%). The median age was $(51,2 \pm 4,8)$ years. The control group consisted of 30 healthy volunteers of similar age category, male and female. We studied blood pressure, ultrasound of the liver, kidney, fetuin A and pro-inflammatory cytokines (TNF-alpha and IL-6) and GFR by conventional methods.

Patients with NAFLD and RPH ($n = 30$) were divided into two groups. Patients in Group 1 ($n = 15$) received Losartan 50 mg / day, Atorvastatin 10-20 mg / day. Patients in Group 2 ($n = 15$) received Losartan 10 mg / day, Atorvastatin 10-20 mg / day in combination with PUFA 2 g / day and UDCA 10 mg / kg / day. Duration of treatment was 6 months. All were given recommendations for a balanced diet and aerobic exercise.

Results. In patients with NAFLD and RPH increasing of pro-inflammatory cytokines (TNF-alpha and IL-6) and fetuin A were indicated. In our study, significantly better result was achieved when assigning complex therapy using UDCA and PUFA - group 2. Significantly better results than were achieved in group 2 in TNF- α . In group 2, there was a significant improvement in renal function.

Conclusions. Combination therapy comprising atorvastatin, losartan, UDCA and RPH in combination with non-drug therapy in patients with NAFLD and RPH compared with taking losartan and atorvastatin combination with non-drug therapy is more effective for the correction of proinflammatory abnormalities and renal function that can help reduce the overall cardiometabolic risk, progression of diseases and improving life prognosis in patients with comorbidity of NAFLD and RPH.

CARDIOHEMODYNAMIC ABNORMALITIES IN PATIENTS WITH NON-ALCOHOLIC FATTY LIVER DISEASE AND HYPERTENSION

Elhadg A., Prosolenko K.O.

According to epidemiological studies, nonalcoholic fatty liver disease (NAFLD) is now ranked first in the structure of chronic diffuse liver diseases worldwide, and is found in one third of the adult population of some countries [1, 9]. Recently, this disease is considered as a multisystem which is primarily linked to the components of the metabolic syndrome and is associated with lesions of the cardiovascular system and kidneys.

The aim of the study was to compare the structural and functional state of the heart and liver in patients with isolated essential hypertension (EH) and in conditions of its combination with NAFLD.

Materials and methods. A total of 117 patients with NAFLD with EH stage II, 2 degree were examined in the National Institute of Therapy named after LT Malaya of the Ukrainian National Academy of Medical Sciences. There were 63 men (53.86%) and 54 women (46.14%). The mean age was 54.4 ± 5.9 years, and the groups were divided according to the presence of NAFLD and the degree of hepatic fibrosis. The distribution of patients was provided according to presence of NAFLD and the NAFLD fibrosis score (NFS). 74 patients with EH + NAFLD with NFS \geq 1.455 - group 1, 43 patients with EH + NAFLD with NFS $<$ 1.455-group 2 and 30 patients EH \neq NAFLD - group 3. The control group consisted of 20 practically healthy persons.

Results. Our patients with NAFLD and EH were characterized by structural and functional disorders of the heart. Patients with comorbidity of EH and NAFLD with liver fibrosis are characterized by a preserved systolic function of the left ventricle and concentric (55.4%) and eccentric (43.8%) LV hypertrophy. Patients with NAFLD and liver fibrosis differ from patients with EH in combination with NAFLD without liver fibrosis and isolated EH with significantly higher values of LV myocardial mass ratio (LVMMR), left ventricular diastolic filling factor E/e. The results of the study showed the presence of a reliable direct relationship between the level of NFS and LVMMR, which proves the effect of the progression of liver damage on the progression of LVH in patients with NAFLD and EH. A reliable correlation was found for NFS and E/e - $r_s = 0.32$.

Conclusions. Comorbidity of EH and NAFLD with liver fibrosis are characterized by preserved systolic function of the left ventricle and more prognostically unfavorable LV remodeling options: concentric and eccentric LVH. This group of patients is characterized by an increase in LVMMR, an integral index of diastolic filling of the left ventricle E/e.

DIFFERENTIAL DIAGNOSIS OF CARDIALGY AT GASTROESOPHAGAL REFLEX DISEASE

Frolova-Romaniuk E., Olaniyan M.

The purpose of the work. To conduct differential diagnostics of extra-ischemic manifestations of gastroesophageal reflux disease and coronary heart disease, which is based on the use of a protonpump inhibitor (kontrolok).

Research methods. 71 patients with cardialgia were examined, aged $48 + 12$ years old, of which 39 (62.9%) men and 23 (37.1%) women.

Results Patients with cardiogenic attacks occurring horizontally at night, chest pain after food intake, and in the background of body tilt or patients who had little effectiveness in taking nitroglycerin, were tested with a proton pump inhibitor (kontrolok). The effectiveness of receiving 20 mg of beakers was evaluated after the day of application. In the case of improving clinical symptoms and reducing the number of angina attacks in the background of the proton pump inhibitor, the patient was diagnosed with gastroesophageal reflux disease and prescribed a gusset at a dose of 40 mg per day for 4 weeks followed by receiving maintenance doses of this proton pump inhibitor for 8 weeks. In case of renewal of symptoms after the end of

maintenance therapy, recommended on-demand therapy (kontrolok at a dose of 40 mg for 8-16 weeks).

Conclusions. The use of an inhibitor of proton pump (kontrolok) provides the possibility of differential diagnosis of atypical manifestations of gastroesophageal illness in outpatient-polyclinic conditions and use in cases where the use of endoscopic methods is inaccessible or contraindicated.

TREATMENT OF GASTROESOPHAGEAL REFLEXIC DISEASE INCLUDING TYPE 2 DIABETES MELLITUS

Frolova-Romaniuk E.Yu., Olaniyan M.

The purpose of the work. To study the features of treatment of gastroesophageal reflex disease in patients with type 2 diabetes mellitus.

Research methods. 109 patients with type 2 diabetes mellitus at the age from 30 to 72 years old were studied, of which 68 women, 41 men, and the average age - 57.4 ± 7.6 years.

The survey algorithm included a collection of complaints, anamnestic data on the duration, severity of diabetes, complications of diabetes, study of glycosylated hemoglobin (HbA1c), pH-metrics on the apparatus Gastroskan-24, endoscopic examination of the esophagus and the stomach with biopsy twice (at 0 and 4th week from the start of treatment).

For heartburn, the main symptom of gastroesophageal reflux disease (GERD), complained only 29.75% of patients, and regurgitation - 9.6% of patients. In 18.75% of patients, voiced voices were determined. A significant number of patients complained of cardiopulmonary attacks - 41.9%, which occurred in the horizontal position at night, chest pain after eating and in the background of the body tilt, and had a positive result in a test using a proton-inhibitor (a control) During conduction of videosephagoscopy, hyperemia of the lower third of the esophagus was detected - in 24 (22%) patients, reflux esophagitis of grade A-27 (25%), degree B-44 (40,6%), in 6 patients the degree of esophagitis was defined as C, and 8 (7.3%) - patients defined endoscopically negative gastroesophageal reflux disease. All patients were prescribed pantoprazole (control) 40 mg twice daily, Mosapride (Mosid) 5 mg three times a day, and rebamipid (mucogen) 100 mg three times a day.

Results Under the influence of treatment almost all symptoms of GERD were eliminated - so on heartburn and regurgitation of complaints did not remain, only 1.2% of patients still recognized voiced voices, and about 3% of patients remained cardiac after the second week of treatment ($p < 0.01$) During the control of esophagoscopy after 4 weeks of treatment, the following data were obtained: reflux esophagitis A st. (according to the Los Angeles classification) was found in 11 patients (10.1%), grade B in 28 (25.7%) patients, and 2 patients in grade C.

LEVEL OF NITRIC OXIDE IN PATIENTS WITH CHRONIC TYPE B GASTRITIS

Hussein Kataya, Zhelezniakova N.

Objective: to determine the level of metabolites of nitric oxide in patients with chronic type B gastritis.

Materials and methods: 57 patients with chronic type B gastritis and 20 practically healthy persons were examined. The diagnosis was established when assessing the complex of complaints, data of anamnesis and instrumental methods of research - videoesophagogastroduodenoscopy with targeted biopsy and subsequent histological examination of the biopsy. The presence of *Helicobacter pylori* was determined by H. pylori stool antigen test. The level of nitriteemia was determined by means of reductant reactor ("Nitrate reductor"). Statistical data has been performed on workstation by means of software "Microsoft Excel" and "Statistica 8.0".

Results. The study showed that in the active phase of chronic type B gastritis there was a significant decrease in the level of NO metabolites. Thus, the level of nitriteemia was $4.49 \pm 0.05 \mu\text{M/l}$, at the same time in healthy individuals it was $5.1 \pm 0.052 \mu\text{M/l}$, the difference is significant ($p < 0,05$)

Conclusions. The active phase of chronic type B gastritis is accompanied by a significant decrease in the level of NO metabolites in the blood.

CLINICAL FEATURES OF CHONDROITIN SULFATE

Karimli F., Vizir M.

Chondroitin sulfate, along with hyaluronic acid and glucosamine sulfate, refers to the natural components of the intercellular substance of the hyaline cartilage. The molecule of chondroitin sulfate is highly charged and has polyanionic properties, due to which it participates in the transport of water, amino acids and lipids. Pharmacokinetic studies have shown that the bioavailability of the drug when administered orally is about 13-15%, with external application reaches 20-40%.

It was shown that chondroitin sulfate inhibits the synthesis of metalloproteinases (stromelysin) by chondrocytes by 28%, and also reduces the expression of metalloproteinase induced by lipopolysaccharides and IL-1 β . Under its influence, the level of IL and other mediators of inflammation in the serum decreases.

The drug activates the synthesis of high-molecular hyaluronic acid synoviocytes, suppresses premature death (apoptosis) of chondrocytes. It exerts a significant influence on the metabolic processes of various joint structures, affecting virtually all major pathogenetic mechanisms of osteoarthritis development. In other words, the mechanism of action of chondroitin sulfate is reduced to inhibition of catabolic and stimulation of anabolic processes, which indicates a chondro-modifying chondroprotective effect of the drug.

The therapeutic activity of chondroitin sulfate has been demonstrated in numerous clinical placebo-controlled trials. It is recommended by the European

Antirheumatic League (EULAR) as a symptom-modifying delayed-action drug for the treatment of osteoarthritis. The effectiveness of the use of chondroitin sulfate preparations in the treatment of osteoarthritis and osteochondrosis is shown. Its use, in particular, reduces pain, both at rest and during movement, reduces the intensity and duration of morning stiffness, improves the function of the joints.

LEVEL OF DIENE CONJUGATES AS A MARKER OF LIPID PEROXIDATION INTENSIFICATION IN PATIENTS WITH CHRONIC TYPE B GASTRITIS

Lamis Khalil, Zhelezniakova N.

Objective: to evaluate the processes of lipid peroxidation by determining diene conjugates in patients with chronic type B gastritis.

Materials and methods: 57 patients with chronic type B gastritis and 20 practically healthy persons were examined. The diagnosis was established when assessing the complex of complaints, data of anamnesis and instrumental methods of research - videoesophagogastroduodenoscopy with targeted biopsy and subsequent histological examination of the biopsy. The presence of *Helicobacter pylori* was determined by *H. pylori* stool antigen test. The blood content of diene conjugates (DC) was established spectrophotometrically by the method of B.V. Gavrilova and M.I. Mishkhorudnaya. Statistical data has been performed on workstation by means of software "Microsoft Excel" and "Statistica 8.0".

Results. It was revealed that an increase in the content of primary lipid peroxidation products was observed in patients with chronic type B gastritis. Thus, the level of diene conjugates was - $17.2 \pm 1.1 \mu\text{mol/l}$. In comparison group the following result was obtained: $9.2 \pm 0.7 \mu\text{mol/l}$. The difference in the indicators of groups was significant ($p < 0,05$).

Conclusions. Exacerbation of the pathological process in patients with chronic type B gastritis leads to an increase in the processes of lipid peroxidation, which is manifested by a significant increase in its primary products, namely, diene conjugates.

CHANGES IN ACTIVITY OF SUPEROXIDE DISMUTASE IN PATIENTS WITH CHRONIC TYPE B GASTRITIS

Malak Sanad, Zhelezniakova N.

Objective: to establish the degree of changes in superoxide dismutase activity in exacerbation formation in patients with chronic type B gastritis.

Materials and methods: 57 patients with chronic type B gastritis and 20 practically healthy persons were examined. The diagnosis was established when assessing the complex of complaints, data of anamnesis and instrumental methods of research - videoesophagogastroduodenoscopy with targeted biopsy and subsequent histological examination of the biopsy. The presence of *Helicobacter pylori* was determined by *H. pylori* stool antigen test. The activity of superoxide dismutase (SOD) of blood was determined spectrophotometrically according to the

degree of inhibition of the reduction of nitrous tetrazole by the method S.Chevari, I.Chaba and J.Secei. Statistical data has been performed on workstation by means of software "Microsoft Excel" and "Statistica 8.0".

Results. In patients with exacerbation of chronic type B gastritis a decrease in activity of antioxidant enzymes was observed. The level of superoxide dismutase in these patients was 2.01 ± 0.03 units of activity per 1 min for 1 g of Hb, respectively. At the same time, in practically healthy individuals the level of superoxide dismutase was 2.2 ± 0.14 units of activity per 1 min for 1 g of Hb, the difference is significant ($p < 0,05$).

Conclusions. Formation of exacerbation in patients with chronic type B gastritis is accompanied by oppression of the antioxidant defence system, which is manifested by a decrease in the activity of superoxide dismutase.

MODERN COMBINED TREATMENT REGIMENS OF AUTOIMMUNE HEPATITIS

Mushi M., Prosolenko K.O.

The recommendations of the American Association for the Study of Liver Diseases (AASLD), 2010 and recommendations of the European Association for the Study of Liver Diseases (EASL), 2015 are relevant for autoimmune hepatitis (AIH) treatment.

The most desirable result of treatment is a complete clinical, biochemical and histological remission with a stable response after the end of therapy. However, most patients do not achieve this goal.

All patients with active AIH should be treated with immunosuppressive drugs. The combination of predniso(lo)ne + azathioprine is characterized by the most favorable characteristics, combining high efficiency and minimal side effects.

In spite of the fact that prednisone monotherapy and the combination of prednisone + azathioprine are equally effective, first-line combined therapy is more preferable, especially in patients with high probability of side effects (emotional instability, osteoporosis, diabetes mellitus, hypertension, obesity). For young women an important aspect of poor compliance is an increase in body weight and cosmetic defects due to corticosteroid treatment.

The usual treatment with prednisolone begins from 60 mg with a gradual decrease in dose and the transition to a maintenance dose. Treatment with azathioprine can be started in any situation if the bilirubin level is below $100 \mu\text{mol} / \text{l}$. The initial dose is 50 mg / day. It is increased taking into account the presence of side effects and the response to a maintenance dose of 1-2 mg / kg. Azathioprine should be used with caution in patients with cytopenia, malignant neoplasms, thiopurine methyltransferase (TMT) deficiency, and pregnant women. In these situations, it is necessary to individually assess the ratio of risk and benefit.

In addition to the classical regime of prednisone + azathioprine, several modifications are proposed that are used in the clinical practice of several specialized centers.

Another grounded rational strategy is delayed use of azathioprine. Beginning of monotherapy with prednisone. Deferred application of azathioprine (usually about 2 weeks) may be appropriate in the treatment of patients with AIH because it allows to solve the problem of diagnosis, and on the other hand, to avoid the diagnostic dilemma of distinguishing azathioprine-induced hepatotoxicity and the initial lack of response to treatment. The hepatotoxic effect of azathioprine is rare, but in patients with a late stage of liver injury, the incidence of this side effect increases. In general, AIH therapy should be adjusted depending on the response, treatment regimens should be individualized, depending on the observed efficacy and tolerability of therapy. Treatment regimens should be individualized.

DEVIATIONS IN CATALASE ACTIVITY IN PATIENTS WITH CHRONIC TYPE B GASTRITIS

Nadine Naser Eddine, Zhelezniakova N.

Objective: to establish the deviations in catalase activity in exacerbation of chronic type B gastritis.

Materials and methods: 57 patients with chronic type B gastritis and 20 practically healthy persons were examined. The diagnosis was established when assessing the complex of complaints, data of anamnesis and instrumental methods of research - videoesophagogastroduodenoscopy with targeted biopsy and subsequent histological examination of the biopsy. The presence of *Helicobacter pylori* was determined by *H. pylori* stool antigen test. The activity of catalase (CT) of blood was determined spectrophotometrically with H_2O_2 substrate by the method S. Chevary et al.. Statistical data has been performed on workstation by means of software "Microsoft Excel" and "Statistica 8.0".

Results. It was found out that the level of catalase activity in patients with chronic type B gastritis was 198.4 ± 13.9 IU mg/Hb. While in practically healthy individuals the catalase activity level was 237.5 ± 12.4 IU mg/Hb ($p < 0,05$).

Conclusions. The presence of active inflammation of gastric mucus in patients with chronic type B gastritis aggravates the suppression of the activity of the antioxidant defence system, which manifests by significant decrease in its enzyme link, in comparison with practically healthy persons.

NON-ALCOHOLIC FATTY PANCREATIC DISEASE: RELEVANT PROBLEMS OF DIAGNOSIS

Okwu-Boms O., Prosolenko K.O.

Catastrophic growth in the spread of obesity in society began to become the character of the global epidemic. Obesity increases the risk of developing serious diseases, including non-alcoholic fatty pancreatic disease (NAFPD). Also, obesity is clearly associated with an increased risk of death from developed diseases. Nowadays, the methods of diagnosis and treatment of NAFPD have many controversial points.

Methods of investigation of NAFLD are consistent with the methods of diagnosis of chronic pancreatitis (general and biochemical blood tests, fecal elastase 1 detection (exocrine pancreatic insufficiency), transabdominal and endoscopic ultrasonography, upper endoscopy, computed tomography (CT) of the abdominal cavity – the method of choice). Diagnostic criteria for NAFLD were distinguished (Shifrin, 2008) - 1. Basic: the presence of abdominal pancreatic pain; reduction of the densitometric parameters of the pancreatic tissue; 2. Additional: hyperamylasemia, clinical and laboratory signs of metabolic syndrome - MS (abdominal type of obesity, hyperlipidemia, hyperglycemia, hypertension); the presence of characteristic fat layers in the pancreas (radial research methods). At carrying out of diagnostics on CT there is a marked fat restructuring of pancreatic parenchyma (lobular composition of glands with the expressed fat layers), decrease of densitometric parameters of parenchyma (measurement of organ density in units of Hounsfield allows to objectify diagnostics). The histological examination is, of course, the "gold standard" for diagnosis of NAFLD, but due to the complexity of its implementation, the clinical picture is evaluated in combination with CT. The transabdominal ultrasound of the pancreas has often low diagnostic value.

Thus, there is a clear link between NAFLD and MS. To date, there are no clear criteria for diagnosis and treatment of NAFLD. Computer tomography is considered as the only non-invasive method of research, which allows reliable diagnosis of NAFLD. The problem of persistent steatosis is not well understood, but it might be appropriate to discuss the distinction in the classification of chronic pancreatitis of a separate component - non-alcoholic pancreatic steatosis / steatopancreatitis associated with obesity / MS and actively engaging in the development of clear algorithms for its diagnosis and treatment.

SYNDROME OF SINUSOIDAL OBSTRUCTION

Onuchukwu Ch., Vizir M.

Syndrome of sinusoidal obstruction, formerly called veno-occlusive disease, is characterized by obstruction of sinusoids not associated with thrombosis, which can spread to the central veins. The disease is also known as the "radicular" form of the Budd-Chiari syndrome or Stewart-Brass syndrome.

Vein-occlusive disease differs from the Budd-Chiari syndrome in that, at the last, obstruction develops in larger branches of the hepatic veins, i.e. the general venous blood flow is disrupted. In recent years, the designation of the disease as a syndrome of sinusoidal obstruction is recommended, since the basis is damage to the sinusoids, and the damage to the central veins is not necessary for the diagnosis. Indeed, 45% of patients with mild or moderate form and 25% with severe form of sinusoid obstruction syndrome at autopsy have no occlusion of the hepatic venules.

Toxic substances - pyrrolizidine alkaloids cause direct damage to the sinusoids, followed by their obstruction. Pyrrolizidine alkaloids are contained in *Heliotropium lasiocarpum*, *Grotalaria*, *Senecio*, *Cynoglossum*. The use of these plants, together with cereals or in medicinal teas, leads to the development of vein-occlusive disease. Other possible causes: alcoholic hepatitis, cytotoxic drugs,

immunosuppressants, radiation therapy at a dose of more than 30 g, oral contraceptives, bone marrow transplantation.

The clinical picture is similar to the chronic form of the Budd-Chiari syndrome. About 10% of patients have a long asymptomatic course of the disease. There is pain in the epigastric region and right hypochondrium, more often dull, less paroxysmal. Strengthening the pain is facilitated by physical work, walking, riding. Simultaneously, nausea, vomiting of food with an admixture of mucus, in some cases, there is a bloody vomiting. The history of dyspepsia after eating bitter bread is important for diagnosis. Body temperature is often elevated to subfebrile and febrile digits. There is a sharp weakness, the patient is losing weight. The main symptom of vein-occlusive disease is hepatomegaly with impaired hepatic function. Ascites with this disease is a very frequent sign, but not mandatory. Appears icteric sclera, sometimes jaundice. The patient can die with the phenomena of hepatic-cell insufficiency, possibly the formation of liver cirrhosis with postsinusoidal portal hypertension.

COMPLIANCE WITH HEMOTRANSFUSION

Panchenko G.Yu., Klimenko M.I., Zaychenko O.E., Frolova-Romanyuk Y.Y., Prosolenko K.O.

Blood transfusion is a serious interference with the vital processes of the body. Sometimes it can cause unwanted severe reactions and complications. Many of them are associated with gross violation of the rules of blood transfusion.

Many schemes and classifications of reactions and complications connected with blood transfusion are offered. According to the classification, all the complications can be divided into 3 main groups:

1) the complication of a mechanical nature; 2) complication of reactive nature; 3) complications associated with the donor's blood contamination.

Complications of a mechanical nature are mainly related to the violation of instructions for harvesting or blood transfusion, errors in the technique. It is a sharp expansion of the heart, air embolism, thromboembolism and thrombosis. During the transfusion of large amounts of canned blood in the elderly with heart disease, there may be a sharp increase in the heart. It is characterized by the fact that during the procedure or at the end of the blood transfusion in the patient there is difficulty breathing, a feeling of compression in the chest, pain in the area of the heart, arrhythmia, tachycardia, there is a decrease in blood pressure. May stop the heart during diastole period. In order to prevent this complication, it is better to transfer red blood cells to patients with risk factors. For signs of overloading of blood circulation it is necessary to stop the transfusion, to carry out bloodletting 200-300 ml, to introduce drugs that tone the heart muscle (calcium chloride, cortiamine, glucose with insulin and vitamins). In case of bradycardia, a solution of atropine sulfate is recommended. If the patient stopped the heart, then conduct general reanimation measures to remove it from the state of clinical death.

The life-threatening complication is air embolism, that is, air entrainment during blood transfusion in the bloodstream. The air that enters the vein moves in

the direction of the right half of the heart, from there - into the pulmonary artery and its branches, clogging them. In this case, there is a sudden lack of consciousness, cyanosis, respiratory arrest (apnea) and heart (syncope). The face becomes pale and cyanogenic, pulse is accelerated and weakened, blood pressure decreases. The first aid consists in the rapid lowering of the main end of the table or bed, artificial ventilation of the lungs, closed heart massage. In the II-IV intercostal space on the right of the sternum, point the right half of the heart and suck off about 200-250 ml of foam blood. Sometimes haemotransfusion may be complicated by embolism with clots of blood. The thromboembolism of the pulmonary artery or its branches is more common.

This complication can be caused by three reasons: improper blood preservation (blood stabilization), incorrect transfusion technique, and tearing of the blood clot in the vein. Thrombi can be detached in distant thrombophilic veins (often lower extremities) due to increased pressure due to blood transfusion, venous pressure. The closure of one of the major branches of the pulmonary artery or the multiple embolism of small branches is accompanied by collapse, pallor and cyanosis of the face, cold, sticky sweat. Appear over-difficult breathing, pain behind the udder and coughing (first dry, and later with the release of bloody sputum). After a while the body temperature rises and the pulmonary heart disease clinic develops.

In case of this complication, it is necessary to immediately stop blood transfusion, introduce analgesic, antispasmodic, cardiac drugs. For the prevention of pneumonia and abscesses of the lungs appoint anticoagulants and sulfanilamide preparations.

SOCIAL-HUMANITIES DISCIPLINES

EDUCATIONAL PROCESS OF KNOWLEDGE

Panchenko G.Yu., Klimenko M.I., Zaychenko O.E., Frolova-Romanyuk Y.Y., Prosolenko K.O.

Reform in the healthcare system creates new requirements in the system of medical education and the formation of specialists of a new type who must have a thorough knowledge of the specialty, have the skills of communication, business communication, be able to adapt to new changes, to understand insurance, economics and jurisprudence. These requirements for a future doctor make up the humanitarian aspect of medical education. Problems of relations with patients and their family members, colleagues, medical law, aspects of the impact of scientific discoveries on human livelihoods, etc., should be reflected in the choice of disciplines studied by medical students in the educational process, and therefore this issue is divided as follows attention .

Professional training in HNMU is carried out on 70 departments, 10 of them departments teach educational-professional programs in humanitarian disciplines. Social-humanitarian training is carried out in the following areas:

Language training (Department of the Ukrainian language, the basics of psychology and pedagogy, Department of Foreign Languages, Department of Latin

Language and Medical Terminology, Chair of Language Preparation for Foreign Citizens);

- public preparation (Department of Philosophy, Department of Social Sciences, Department of Public Health and Healthcare Management);

- moral and ethical and legal training (department of propaedeutics of internal medicine №1, bases of bioethics and biosafety, the Department of Forensic Medicine, medical law of the name of the deputy professor MS Bokarius, department of psychiatry, narcology and medical psychology). It should be noted that these departments are not purely humanitarian, but they are taught very important courses in the social and humanitarian direction.

The needs of language training, not a lot of questions and are necessary in any university, including in medical. In HNMU, language learning is conducted in the Ukrainian language (including professional), Latin, as well as foreign languages. The most important, from our point of view, is the moral, ethical and legal training of a medical student. It is these areas that combine medical and humanitarian disciplines whose knowledge will be essential to the future physician in everyday clinical practice. It is necessary to distinguish three blocks of knowledge: psychology, communicability and legal aspects of activity. The doctor communicates not only with the patient, but also with relatives, colleagues, etc., so important courses in the study of general and age psychology, psychology of interpersonal communication. The second issue is the issue of communicability. During conducting practical classes, in particular in the form of role-playing games, we pay attention to the difficulties of communication in the connection "patient-doctor". After all, it is very important for a doctor-clinician to deal with the problem. It happens that a young doctor faced with this problem can not communicate with the patient, which leads to an incomplete collection of anamnesis and an erroneous diagnosis. Very often the doctor comes to the patients who can not explain the symptoms of the disease, psychologically unstable, elderly people with hearing impairment, and with each of them the doctor should talk about the subject, collect the history of the disease to determine the diagnosis and choice of treatment tactics. Thus, it is only through the combined efforts of the medical and humanitarian departments that the student can be trained in professional communication skills.

Legal training includes a whole range of issues. The study of bioethics allows future physicians to study the rules, patterns and standards of behavior that are mandatory, including in the field of legal regulation of the interaction of doctors and patients. Part of the legal mechanism for regulating medical care is the issue of informed consent for medical intervention. This is where the connection of medical and humanitarian disciplines occurs when knowledge of clinical symptoms and diagnostic methods allows the appointment of the necessary methods of examination, except for informative or even harmful to health, because diagnostic studies may have contraindications and are prescribed by the doctor without the need lead to loss of patient health. And here the legal relations between the sick and the doctor are coming into force. This is another example of cross-cutting clinical and humanitarian disciplines in the learning process.

IN THE CLINICO-PHARMACOLOGICAL ASPECT, THE SIDE EFFECTS OF DRUGS

Panchenko G.Yu., Klimenko M.I., Zaychenko O.E., Frolova-Romanyuk Y.Y., Prosolenko K.O.

In the clinico-pharmacological aspect, the side effects of drugs are divided into 7 groups.

1. Pharmacotoxic reactions are caused by an absolute or relative overdose of medicinal substances and depends primarily on the dose of the medication. Dose - the amount of medicinal substance, expressed in units of mass, volume or biological activity, and the degree of dilution in biological media of the organism or in solvents - concentration. In some cases, changing the dose can cause not only quantitative but also qualitative changes in the pharmacological effect. Since the pharmacological effect is determined by its degree (range of doses), the excess of this measure will necessarily lead to the appearance of another pharmacological effect. For example, phenobarbital has a hypnotic effect in a given dose range, the degree of which (depth and duration of sleep) increases within a defined range with increasing dose. With further increase in dose, a qualitatively new condition arises - anesthesia, its depth in a certain range of doses also increases. Exceeding this range is accompanied by a qualitatively new effect - toxic or fatal. Sometimes a qualitative change even leads to a distortion of the pharmacological effect. So, if in therapeutic doses, caffeine stimulates the central nervous system, then in a large dose, on the contrary, it depresses them.

The pharmacotoxic effects of drugs on the body include ulcerative lesions of the mucous membrane of the digestive system, changes in the number of blood cells, disorders of the parenchymal organs, the cardiovascular system, development of tumors, effects on the auditory nerve, on the fetus, neurogenic and psychogenic reactions (hyperreactivity, paradoxical emotional psychosis, hallucinations, etc.), nonspecific properties of the drug: the effect on the fetus during pregnancy (embryotoxicity, teratogenic effect, fetotoxicity), carcinogenic, mutagenic effect. Especially it should be borne in mind that some drugs may have a negative effect on the development of the fetus (embryotoxic action) and cause birth defects of the organs (teratogenic effect). Re-administration of medicinal substances may be accompanied by a decrease or increase in the reaction of the body to the drug. Reduced body reaction to drugs (hypo-reactivity) is called addiction, manifested by tolerance or tachyphylaxis. Increased body reaction (hyperreactivity) is manifested by allergy, sensitization and idiosyncrasy. When you re-enter the drug, there may be special conditions - drug dependence and cumulation.

Addiction (tolerance, tolerance, tolerance) is a decrease in sensitivity to a drug after it is re-administered, requiring an increase in dose to cause the effect of the same intensity as previously observed with a lower dose. Adoption - partial or complete loss of the therapeutic (therapeutic) effect of prolonged use of drugs without drug dependence, ie development of passion. In the appointment of laxatives of plant origin, which are found in antraglycosides (roots of rhubarb, cortex, senadaksin), in a few weeks, the laxative effect is reduced. Addiction is a general

biological characteristic that can also be observed in microorganisms after the administration of small doses of chemotherapeutic agents. Overcoming addiction can be either an increase (within the permissible limits) of the dose, or a substitution of the drug or interruption for a certain time of its acceptance. Rapid relief of the therapeutic effect after repeated use, which develops for a few minutes to one day, is called tachyphylaxis (Greek tachys - fast, phylaxis - protection). An example of tachyphylaxis may be a reduction in the hypertensive effect of ephedrine: the first administration of the drug is a clear increase in blood pressure; After repeated 2-3 injections made with an interval of 20-30 minutes, there is a significant decrease in vasoconstrictive effect. The phenomenon of tachyphylaxis is characteristic of adrenomimetics (adrenaline, norepinephrine), psychostimulants (phenamine, caffeine), cholinergic substances (atropine, platyphilin), and others.

Significantly, tolerance to medicinal substances develops slowly over several weeks of continuous intake. The property to cause tolerance have sleeping pills (especially derivatives of barbituric acid), tranquilizers, non-narcotic analgesics, antihistamines, laxatives, and others. to substances similar in chemical structure, cross-habituation is possible.

Cumulation. Cumulation (Latin cumulatio - increase, accumulation) can be caused by accumulation in the body of the active substance (material cumulation) or the summation of its effects (functional cumulation).

Material cumulation occurs after re-administration of slow-eliminating drugs. The partial administration leads to faster accumulation and the formation of high concentrations of matter in the blood and tissues, accompanied by an increase in the effect, up to the development of toxic phenomena.

INDICATIONS AND CONTRAINDICATIONS TO HEMOTRANSFUSION

Panchenko G.Yu., Klimenko M.I., Zaychenko O.E., Frolova-Romanyuk Y.Y., Prosolenko K.O.

Absolute indications for blood transfusion: lethal bleeding, shock III, IV stages, clinical death. These indications should be well-founded. Often some clinical signs are not enough for this, but a decrease in systolic pressure below 100 mmHg. after a blood loss indicating a 30% BCC deficiency, is the basis for transfusion. And here it is not necessary to immediately use the whole blood. It is necessary to start with the infusion of crystalline solutions, later transfer to the erythrocytic mass, and then over the course of the day, if necessary, to transfuse whole blood.

According to the relative indications, the patient can do without blood transfusion. It is only one of the components of the treatment complex, but it is not decisive. It is desirable for a patient to pour blood, but if there are contraindications for it, you can refuse it.

Relative indications for blood transfusions are small parenchymal and capillary hemorrhages, shock I, II stages, leukopenia, hypoproteinemia, endogenous and exogenous intoxication, sepsis, acute and chronic purulent processes, inflammatory processes with sluggish flow, slowed regeneration of wounds,

intoxication with poisons that make hemoglobin on carboxyhemoglobin (a tad-gas) and methemoglobin (phenol, aniline), preoperative preparation.

In recent years, relative indications for transfusion of whole blood have been significantly narrowed. Absolute contraindications to hemotransfusion are acute hemorrhage in the brain and thrombosis of its vessels, pulmonary edema.

Relative contraindications to blood transfusions are as follows:

1) pathology of the cardiovascular system (acute septic endocarditis, myocarditis, heart disease, circulatory disorders II and III degree, hypertonic illness II degree, severe atherosclerosis of the vessels of the brain, thromboembolism);

2) lung disease (active and disseminated pulmonary tuberculosis);

3) diseases of the kidneys and the liver, accompanied by a violation of their functions (since a large amount of protein decay products is introduced with a large amount of canned blood, this puts high requirements on the organs that decontaminate them; therefore, relative contraindications to blood transfusions can be amyloidosis of the kidneys, acute glomerulonephritis, nephrosclerosis, acute and chronic hepatitis);

4) acute rheumatism;

5) allergic diseases (bronchial asthma during exacerbation);

6) hemorrhagic vasculitis;

7) CNS disease (concussion, clotting and compression of the brain).

Thus, the approach to blood transfusion in each patient should be individualized with strict consideration of indications and contraindications.

IMPLEMENTATION OF INFORMATION TECHNOLOGIES IN THE EDUCATIONAL PROCESS

Panchenko G.Yu., Klimenko M.I., Zaychenko O.E., Frolova-Romanyuk Y.Y., Prosolenko K.O., Pion T.I.

The processes of informatization of modern society led to the need to reorganize education and ensure a new level of quality of training specialists. And in this respect, from our point of view, the role of a teacher becomes multilevel, requires competence not only in his discipline, but also the ability to use innovative pedagogical technologies for the organization of the educational process. The implementation of the national strategy for building a new health care system in Ukraine requires the modernization of the educational process from medical universities. Before medical institutions the task of training a doctor of a knowledgeable, thinking, possessing modern information technologies, is able to independently extract and apply knowledge in practice. In the Law of Ukraine "On Higher Education" the educational process is characterized as "intellectual, creative activity", which gives the scientific and pedagogical workers the right to choose methods and means of learning. Now the issue of using information and communication technologies (ICTs) in education is widely discussed in special editions.

Priority directions of application of TIC in the training of future physicians are:

- introduction of medical information systems, in particular eHealth, in the practice of health care;
- creation of electronic educational resources (EOR);
- use of multimedia technologies;
- hosting webinars;
- distance learning and others.

Creating a qualitative EA is the first step towards the implementation of ICT in the learning process and gives the teacher the right to choose their creation and use. To EOR can be attributed: an electronic course of lectures; methodical instructions and recommendations; electronic textbook; interactive collection of clinical tasks; virtual laboratory workshop; didactic tests of various intended purposes; creation of own personal site; conducting a pedagogical blog; other types of electronic educational resources. Employees of the department of internal medicine number 1 of the KhNMU actively create educational and methodical publications for students in electronic form. Effective use of EAA involves two factors: the first is accessibility, the second - the student's motivation to work independently. The Researcher of the educational institution can serve as an EOP accessibility tool. Kharkiv National Medical University has its repository, which acts as an electronic archive of the results of pedagogical and scientific activity.

IRRITABLE BOWEL SYNDROME OR MICROSCOPIC COLITIS WHAT IS THE POINT

Pius Anmalugsi, Andrieieva A.

Overview: Microscopic colitis is a focal bowel disease that affects the colon and rectum. The word "Microscopic" puts this disease in a different world when it comes to infectious bowel disease (IBD). It represents completely different symptoms and even evade the diagnostic method of Gold Standard Colonoscopy, which is used in the confirmation of IBD. Preliminarily, to go further, let's determine the irritable bowel syndrome (IBS); which is a functional gastrointestinal disorder, characterized by abdominal pain and changes in the training of the intestines in the absence of specific and unique organic pathology, noting during colonoscopy. IBS and microscopic colitis are similar symptoms, such as abdominal pain, pneumonia, diarrhea, fecal incontinence. A study documented by Crohn's and Colitis Organization UK revealed that microscopic colitis (MIC) was detected in about one in twenty people diagnosed with IBS. This shows that the microscopic colitis should be in the league and pay more attention to the diagnosis. The etiology of MC is unknown, but research suggests that there is no single cause other than a combination of several causes that cause a viral response, which is a completely different etiology of IBS. However, when biopsies are taken from the intestinal membrane and examined under a microscope, one can see changes in the substrate, or lymphocytic colitis, or a variant with collagen colitis, which shows an intense attack consisting of lymphocytes, hence the name of the microscopic colitis. For IBS, a biopsy will

be noted. Therefore, only because there are no visible changes in the lumen of the intestine, this is not overturned by the fact that there is no "microscopic" damage. The correct diagnosis of this disease is necessary in terms of management and treatment. The best treatment methods for microscopic colitis are Entocort (budesonide) or bismuth subsalicylate (Pepto-Bismol). What are even more advanced levels of management than those managed by patients diagnosed with IBS.

Conclusion: In the field of medicine, an effective diagnosis is needed for proper treatment and treatment of diseases, irritable bowel syndrome, smeared microscopic colitis, and an interrupted course of treatment in many patients. It is necessary to conduct a thorough study, when patients come with complaints, reminiscent of microscopic colitis and irritable bowel syndrome.

PROARRHYTHMIC RISK OF ANTIARRHYTHMIC THERAPY

Radzhabov I., Vizir M.

Many modern antiarrhythmic drugs with long-term use have a proarrhythmic side effect. This certainly requires the timely identification of patients prone to the occurrence of proarrhythmias.

According to a number of researches, the clinical risk factors for proarrhythmias are female sex, elderly age, hypokalemia, hypocalcemia, prolongation of QT and QRS intervals, hypothyroidism, pheochromocytoma and many cardiac and noncardiac abnormalities. Among the drug factors the risk can be increased by rapid dose rising, high doses, drug accumulation, interaction with other drugs, including diuretics, other antiarrhythmics, drugs with negative inotropic action.

The main trigger factor for proarrhythmogenesis is the prolongation of the QT-interval, which, on the one hand, has an antiarrhythmic effect, and on the other hand, promotes the development of early post-depolarizations and the occurrence of ventricular rhythm disturbances. Elongation of the QT-interval more than 500 ms is associated with an increased risk of sudden cardiac death. The prolongation of the QT interval and bidirectional ventricular tachycardia are partly dose-dependent and occur mainly at an early stage of therapy.

A key component of the development of the acquired syndrome of elongated QT, which is the result of drugs of various classes, is a nonspecific drug blockade of potassium channels. It should be noted that only a small group of people (less than 10%) is susceptible to prolongation of the QT interval and arrhythmias caused by drug compounds.

Regular ECG analysis was successfully used to detect signs of proarrhythmias in most of trials of antiarrhythmic drugs. In particular, ECG monitoring was systematically used for 1-3 injections of flecainide, propafenone or sotalol, to identify individuals at increased risk of proarrhythmia. Based on these studies, ECG registration is meaningful in all patients before the use of antiarrhythmic drugs and planned during treatment.

COURSE AND PROGNOSIS OF TAKOTSUBO CARDIOMYOPATHY

Samara R., Vizir M.

Stress-induced Takotsubo cardiomyopathy is a nosological form of acquired cardiomyopathy characterized by transient left ventricular dysfunction in response to physical or mental stress, clinically and electrocardiographically reminiscent of acute coronary syndrome, described primarily in postmenopausal women with no signs of ischemic heart disease.

Complications occur in about 20% of patients with Takotsubo cardiomyopathy. These include heart (left ventricular) failure, pericarditis, cardioembolic stroke, rhythm and conduction disorders: sinus bradycardia or tachycardia, sinoatrial block, atrioventricular block, atrial fibrillation (6-7%), ventricular tachycardia or ventricular fibrillation, prolongation of the QT interval and torsades de pointes. Ventricular tachycardia and ventricular fibrillation complicate Takotsubo cardiomyopathy in 9% of cases. The most formidable complications are intracardiac thrombus formation, which occurs, according to some data, in different periods of the disease in 8% of cases, cardiogenic shock, cardiac arrest, pulmonary edema, myocardial thinning and rupture, and sudden death.

Despite the bright clinical and instrumental symptoms of Takotsubo cardiomyopathy, the prognosis for this disease is favorable. According to researches, 95% of patients have complete recovery of transient left ventricular dysfunction within 4-8 weeks, while a third of patients have recovery by the end of the first week of in-patient treatment. The average recovery time is approximately 2-3 weeks. The risk of recurrence is estimated at 2-10%. The mortality from Takotsubo cardiomyopathy is from 1 to 3.2%.

Thus, Takotsubo cardiomyopathy is a rare idiopathic disease classified by modern cardiology within the framework of acquired cardiomyopathy, which is due to hyperkatecholamineemia, a state of "deafness" of a certain part of the myocardium that gives an infarct-like clinical, electrocardiographic and biochemical picture, but unlike acute myocardial infarction that has a favorable prognosis.

STATUS OF MALONIC DIALDEHYDE IN PATIENTS WITH CHRONIC TYPE B GASTRITIS

Sultan Basel, Zhelezniakova N.

Objective: to evaluate the malonic dialdehyde changes in patients with chronic type B gastritis.

Materials and methods: 57 patients with chronic type B gastritis and 20 practically healthy persons were examined. The diagnosis was established when assessing the complex of complaints, data of anamnesis and instrumental methods of research - videoesophagogastroduodenoscopy with targeted biopsy and subsequent histological examination of the biopsy. The presence of *Helicobacter pylori* was determined by H. pylori stool antigen test. The blood content of malonic dialdehyde (MDA) without initiation, as well as with the initiation of NADPH₂ and ascorbate, was evaluated by the method of Yu.A. Vladimirov and O.I. Archakov.

Statistical data has been performed on workstation by means of software “Microsoft Excel” and “Statistica 8.0”.

Results. It was revealed that active inflammation in gastric mucus is accompanied by an increase in the content of malonic dialdehyde: MDA without initiation - $9.1 \pm 0.4 \mu\text{mol/l}$, MDA with initiation of NADPH2 - $11.6 \pm 0.7 \mu\text{mol/l}$. In healthy individuals, the following results were obtained: MDA without initiation $7.00 \pm 0.22 \mu\text{mol/l}$, MDA with initiation of NADPH2 $8.24 \pm 0.23 \mu\text{mol/l}$. The comparative analysis of the examined groups has proved the significant difference ($p < 0,05$) in activity of MDA.

Conclusions. Thus, as a result of studies, it has been found out that active inflammation of gastric mucus in patients with exacerbation of chronic type B gastritis cause the development of abnormalities in lipid peroxidation processes, which manifests by significant increase of its primary products, namely malonic dialdehyde.

SECONDARY PREVENTION OF CORONARY ARTERY DISEASE IN DIABETES MELLITUS

Sytnyk K.O., Hauwa Kaka A

Coronary artery disease (CAD) is the most frequent complication of diabetes mellitus (DM) and the main cause of death in patients with diabetes. Normalization of glycemia prevents the development and progression of microvascular complications of diabetes, it should be sought to achieve normogluccemia in the treatment of patients with type 2 diabetes. In contrast to the relatively weak contribution of intensive glycemic control to reducing the incidence of cardiovascular events in diabetes mellitus, the correction of lipid disorders in patients with diabetes, according to a number of studies, contributes to a significant reduction in macrovascular complications of diabetes mellitus.

The results of the clinical trials convincingly suggest that statin therapy is useful for patients with type 2 diabetes, even if they have no clinical signs of coronary heart disease or high levels of LDL cholesterol. Treatment of patients with diabetes type 2 statins safely and significantly reduces the risk of cardiovascular complications. Statins are recommended for most patients with type 2 diabetes (except for rare cases where the individual risk of cardiovascular complications is rather low). In this case, doses of statins should be greater than in patients without diabetes.

Other important directions of secondary and primary prevention of cardiovascular complications in diabetes are prescriptions of antiplatelet drugs, firstly aspirin. Aspirin should receive all patients with diabetes with a diagnosis of coronary artery disease. As primary prevention, aspirin is indicated for patients with type 2 diabetes with high cardiovascular risk: patients over 40 years of age or with other risk factors. Clopidogrel in patients with diabetes is recommended in addition to aspirin with severe, progressive CAD or asymptomatic aspirin.

Beta-blockers should be used in patients who have suffered myocardial infarction, to reduce mortality. Non-selective β -blockers without vasodilation

activity (propranolol) and typical β 1-selective β -blockers (atenolol, metoprolol) enhance insulin resistance of peripheral tissues and contribute to the development of dyslipidemia, therefore they should be avoided in the treatment of patients with diabetes. Highly selective β -blockers have a lesser degree of negative metabolic effects, and β -blockers with vasodilation activity, such as nebivolol, carvedilol, are able to improve carbohydrate and lipid metabolism and increase tissue sensitivity to insulin. these drugs should be preferred in the treatment of patients with diabetes or MS.

Summing up the above patients with association DM and CAD must receive combination treatment witch include aspirin, statins and carvedilol.

FEATURES OF ANTIHYPERTENSIVE THERAPY IN THE ELDERLY WITH A DISORDER OF GLUCOSE METABOLISM.

Sytnyk K.O., Adeniyi Adelola Glory

Hypertension and diabetes are the traditional risk factors for cardiovascular disease. Almost 75% of patients with hypertension have a disorder of glucose metabolism. Prevalence of glucose intolerants increases with increasing systolic blood pressure and age. Increasing the level of glycosylated hemoglobin increases the risk of mortality and cardiovascular disease. Thus, with an increase in the level of glycosylated hemoglobin by 1%, the risk of death from all causes increases by 24% for men and 28% for women, the risk of cardiovascular disease increases by 21% for both men and women, the risk of developing chronic heart failure is increasing among men by 25%, among women - by 20% (KT Khaw et al., 2004).

It should be accentuated that individuals with established cardiovascular disease (CVD), diabetes, kidney disease are classified as having a significantly increased cardiovascular risk.

European guidelines for the prevention of coronary artery disease in clinical practice will contribute to doubling the number of people taking cardiovascular drugs for primary prevention. Older people have a greater risk of developing metabolic syndrome (MS), which potentially increases the risk of various chronic diseases. In prospective studies, it has been shown that MS increases the risk of type 2 diabetes up to 52%. According to the Framingham Cohort, the presence of MS is a powerful predictor of the first identified diabetes (its contribution is 62% for men and 47% for women). A combination risk factors of MS, not including elevated blood glucose (≥ 5.6 mmol / L), contributes to a fivefold increase risk of type 2 diabetes.

Antihypertensive treatment in patients with hypertension elderly than 60 years contributes to a significant reduction in cardiovascular morbidity and mortality. For many elderly patients, two or more medications are needed for effective blood pressure monitoring. Medicinal treatment should take into account the risk factors, the specificity of lesions of target organs and associated cardiovascular and other diseases that are common in the elderly.

MODERN APPROACHES TO THE TREATMENT OF CHRONIC HEART FAILURE

Sytnyk K.O., Akoto Sesime

According to the recommendations of the European Society of Cardiologists and the European Association for Chronic Heart Failure, chronic heart failure (CHF) is a clinical syndrome in which the patient has the following symptoms: shortness of breath alone or under stress, fatigue, leg swelling, tachycardia, third heart tone, heart sounds, tachypnoe, wheezing in the lungs, pleural urge, swelling of the jugular veins, edema, hepatomegaly; Objective signs of structural disturbances of the heart at rest: Echocardiography - dilatation of the cavities of the heart, decrease LV LV, diastolic dysfunction of LS, increase of the concentration of natriuretic peptide. It is noted that many patients with CHF have both signs of systolic and diastolic dysfunction of myocardium at rest or at loading. Patients with diastolic CHF have symptoms of disease with preserved LV EF (> 45-50%). Preserved systolic function of LV is present in 50% of patients with CHF.

The most frequent etiological factors of CHF are coronary artery disease (CAD), hypertension, cardiomyopathy (the heading also includes myocarditis), the use of a number of drugs, toxins, endocrine diseases, nutritional factors, infiltrative diseases.

It is noted that according to the scheme of diagnosis and classification of CHF, taking into account the serum level of the brain natriuretic peptide, the diagnosis of CHF is only valid if the level of the above peptide exceeds 400 pg / l. Otherwise, it is necessary to use a diagnostic algorithm aimed at finding other diseases that lead to shortness of breath, edema syndrome.

Targets of treatment CHF. It is possible to formulate six obvious goals in the treatment of CHF:

- Prevent the development of symptomatic CHF [for stage I of CHF]
- Elimination of CHF symptoms [for stages IIA-III]
- Slowing the progression of the disease by protecting the heart and other target organs (brain, kidney, vessels) [for stages I-III]
- Improving the quality of life [for stages IIA-III]
- Reduction of hospitalizations (and costs) [for stages I-III]
- Improved prognosis [for stages I-III]

It can be said that any type of CHF treatment used should help achieve, at least two of any of the six primary goals of disease control.

There are six ways to achieve the goals in the treatment of decompensation: Diet; Physical activity; Psychological rehabilitation, organization of medical control, schools for patients with CHF, Medication therapy, Electrophysiological methods of therapy; Surgical, mechanical methods of treatment.

Apparently, treatment with medication, although is a very important. First line treatment include ACE inhibitors, ARA, BAB (ivabradine with non-tolerability of BAB or background of treatment of BAB with heart rate > 70 in min), Antagonists of aldosterone, Diuretics, Glycosides and Ω -3 polyunsaturated fatty acid.

ACETYLSALICYLIC ACID IN THE PREVENTION OF ATHEROTHROMBOSIS

Sytnyk K.O., Faith Kpanaki

In recent years, a large number of studies have been conducted that analyze the causes of mortality; the effectiveness of the use of separate strategies and components of prevention programs in different population groups. On the basis of the results of the research, two main strategies for primary prevention of chronic non-infectious diseases were formed: a "high risk strategy" (screening for the identification of persons with an increased risk of developing cardiovascular diseases (CVD) and / or oncological diseases and the following preventive measures among them) and " population strategy "(impact on risk factors throughout the population). To secondary and tertiary prophylaxis include a set of measures aimed at slowing the progression of diseases already existing in patients and reducing their adverse effects. Particular attention is being paid to solving the problem of high cardiovascular mortality. Thrombosis plays a key role in the development of various cardiovascular complications. In the pathogenesis of abnormalities of blood supply to organs and tissues - coronary artery disease (acute coronary syndrome, myocardial infarction (MI), ischemic cerebral stroke, gangrene of limbs, lameness, occupy an important place in inflammatory and atherosclerotic damages of vessels with intima integrity, slowing blood flow, rheological properties of blood. Recognition of atherothrombosis is the basis of the pathogenesis of most CVD, a new understanding of the role of molecular mechanisms of thrombotic formation in the occurrence of vascular catastrophes have made antibodies flatulent preparations are the basis of treatment for all cardiovascular pathology. According to the data of large multicenter studies, it is precisely anti-aggregates, along with hypolipidemic drugs, that significantly affect the developmental rate and the outcome of acute vascular situations, improve the quality and life expectancy of patients. Although the development of new anti-aggregant drugs, to date the most widely used drug for the prevention of thrombosis remains acetylsalicylic acid (ASA). The high efficiency of ASA and its low cost have made it one of the most popular drugs. The use of ASA as an anti-aggregant is included in the recommendations of most professional associations of cardiologists, neurologists and doctors of other specialties. These recommendations are based on the results of a large number of randomized trials.

HEART RATE AS A RISK FACTOR FOR DEVELOPING CARDIOVASCULAR DISEASE

Sytnyk K.O., Ihechiluru Esther Nzeako

The results of clinical studies have shown that heart rate more than 80-85 beats / minute in rest is directly related to the risk of arterial hypertension and atherosclerosis and is a significant predictor of cardiovascular morbidity and mortality. Several epidemiological studies have shown that these relationships do not depend on other risk factors for the development of atherosclerosis, they are

recorded as those without symptoms and with the presence of such diseases. The results of experimental work and clinical trials suggest that hemodynamic changes associated with an increase in the frequency of heart rate directly affect the arterial wall, accelerating the pace of development of atherosclerotic lesions. Moreover, the heart rate is directly related to the development of cardiovascular events as a result of the development of the latter. In the light of the data presented it seems appropriate to attribute the frequency of heart rate to the number of major risk factors for coronary heart disease.

CROSS SYNDROMES IN RHEUMATOLOGY

Tetei Menhas Emmanuel, Zelena I.I.

The diagnosis of an overlap syndrome is made when the patient has enough clinical and serological signs to diagnose a specific connective tissue disease, but in addition there are also symptoms of another disease. For example, a patient with systemic lupus erythematosus has a rheumatoid factor in the serum and erosive arthritis similar to that of rheumatoid arthritis (a cross syndrome with a combination of signs of systemic lupus erythematosus and rheumatoid arthritis is known as rhupus). Cross-over syndrome develops in more than 25% of patients suffering from a single connective tissue disease. Despite the fact that the symptoms of both diseases can be observed simultaneously, usually the symptoms of one prevail over the symptoms of the other. In most cases, the cross syndrome includes Sjogren's syndrome in combination with rheumatoid arthritis, systemic lupus erythematosus, systemic scleroderma, polymyositis, SZST, primary biliary cirrhosis, autoimmune thyroiditis, chronic active hepatitis, mixed cryoglobulinemia and hypergammaglobulinemic purpura.

The cross-sectional form of SSD with DM / PM (pCSSD - DM / PM), according to the literature, occurs from 10% to 37% of cases. DMCC / DMD is characterized by the presence of ANA (91%), autoAAT to Scl-70 (36%), autoAT to Pm-Scl (80%). AutoAt to Pm-Scl, being in 10-17% of cases associated with other CDST, are a highly sensitive marker for the SSD-PM overlap and are found in most patients with this clinical form.

When combined with a PM / DM combination, it is possible to detect other autoAtAs, such as U5-RNP, less frequently to CA. Anti-synthetase, or auto-toBT to Jo-1 practically do not occur in SSD and its cross-over with myositis. Their presence is usually associated with the so-called. antisynthetase syndrome with severe myositis, interstitial lung fibrosis and arthritis.

The immunogenetic marker SSD-PM, according to various researchers, is HLA-DR3, which is found in 75-100% of patients. With an increase in the rate of progression of the disease, which sometimes occurred years after the onset of a relatively quiet development of the disease, a distinctive cross-over of previously unidentified antibodies was noted in the blood of patients: autoAAT to Pm-Scl with autoAT to DNA, anti-centromeric autoantibodies to Ro / La. Data on the combination of autoAT to Pm-Scl with myositis-specific autoAAT to Jo-1 or Mi-2

autoantibodies is not found in the literature. Immunogenetic analysis reveals DR B1 * 01 antigen in patients with SSD-PM / DM.

The cross-over form of SSA-RA is characterized by the presence of AHA (96%) and autoAT to Scl-70 (28%), ACCP (27%) and RF (72%). If there are severe polyarthritis in the patients with diagnostic signs of RA (multiple erosions, etc.), when there are criteria for both diseases, the question is about the cross-form of SDS-RA. Clinico-radiological similarity is complemented by frequent detection of RF, but more often detected ANA and autoAAT to Scl-70. Autoantibodies to cyclic citrullinated peptide ACCP are a highly specific diagnostic marker of RA, as more than 80% of cases are detected in the sera of RA patients.

RARE SYNDROMES IN CARDIOLOGY

Zelena I.I., Joshva Saveriar

When reading medical literature, especially the publications of past years, there are often eponymous terms - symptoms and syndromes, named after the names of their authors. In our enlightened time, in the era of computed tomography and immunoassay, some of them represent a purely historical interest, others continue to be used in daily medical practice.

In the practical activity of the esculapa of any specialty, "interdisciplinary" polyorganic syndromes, especially genetically determined, are not always so exotic and casuistic, but, as a rule, are very difficult to diagnose.

Erdheim's disease (astringent aneurysm) is characterized by the acute development of a relaxing aneurysm on the background of atheromatosis or cystic medionecrosis. The cystic mediation of the neck is a manifestation of the degeneration of elastic fibers, on the spot where cysts filled with metachromatic staining material appear. Morphological changes in the aorta are the same as in Marfan's syndrome, however, the lung manifestations of this syndrome are not detected. The acute development of aneurysm is provoked by puberty period and pregnancy. The type of inheritance is autosomal dominant, the frequency in the population is 4: 10,000. The morphological picture of the disease is described by Erdheim et al. in 1930

Striker's syndrome is generalized arterial calcification (occlusive infantile arteriopathy, infantile coronary sclerosis). It is characterized by the formation of calcifications in the walls of the vessels, especially in the inner elastic layer. A substance is stacked around the elastic fibers, histochemically stained in the same way as mucopolysaccharides. In the later stages of the disease, the elastic sheath ruptures. In an intimate, occlusive changes develop. Patients usually die in the first 6 months. life due to myocardial infarction. The cases of infarction of other organs (kidneys, intestines, spleen), giving the corresponding clinic are described. The diagnosis is based on the presence of peripheral arterial calcification and ECG changes that are characteristic of coronary artery thrombosis. The disease is inherited by an autosomal recessive type, described by Stryker in 1946.

The Holt-Oramma syndrome (angiodigital dysplasia, "heart and arm syndrome") in the classical form is characterized by a defect of the peritoneal septum

and an abnormality in the development of thumb fingers. The anomaly of the thumbs is that they are arranged in the same plane with other fingers. The defect of the interstitial septum causes a specific interatrial arrhythmia: on the ECG, the elongation of the P-P interval, sinus bradycardia with a tendency toward the sinoatrial block and the atrioventricular nodal rhythm. In rare cases, atrial fibrillation is observed. The heart failure may also be a defect in the interventricular septum, anomalies of large vessels. Sometimes other bone deformities are observed. The syndrome is inherited autosomally-dominant, described by Holt and Oramm in 1960.

QUALITY OF LIFE OF PATIENTS WITH ISCHEMIC HEART DISEASE Zelena I.I., Allade Oluvatosin

Ischemic heart disease (IHD) is a chronic disease that contributes to the life and survival of the patient by changing his condition, emotional perception. The emergence of myocardial infarction, its complications, the need for intervention or cardiac surgery leads to changes in the entire future patient.

Aim: to explore the cognitive component of the inner picture health (IPH) in patients with various forms of coronary artery disease - 60 patients with stable ischemic heart disease, which has been aortic coronary bypass surgery and 57 patients who performed stenting of coronary arteries in planned order, as well as patients with acute coronary syndrome (ACS) who received invasive treatment tactics, of which 75 patients with ACS without segment elevation and 78 patients with ST segment elevation. In all patients applied the SAQ and SF 36 questionnaires.

Materials and methods. We analyzed IPH in 60 patients with stable ischemic heart disease, which has been aortic coronary bypass grafting and 57 patients with coronary artery stenting in the planned order, 75 patients with ACS without elevation of the segment. 78 patients with STS with elevation of segment ST, which is provided with invasive treatment tactics. In all patients applied SAQ and SF questionnaires.

The cognitive component provides awareness of complexity disease, health prospects. The attachment to treatment is an integral part of the cognitive component of the IPH patient.

Results: The data obtained show that the majority of patients 77.8 ± 14.6 on the SAQ questionnaire satisfied with in-patient treatment hospital department. According to the scale of the attitude to the disease, we obtained the indicators in the majority of patients are 46.3 ± 17.8 , that is, they are understated. Patients need knowledge of the disease, which will contribute more the informed attitude of the patient to his condition and lead to more active participation in the process of rehabilitation. General state of health patients for on the scale of SF-36 note an average of (42.6 ± 14.3) , which is lower the average, this indicates a low rating for patients with their condition health now and the negative characteristics of the prospects for treatment.

Conclusion. For successful rehabilitation of patients with coronary heart disease is important build strategies for optimizing health, increasing each of them

component of the HQ. When working requires a comprehensive approach the doctor can. Provide information on the disease, including CHD, ACS and psychologist to control the acceptance and awareness of the information received its integration into the internal picture of health.

DIAGNOSTIC WORTH OF DETERMINATION OF C-REACTIVE WHITE IS IN SPUTUM, AS A MARKER OF LOCAL INFLAMMATORY PROCESS

Zelena I.I., Ogonii Modji

Increasing the level of C-reactive protein (CRP) is universal a sign of ignition regardless of localization and other characteristics inflammatory process, which allows to call it the main marker systemic inflammation in the body. Detected rather pronounced the relationship between inflammation of the respiratory system and systemic inflammatory manifestations. Given the general biological function of CRP, it is necessary to consider the regular detection of this protein directly in "Hearths of defeat". The purpose of the study: to assess the diagnostic value of the level determination CRP in serum and sputum in patients with asthma. Materials and methods: all patients had a general- clinical examination, computer spirometry. Serum and serum CRP level sputum was determined by a semi-quantitative latex agglutination method.

Results: 64 patients with BA II-III severity were examined. In of patients with asthma had a significant increase in serum blood pressure in comparable to healthy people. Results of determination of CRP in the sputum showed it increased by 4.6 times ($p < 0,05$). Also found that the sputum level of CRP was significantly higher than in serum ($p < 0,05$). In a correlation analysis between the level of CRP in the sputum and FEV1 in patients with asthma, a strong reciprocal relationship was found ($r = -0.82, p < 0.01$).

Conclusion: increasing the level of CRP is a universal sign inflammation, and a significant increase in its level in the sputum confirms its diagnostic value as a marker of the activity of the inflammatory process in bronchial tree.

АЛЬБІНІЗМ: ФОКУС НА УРАЖЕННЯ ОРГАНУ ЗОРУ

Атрощенко К.В., Лапшина К. А.

Альбінізм - рідкісна генетична патологія, при якій повністю або частково відсутній меланін - пігмент, який знаходиться в шкірі, волоссі, райдужній оболонці ока і забарвлює їх в певний відтінок. Спадкування його гетерогенне, частіше аутосомно-рецесивне. В офтальмології альбінізм прийнято розділяти на очно-шкірний і очний, повний і неповний.

Для повного очно-шкірного альбінізму, обумовленого абсолютною відсутністю пігменту, характерні блідість і нездатність шкіри до засмаги, білий колір волосся, світло-блакитний колір райдужки, повністю просвічує при транслюмінації, альбінітична картина очного дна (на білому тлі просвічує склери проглядаються хоріоїдальні судини), гіпоплазія жовтої

плями, невиразність центральної ямки сітківки, світлобоязнь, зниження гостроти зору до 0,2-0,1 і менше. Як правило, відзначаються маятникоподібний ністагм, нерідко аметропії, досить часто (до 70%) сходяться або розходяться косоокість, дальтонізм. Характерні кон'юнктивіти, іноді розвиток катаракти, ретиніт.

При неповному очно-шкірному альбінізмі всі вищенаведені симптоми виражені значно слабше, ніж при повному. При цьому має місце не ахромії, а лише гіпохромія шкіри, волосся і очного дна. Гострота зору у таких хворих не нижче 0,2-0,3. Світлобоязнь і ністагм з віком слабшають.

Очний альбінізм, як неповний, так і повний, зустрічається вкрай рідко, проявляється гіпо- та депігментацією райдужки і очного дна при відсутності дефектів пігментації шкіри і волосся, світлобоязню, ністагмом, зниження зору.

Для альбінізма характерна те чи інше вираження порушення бінокулярного зору. Альбіноси не здатні до сприйняття глибини при дослідженні з стереограми. Зорові порушення при альбінізмі пов'язують з порушенням нормального меланогенезу в пігментному епітелії сітківки в області жовтої плями, який починається на 5-ий день і закінчується в кінці внутрішньоутробного розвитку. Після народження пігмент в хроматофорах райдужки кумулюється протягом декількох місяців, від чого і залежить зміна кольору очей немовлят. Основу зорових порушень становлять гіпоплазія макули, а також порушення нормального співвідношення перехрещених і неперехрещених волокон в зоровій хіазмі.

У практиці офтальмолога альбінізм доводиться диференціювати з рядом спадкових або набутих захворювань, при яких очні альбінітичні прояви є одним із симптомів, наприклад, синдрому Херманського-Пудлака, Чедіака-Хигаси, Клейна-Варденбург.

Синдром Хеанського-Пудлака характеризується поєднанням альбінізму з геморагічним діатезом, який успадковується по аутосомно-рецесивним типом. Своєчасне виявлення даної патології може запобігти летальному результату внаслідок кровотечі.

Для синдрому Чедіака-Хигаси характерне поєднання альбінізму, альбінітичних офтальмологічних знаків (зниження гостроти зору, світлобоязнь, ністагмом) з аномаліями лейкоцитів (гігантська зернистість), схильністю до рецидивуючих гнійним інфекцій, із загальним гіпергідрозом, гепато- і спленомегалією. Можуть спостерігатися набряк зорового нерва, зменшення слезовиділення, іноді катаракта і помутніння рогівки.

Синдром Клейна-Варденбург включає комплекс спадкових аномалій: вроджену глухоту, Брахіцефалія, часткову гіпохромію (окремі пасма сивого волосся, обмежені ділянки депігментації шкіри, гетерохромія райдужки). Відзначається також посивіння медіальної частини брів, блефарофімоз, гіпоплазія орбіт, потовщення хрящів століття, гіперметропія.

Офтальмологічна допомога при альбінізмі спрямована на підвищення гостроти зору, зменшення світлобоязні, ністагму і виправлення косоокості. Велике значення надається точної і повної постійної корекції, при якій не тільки підвищується гострота зору, але і дещо зменшується ністагм. З метою

корекції аметропії застосовуються окуляри або коригуючі контактні лінзи з імітованими в них радужкою і зіницею, є повідомлення про ефективність призначення альбіноса додаткової корекції для поблизу, телескопічних очок. Зменшенню світлобоязні сприяють окуляри-світлофільтри. Хірургічне лікування косоокості має косметичну мету, його необов'язково проводити в ранньому віці, хоча є спостереження істотного зменшення ністагму після операції виправлення косоокості у альбіносів.

ЦЕЛИАКИЯ: НЕОБХОДИМОСТЬ СКРИНИНГА

Бегмурадова Л., Лапшина К.А.

Целиакия - это мультисистемное аутоиммунное расстройство у генетически предрасположенных лиц, вызванное непереносимостью глютена. Глютен представляет собой белковый комплекс, содержащийся в пшенице, ржи и ячмене. У лиц с целиакией его употребление вызывает иммунологическое опосредованное воспалительное повреждение слизистой оболочки тонкого кишечника и последующее нарушение абсорбции питательных веществ. Целиакия может проявляться как желудочно-кишечными, так и негастроинтестинальными симптомами.

Задача оценки распространенности целиакии заключается в том, что в ряде исследований диагноз основывался на серологическом тестировании без гистологического подтверждения, потенциально переоценивая распространенность целиакии из-за ложноположительных серологических тестов. Целиакия вызвана иммунным ответом на глютен у генетически восприимчивых лиц. В частности, люди с аллелями, которые кодируют белки HLA-DQ2 и DQ8, подвержены высокому риску заболевания.

Рекомендации по клинической практике рекомендуют алгоритмический подход к диагностическому тестированию целиакии, начиная с теста tTG IgA и дальнейшего тестирования на основе вероятности заболевания. Рекомендации по клинической практике в США и Европе рекомендуют биопсию кишечника для подтверждения диагноза целиакии и для выявления целиакии от других заболеваний, поражающих тонкий кишечник.

Наличие заболевания характеризуется постоянными симптомами мальабсорбции, несмотря на приверженность безглютеновой диете в течение 6-12 месяцев. Такие пациенты могут получать лечение кортикостероидами и другими иммунодепрессантами, такими как азатиоприн, 6-меркаптопурин или циклоспорин.

Как обсуждалось ранее, клиническое улучшение на основании придерживания безглютеновой диеты не является диагностикой целиакии, так как описано много других форм реакции на глютен. Симптоматическое улучшение также может быть вызвано эффектом плацебо или другими здоровыми изменениями, которые происходят в сочетании с модифицированной диетой.

THE ROLE OF STATIN THERAPY IN PATIENTS WITH ARTERIAL HYPERTENSION AND ISCHEMIC HEART DISEASE

Джасміт Каур, Зайченко О.Є., Панченко Г.Ю.

The combination of arterial hypertension (AH) and ischemic heart disease (CHD) in its prevalence and risk of complications is the most significant social problem. These diseases often accompany each other, and this can be attributed to the fact that the levels of systolic (diastolic) and diastolic (DBP) blood pressure (BP), as well as the risk of developing coronary artery disease, are in a direct linear relationship. The situation can be improved by improving the functional state of the endothelium. The anti-inflammatory properties of statins and their beneficial effect on endothelial function are of great importance in the therapy of both hypertension and ischemic heart disease.

Objective: to develop effective approaches to correcting the state of the endothelium with the use of antihypertensive drugs together with statins in hypertensive disease in combination with coronary artery disease.

Material and methods. 50 patients with essential hypertension I-II st. in combination with stable angina II functional class, among which there were 36 men (73%) and 14 women (27%), the patients were divided into 2 groups: 1 group (24 patients) received standard antihypertensive therapy (bisoprolol 10 mg / day and ramipril 10 mg / day), 2-group (26 patients) - in addition to standard therapy, rosuvastatin was received at a dose of 20 mg / day. The lipid spectrum of the blood, endothelin-1 level, NO₂ and NO₃ level were determined.

Results. After 3 months of rosuvastatin therapy, total CH and LDL cholesterol decreased by 18% ($p < 0.05$) and 16% ($p < 0.05$), respectively. After 12 weeks of statin therapy, target levels of LDL cholesterol were achieved in 22 patients (83.3%). The development of lipid-lowering effect was accompanied by the subsequent normalization of the functional state of the endothelium, as evidenced by a significant and more pronounced increase in the levels of NO₂ and NO₃. The appointment of rosuvastatin contributed to the potentiation of the antihypertensive effect of standard therapy, as evidenced by the tendency to a more significant decrease in blood pressure in group II of patients. The appointment of standard anti-hypertensive therapy for lipid-lowering rosuvastatin, allowed to improve the state of the endothelium after 2 weeks of treatment. This was manifested in a decrease in the manifestations of oxidative stress and imbalance between endothelial vasoconstrictors and vasodilators.

ОГРАНИЧЕНИЯ ОСНОВНЫХ МОДЕЛЕЙ ОЦЕНКИ СЕРДЕЧНО-СОСУДИСТОГО РИСКА

Еременко А., Визир М.

Благодаря достижениям в диагностике и лечении сердечно-сосудистых заболеваний (ССЗ) и увеличению продолжительности жизни, все больше людей переживают первые события ССЗ, а модели вторичной профилактики используются все чаще. Международное медицинское сотрудничество, рассмотрев 16 моделей

прогнозування ризику ССЗ, з метою оцінки 20-місячного ризику визначило найбільш важливими факторами вік, чоловічий пол, поточне куріння, діабет, індекс маси тіла, кількість вовлечених судинистих клубов, події ССЗ в період попереднього року, анамнез серцевої недостатності, фібриляції передсердь, відсутність прийому статинів і антиагрегантів. Лідером досліджень в цій області залишається американське дослідження Framingham. В даний час існують і використовуються такі моделі оцінки ризику, як Framingham, SCORE, ASSIGN SCORE, QRISK 2, PROCAM, WHO/ISH, Reynolds, INTERHEART. Передбачуваність більш високого ризику спостерігалася у жінок порівняно з чоловіками в багатьох моделях.

Дані моделі були адаптовані для використання по всьому світу, але було визнано, що існують обмеження в різних популяціях:

- Обмеження кількості факторів, зібраних в когортних дослідженнях для включення в розробку моделі ризику. Додаткові фактори, такі як соціальний статус, оточення і етнічна належність, як було встановлено, також впливають на ризик.

- Фактори образу життя, такі як харчові звички, фізична активність і частота куріння, можуть суттєво відрізнятися між суспільствами і в більшій ступені між країнами; таким чином, їх вплив на ризик може бути не точно відображено в різних популяціях.

- В глобальному масштабі показники серцево-судинних катастроф суттєво відрізняються між популяціями.

- В період десятиліть спостерігалися тимчасові зміни в співвідношенні поширеності факторів ризику і частоти ССЗ.

- Було виявлено багато нових біомаркерів, пов'язаних з ССЗ, які на даний момент не включені в вихідні моделі.

СТРЕС-ІНДУКОВАНА КАРДІОМІОПАТІЯ: РІДКІСНИЙ СИНДРОМ В КАРДІОЛОГІЇ

Захаренкова А.В., Лапшина К.А.

Стрес-індукована кардіоміопатія, представляє собою транзиторну дисфункцію лівого шлуночка, імітуючу гострий коронарний синдром з елевацією сегмента ST без ураження коронарних артерій і виникає на тлі гострого емоційного або фізичного стресу.

Вперше кардіоміопатія була визначена в 1990 році японським дослідником Х. Сатохом. Назва виявленого явища визначило форму розширення серця, а в 1977 році К. Курамото описав аналогічне стан, який розвинувся після гемтонаффузії. В останнє десятиліття минулого століття подібні випадки були описані декількома японськими авторами. Максимальне число спостережень, включило 88 пацієнтів, що описано дослідником К. Цусикаши. В європейській популяції симптоми такоцубо-подібної дисфункції лівого шлуночка описані вперше в 2003 році.

Провокуючими факторами є серйозні емоційні або фізичні навантаження, а також інші причини гіперсимпатікотонії - підвищення внутрішньочерепного тиску - масивні ішемічні інсульти, геморагічні інсульти, прийом симпатоміметиків.

В патогенезі захворювання виділяють чотири теорії: 1) локальний спазм; 2) багатососудісний спазм; 3) участь катехоламинів (підвищення рівня їх у крові, підвищена чутливість рецепторів); 4) обструкція виносного тракту ЛЖ.

Основними критеріями КМП є:

- "ішемічні" зміни на ЕКГ;

- незначні зміни коронарних артерій або відсутність тромбозу на ангиографії;

- дилатація апікальних або середніх сегментів лівого шлуночка з компенсаторним гіперкінезом базальних сегментів при ехокардіографії;

- непропорційально низькі рівні серцевих біомаркерів у порівнянні із ступенем дисфункції лівого шлуночка;

- швидке покращення функції лівого шлуночка.

Типові зміни на ЕКГ включають: елевацію ST в прекардіальних відведеннях при комп'ютерній томографії більш виражена в II, V3-V5; елевація або відсутність депресії ST в нижніх відведеннях, часто деперсія ST в aVR.

Специфічне лікування не розроблено, але в гострому періоді захворювання показано застосування транквілізаторів, якщо розвиток синдрому спровокував емоційний стрес. Назначаються інгібітори АПФ, бета-адреноблокатори, антикоагулянти, діуретики, антагоністи кальцію. На фоні підтримуючої терапії завжди відбувається різке видужання протягом 2 місяців. В 5% випадків виникає рецидив захворювання, ймовірно, викликаний асоційованим пусковим механізмом.

ВЛИЯНИЕ ЛОСАРТАНА И КАНДЕСАРТАНА НА ПОКАЗАТЕЛИ АДИПОНЕКТИНА И ЛЕПТИНА У БОЛЬНЫХ С ИЗБЫТОЧНЫМ ВЕСОМ, ГИПЕРТОНИЧЕСКОЙ БОЛЕЗНЬЮ И НАРУШЕНИЕМ ТОЛЕРАНТНОСТИ К ГЛЮКОЗЕ

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Цель исследования: исследовать влияние 6-ти месячной терапии лосартаном в сравнении с кандесартаном на секрецию адипонектина и лептина, и на метаболический профиль пациентов с гипертонической болезнью, ожирением и нарушением толерантности к углеводам.

Материалы и методы. В исследование включено 44 человека (18 мужчин и 26 женщин) в возрасте 36-70 лет (средний возраст которых составил 56 ± 2 года). Всем пациентам проводили оценку клинической и гипотензивной эффективности терапии, сомато- и антропометрию (ИМТ). Исследовали основные параметры жирового и углеводного обмена (липидограмма, гликозилированный гемоглобин (HbA1c), глюкоза, иммунореактивный инсулин), также показатели секреторной активности жировой ткани (лептин,

адипонектин), а также исследование соскудов глазного дна . Все пациенты были рандомизированы на 2 группы: больные 1-й группы (n = 18) получали лосартан (50 мг утром 1 раз в сутки,), 2 группы (n = 26) - кандесартан (16 мг утром 1 раз в день).

Результаты и их обсуждение. В течение всего периода наблюдения клиническая эффективность и уровень снижения систолического и диастолического давления в обеих группах пациентов не имели клинически-значимых отличий. Оба режима лечения были связаны со снижением общего холестерина и ХС ЛПНП по сравнению с базовыми показателями. 6-ти месячная терапия с использованием лосартана (60%, $p < 0,01$), и, в меньшей степени, кандесартана приводила к увеличению секреции адипонектина. При этом содержание лептина повышалось при применении лосартана ($p < 0,05$) и снижалось при применении кандесартана. Наряду с этим необходимо отметить у пациентов из 1-й группы наблюдалось снижение уровня глюкозы ($P < 0,05$), и гликозилированной гемоглобина ($p < 0,05$), натошак. На глазном дне отмечалось уменьшение извитости сосудов,

Заключение. Результаты исследования показали, что лосартан, как частичный агонист рецепторов PPAR- γ , и, в меньшей степени, кандесартан, улучшают метаболический профиль и повышают секрецию адипонектина у пациентов с гипертонической болезнью, ожирением и нарушением толерантности к углеводам. Лосартан показан больным с нарушением толерантности к углеводам и повышением уровня глюкозы, так как, он в большей степени способствовал снижению уровня глюкозы в сыворотке крови и уменьшал проявления ретинопатии.

ВЗАЄМОЗВ'ЯЗОК ПОРУШЕНЬ ЛІПІДНОГО ОБМІНУ ТА ГІПЕРУРИКЕМІЇ З АНТРОПОМЕТРИЧНИМИ ПОКАЗНИКАМИ У ХВОРИХ НА МЕТАБОЛІЧНИЙ СИНДРОМ

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Мета: оцінити взаємозв'язок порушень ліпідного обміну та гіперурикемії з антропометричними показниками і чинниками ризику розвитку серцево-судинних захворювань у пацієнтів з метаболічним синдромом (МС).

Матеріали і методи: У дослідження були включені 60 хворих (24 жінки і 26 чоловіків) на метаболічний синдром, дисліпідемію, гіпертонічну хворобу та ожиріння з високим кардіоваскулярним ризиком, середній вік яких складав $45,7 \pm 1,4$ року. Для верифікації діагнозу МС використовували критерії Міжнародної діабетичної асоціації (2005 р.). Індекс маси тіла (ІМТ) складав від 24 до 41 (середнє значення $37,6 \pm 3,3$ кг/м²), у 14 пацієнтів була діагностована гіпертонічна хвороба I ст., у 36 - II ст., окрім цього у 28 пацієнтів була діагностована гіперурикемія понад 420 ммоль/л. Контрольну групу склали 20 практично здорових добровольців. Усім пацієнтам визначали

антропометричні параметри (окружність талії та стегон, індекс відношення талії до стегон), проводили добове моніторування АТ, визначали рівень сечової кислоти в сироватці крові, вміст глюкози натщесерце, іммуноферментним методом оцінювали ліпідний спектр крові. При аналізі статистичних даних використовували пакет Statistica 6,0 і непараметричний кореляційний аналіз Спірмена.

Результати та їх обговорення: Аналізуючи чинники ризику розвитку ГХ та дісліпідемії у хворих на МС, слід зазначити, що найчастіше зустрічається ожиріння у 60 хворих (100%), з них I ст. - у 15 пацієнтів (25%), II ст. - у 40 (66,6%), III ст. - у 5 хворих (8,3%); спадковість відносно серцево-судинних захворювань (наявність ГХ у одного або обох батьків) зареєстрована у 28 хворих (46,6%).

Статистично значимий взаємозв'язок був виявлений між віком, тривалістю гіпертонічної хвороби, індексом маси тіла (ІМТ), окружність талії (ОТ), змістом глюкози натщесерце і рівнем сечової кислоти. Ми виявили, що гіперурикемія, підвищення ІМТ та ОТ супроводжується підвищенням середньодобових значень артеріального тиску (СДАТ) систолічного та пульсового АТ (ПАТ). В результаті проведеного кореляційного аналізу, доведено, що рівень сечової кислоти щільно взаємозв'язаний з параметрами абдомінального ожиріння у хворих на МС, що підтверджується статистично значущими позитивними кореляційними залежностями з ОТ ($r=0,69$; $p=0,001$), ІТС ($r=0,58$; $p=0,001$), ІМТ ($r=0,62$; $p=0,001$), а також для СДАТ ($r=0,498$; $p=0,012$) і ПАТ ($r=0,59$; $p=0,001$). При цьому у хворих з МС і гіперурикемією було виявлено достовірне збільшення високих значень ЗХС ($p=0,046$) і ХС ЛПНЩ ($p=0,032$), що супроводжувалися тенденцією до зниження змісту ХС ЛПВЩ.

Висновки: Гіперурикемія у хворих на МС асоціюється з більш вираженим абдомінальним ожирінням, високим рівнем СДАТ та ПАТ, а також з вираженим порушенням ліпідного обміну, що свідчить про високу значимість даного показника при оцінці змін метаболічних параметрів у даної категорії хворих.

ВЗАЄМОЗВ'ЯЗОК АНТРОПОМЕТРИЧНИХ ПОКАЗНИКІВ І МЕТАБОЛІЧНИХ ПОРУШЕНЬ У ХВОРИХ НА АБДОМІНАЛЬНУ ФОРМУ ОЖИРІННЯ І СУБКЛІНІЧНИМ ПЕРЕБІГОМ ГІПОТИРЕОЗУ

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Мета роботи: визначення взаємозв'язку антропометричних показників і вираженості метаболічних порушень у пацієнтів з абдомінальним ожирінням і супутніми субклінічним гіпотиреозом, викликаним вживанням пероральних контрацептивів.

Матеріали і методи: Проведено дослідження - 52 осіб, з яких 23 пацієнтки з абдомінальним ожирінням і субклінічним гіпотиреозом і 29 пацієнток з абдомінальним ожирінням. Групи біли ідентичними за віком і

статтю. Антропометричні дослідження включали вимір росту, маси тіла, розмірів талії (РТ) і стегон (РС), розраховувався індекс маси тіла по Кетле (ІМТ). Поряд з цим проводилося дослідження біохімічних показників крові. Визначалися рівні ліпідів крові: загальний холестерин (ХС), тригліцериди (ТГ), холестерин ліпопротеїдів низької щільності (ХС ЛПНЩ) і холестерин ліпопротеїдів високої щільності (ХС ЛПВЩ), глюкоза крові, інсулін, розраховувався індекс інсулінорезистентності НОМА, проводилося дослідження ТТГ і Т4 з метою верифікації субклінічного гіпотиреозу. Критеріями абдомінального ожиріння (АТ) відповідно до критеріїв АТР ІІІ (Adult Treatment Panel ІІІ) служили розмір талії ≥ 102 см для чоловіків і ≥ 88 см для жінок. Для оцінки статистичної взаємозв'язку між показниками застосовувався кореляційний аналіз Спірмана.

Результати: Аналіз показників в групах досліджуваних параметрів показав, що статистично достовірні відмінності ($p < 0,05$) були виявлені у хворих по рівню інсуліну і індексу НОМА. Кореляційний аналіз показників визначив взаємозв'язок між масою тіла і глюкозою ($r = -0,187$, $p = 0,02$) і Т4 ($r = 0,215$, $p = 0,0415$), так само виявлено взаємозв'язок між ІМТ і інсуліном ($r = -0,209$, $p = 0,032$) і Т4 ($r = 0,215$, $p = 0,014$). При цьому в групі порівняння значущих корелятивних взаємодій не виявлено.

Висновки: у пацієнтів з абдомінальним ожирінням і супутніми субклінічними проявами гіпотиреозу головним виявленим порушенням була патологія вуглеводного обміну обумовленим, за нашими припущеннями, впливом гормону Т4. Виявлені достовірні зміни маси тіла у цих хворих були зумовлені затримкою рідини, що є характерним проявом для клініки субклінічного гіпотиреозу. Жінкам перед початком вживання пероральних контрацептивів обов'язково необхідне визначення рівня Т4 в сироватці крові з подальшим контролем.

НЕКОТОРЫЕ ПОКАЗАТЕЛИ ВОСПАЛИТЕЛЬНОГО СИНДРОМА У ПАЦИЕНТОВ ГИПЕРТОНИЧЕСКОЙ БОЛЕЗНЬЮ, ИБС И ИЗБЫТОЧНЫМ ВЕСОМ

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С-реактивный белок (СРБ) в практической медицине используется для диагностики, главным образом, воспалительных заболеваний органов человека и применяется в клинической практике в качестве основного, хотя и достаточно неспецифичного, маркера воспаления. Имеются многочисленные доказательства того, что СРБ является сильным независимым маркером воспаления в кардиологии. Его повышение отмечается при многочисленных сердечно-сосудистых заболеваниях, особенно при инфаркте миокарда, ишемическом инсульте, заболеваниях периферических сосудов, воспалительных заболеваниях миокарда и даже внезапной сердечной смерти в отсутствии известных сердечно-сосудистых заболеваний.

Цель работы: исследование показателей воспалительного синдрома у пациентов с коморбидным течением гипертонической болезни (ГБ), ожирением и ИБС.

Материалы и методы: обследовано 48 пациентов с ГБ, ИБС и ожирением, которые были разделены на 2 группы: 1-я – пациенты с повышенным уровнем СРБ (n=28); 2-я – пациенты с нормальным уровнем (n=20). Все пациенты в обеих группах были сопоставимы между собой по возрасту и полу.

Во всех пациентов проводилось определение антропометрических показателей: роста, веса, объема талии (ОТ), рассчитан ИМТ, а также проводились лабораторные исследования: липидного спектра крови (общий холестерин (ОХ); триглицериды (ТГ), липопротеиды высокой плотности (ЛПВП); липопротеиды низкой плотности (ЛПНП), Оценку достоверности показателей между группами проводили по параметрическому критерию Стьюдента.

Результаты и их обсуждение. Имело место наличие статистически достоверного ($p < 0,05$) повышения уровня высокочувствительного СРБ в группе пациентов с ГБ и ожирением сравнению с группой контроля.

Выявлены также значительные изменения в липидном спектре крови у больных. Так была установлена прямая корреляционная зависимость между высоким уровнем АД и повышением уровня СН (соответственно $r = 0,56$, $p < 0,05$), триглицеридами и ОХС (соответственно $r = 0,38$, $p < 0,05$), избыточным весом и сниженным уровнем ХСЛПВП. Полученные данные свидетельствуют о том, что пациенты с ГБ и ожирением имеют более выраженные атерогенные изменения липидного спектра крови на фоне повышения СРБ, как одного из маркеров системного и локального воспаления, а также признанного фактора риска развития сердечно-сосудистых заболеваний и их осложнений, что позволяет рассматривать ожирение в качестве дополнительного фактора риска прогрессирования атеросклеротических изменений и ассоциированных с ним поражений коронарных артерий и инфаркта миокарда. При этом, назначение 40 мг аторвастатина в течение 8 недель оказывало достоверное влияние на липидный спектр крови у исследуемых пациентов, однако, приводило не только к достоверному ($p < 0,01$) снижению уровня ХС ЛПНП), но и к достоверному ($p < 0,001$) снижению СРБ (с $9,2 \pm 0,6$ мг/л до $6,8 \pm 0,5$ мг/л). Таким образом, пациенты с гипертонической болезнью и ожирением должны принимать не только препараты ИАПФ, но и статины с целью коррекции не только уровня АД, а также с целью дополнительного влияния на уровень СРБ для снижения риска прогрессирования ишемической болезни сердца.

Заключение: результаты исследования показали, что большое значение в повышении уровня СРБ у пациентов с ГБ, ожирением и ИБС имеет величина ИМТ и уровень АД, что обуславливает применение в терапии этих пациентов не только антигипертензивных препаратов, но и применение диет и адекватных физических нагрузок для снижения веса больных.

ЗАСТОСУВАННЯ НІТРАТІВ У ХВОРИХ НА ІХС

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Мета роботи: вивчити вплив переривчастої схеми призначення органічних нітратів на гуморальні фактори, що визначають розвиток толерантності при тривалій терапії у хворих з стенокардією.

Матеріали і методи: обстежено 50 хворих на стенокардію напруження III функціонального класу. Хворі були розбиті на 2 групи по 25 пацієнтів у кожній, ідентичні по статі і віковому цензу. Всі пацієнти отримували препарат - ізосорбїду динітрат (ІСДН) - кардикет-ретард протягом 3-х тижнів. З них - 25 пацієнтів - I групи - приймали ІСДН по безперервній схемі (20 мг 3 рази на день); друга група хворих – за переривчастою схемою (20 мг 2 рази на день з тривалістю безнітратного періоду не менше 12 годин). Величину ефективної разової дози нітрату підбирали методом парних велоергометрій (ПВЕМ) і холтерівського моніторингування ЕКГ. Інтенсивність перекисного окислення ліпідів (ПОЛ) в плазмі крові оцінювали за рівнем ТБК-активних продуктів фотометричним методом; активність Е-1 імуноферментним методом, нітритів (NO₂) - спектрофотометрическим. Через 3 тижні проводили контрольне дослідження.

В кінці курсу терапії достатній антиангінальний ефект, за даними ПВЕМ спостерігався у 21 (70%) хворих I-ї групи: загальний обсяг виконаної роботи (ЗОВР) підвищився на 12%, ($p < 0,05$), потужність порогового навантаження (ППН) на 10%, ($p < 0,05$). Рівні ТБК-активних продуктів і ендотеліну-1 знизилися на 37% ($p < 0,05$) і 40% ($p < 0,05$), відповідно. Концентрація NO₂ підвищилася на 76% ($p < 0,05$). У 9 хворих (36%) I-ї групи монотерапія була недостатньо ефективною: МПН і ООВР ($p < 0,05$) в динаміці лікування знизилися. Цей стан супроводжувалося активацією ПОЛ: рівень ТБК-активних продуктів зріс на 49% ($p < 0,05$) і досяг початкового значення ($p > 0,05$) рівень ендотеліну-1 в плазмі виріс на 45% ($p < 0,05$) у порівнянні з періодом компенсації.

У 2 групі на тлі переривчастої терапії достатній антиангінальний ефект ІСДН протягом усього періоду спостереження був у 91% хворих, рівень ендотеліну-1 знизився на 37,2% ($p < 0,01$), достовірного зміни інших показників не відбулося. Індивідуальний аналіз даних ПВЕМ дозволив виявити розвиток часткової толерантності тільки у (3%) хворих, проте ще у 6% хворих цієї групи розвинувся синдром ранньої негативної післядії, який проявився нападами безбольової ішемії міокарда нетиповою для даних хворих.

Висновки: призначення переривчастої схеми застосування нітратів більш ефективно, ніж безперервна монотерапія, однак слід очікувати позитивних результатів від додаткового призначення ІАПФ, здатних підсилювати дію нітратів, контролювати А-II-залежні механізми розвитку толерантності і надавати додатковий вплив на обмін брадикиніна.

АУТИЗМ: ОСОБЕННОСТИ, КОТОРЫЕ НЕОБХОДИМО ЗНАТЬ ВРАЧУ-ТЕРАПЕВТУ

Лапшина К.А.

Аутизм диагностируется на основе нарушений взаимного социального взаимодействия и социального общения, а также ограниченных повторяющихся интересов и поведения. Нарушения социальной коммуникации включают в себя: аномалии или задержки в использовании и понимании разговорной речи; нарушения в невербальных социальных навыках (использование или понимание зрительного контакта, жестов, языка тела, выражения лица и т. д.); неспособность реагировать, инициировать или наслаждаться социальными взаимодействиями с другими людьми, особенно со сверстниками, а также отсутствие творческой и/или взаимной социальной игры [NICE Clinical Guidelines, No. 170].

Жесткое и повторяющееся поведение включает в себя: стереотипные двигательные движения; повторяющиеся игровые модели; необычные интересы; неприятие перемен или новых ситуаций; соблюдение установленных процедур; настаивая на том, чтобы следовать собственной программе и чрезмерной реакции на сенсорные стимулы, например, текстуры, звуки, запахи или вкус.

Важно отметить, что большинство детей с аутизмом не проявляют трудностей во всех перечисленных выше областях, а проявления и тяжесть симптомов различаются в разных ситуациях и с возрастом. Однако для почти всех людей сочетание социальных дефицитов и жестких моделей поведения оказывает глубокое и повсеместное воздействие на их жизнь и на жизнь их семей. Действительно, рейтинг родителей в отношении уровней стресса сильно коррелирует с наличием ограниченного, повторяющегося и стереотипного поведения у их ребенка [Gabriels et al., 2005].

Некоторые аспекты основных дефицитов носят врожденный характер, другие в значительной степени нетипичны по типу или интенсивности (например, буквальное понимание языка и необычных интересов или озабоченностей). Признание этих различных видов дефицита помогло информировать о подходах к психосоциальным вмешательствам.

В широком смысле доступные вмешательства по поводу особенностей аутизма делятся на две области: а) психосоциальные вмешательства с ребенком / молодым человеком или родителями / опекунами, которые предоставляют информацию об основных признаках аутизма, но в основном направлены на улучшение социальных и коммуникативных навыков (эти вмешательства обычно также предоставляют некоторую информацию о повторяющихся, стереотипных или жестких поведении и советах по управлению поведением, которые бросают вызов); б) использование фармакологических вмешательств для уменьшения аспектов жесткого или повторяющегося поведения, которые, как представляется, связаны с проблемами психического здоровья или поведением, которое бросает вызов.

Для детей школьного возраста и молодых людей существует программы, которые предлагают групповую социальную подготовку. Эти вмешательства направлены на то, чтобы улучшить способность участников понимать социальные ситуации, общаться с другими людьми и разрабатывать стратегии преодоления конфликтов, такие как использование умственных «наборов инструментов» в сложных социальных ситуациях.

Другим распространенным подходом является использование поведенческих принципов, таких как репетиция, а также использование описательных и иллюстрированных книг («рассказов»), чтобы помочь детям и подросткам с аутизмом лучше понять социальные ситуации. Цель состоит в том, чтобы улучшить социальное взаимодействие и саморегуляцию и уменьшить беспокойство и вспышки гнева.

Социальные истории предоставляют индивидуальные подходы к решению проблем для развития навыков и управления проблемным поведением и представляют собой решения как для ребенка, так и для его окружения [Sansosti, 2004].

MODERN METHODS OF DIAGNOSTICS OF BRUGADA SYNDROME

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Brugada syndrome (SB) is a canalopathy, which is based on a molecular-genetic anomaly in the regulation of the ion channels of the cardiomyocyte, which is a predictor of a high risk of sudden cardiac death.

The frequency of Brugada syndrome is at least 1:10 000. To date, at least 5 genes responsible for the development of this condition are known. Mutation in any of them can lead to the development of the disease.

The diagnosis of the Brugada syndrome is based on the ECG pattern and is determined by the signs of the right bundle branch blockade (BPNT) in combination with the characteristic ST segment elevation in leads V1 to V3, provided there is no heart disease, ischemia or electrolyte imbalance. Clinical manifestations most often are episodes of loss of consciousness, arising from the development of polymorphic ventricular tachycardia or ventricular fibrillation. Seizures often occur at night or during the day at rest. In children, these symptoms can occur against the background of a rise in temperature. Syndrome Brugada may not have clinical symptoms and manifest only characteristic changes on the ECG. Since arrhythmic attacks predominantly occur at night, an effective alternative in this case is a 24-hour ECG monitoring using a 12-channel recorder.

The electrocardiographic criteria of the Brugada syndrome are: specific rise of the ST segment in V1-V3; blockade of the right leg of the bundle; the transient elongation of the interval PQ; attacks of polymorphic ventricular tachycardia. There are 2 main variants of ST segment changes in the right thoracic leads: arched (coved) and saddle (saddleback).

Currently, the diagnosis is possible in the presence of an ECG pattern of type 1, both from spontaneous changes in the ECG, and from the results of drug tests, but with one of the following conditions:

- documented polymorphic ventricular tachycardia or ventricular fibrillation;
- cases of sudden cardiac death at the age of less than 45 years among relatives;
- an electrocardiographic pattern characteristic of the Brugada syndrome in relatives;
- the possibility of provoking VT with programmed electrical stimulation;
- Attacks of loss of consciousness or disturbance of respiration by type of agonal at night.

Observation of patients with Brugada syndrome made it possible to identify a number of additional changes in the ECG that are characteristic for this condition. First of all, it is the violation of electrical processes in the ventricular myocardium - the presence of late ventricular potentials and fragmentation of the QRS complex. In addition, it may be signs of weakness syndrome of the sinus node, a change in the shape and polarity of the P wave, as well as its expansion, prolongation of the PQ interval (ECG picture of the AV block of the 1st degree, moderate prolongation of the QT interval, but not, however, the diagnostic criteria for the syndrome of the elongated QT Atrial fibrillation is often found in the SB, but it is not a diagnostic symptom. Clinical management of patients with SB is a challenge. Standing under constant outpatient supervision often does not allow to avoid the development of fatal arrhythmias, and the apparent absence of heart disease does not exclude the possibility that SB may occur in the patient during a lifetime. Small diagnostic reliability of the ECG leaves a wide field for differential diagnosis. Myocardial diseases such as myocarditis and cardiomyopathies can lead to the development conduction abnormalities on the right leg of the n. His, but accompanied by an atypical ECG picture, which gives grounds for suspecting the presence of SB. Location of the myocardium with a disturbed electrical function in the right ventricular myocardium suggests differential diagnosis with arrhythmogenic right ventricular dysplasia. Along with echocardiography, in this case it is recommended to use computed tomography.

MYOCARDIAL INFARCTION IN YOUNG PATIENTS

Наллусамі Нантіні, Зайченко О.Є., Панченко Г.Ю.

Currently, the number of hospitalizations of young patients under the age of 40 with the diagnosis of acute myocardial infarction (MI) is increasing. This category of patients has different risk factors from older people, complications and prognosis.

The purpose of the study is to evaluate the characteristics of risk factors and the course of MI in young people.

35 patients with Q-wave infarction were examined, 18 of them were under 40 years old and 17 were over 40 years old male. Patients were questioned, clinical and instrumental examinations, ECG, ECHO.

Results: Among the risk factors in young (95%) patients, hereditary burden prevailed compared with elderly patients (60%). Risk factors 80 such as smoking (90%), alcohol abuse (60%), drug use (6%), nervous stress (85%) and obesity (65%) were more frequent in young people (in the elderly 15%, 10%, 0%, 30%, 20%, respectively). In the elderly, the risk factors were hypodynamia (90%), arterial hypertension (85%), diabetes mellitus (65%). In young, these factors were respectively 10%, 15%, 0%. Hypertriglyceridemia and increased LDL levels and a decrease in HDL cholesterol were equally common in both groups (85%, 80%, 90%). On ECG localization of myocardial infarction in young on the anteroposterior region 45%, front widespread 20%, anteroposterior 20%, posterior wall 15%, and in the elderly, respectively 25%, 45%, 10%, 15%, circular IM 5%. Echocardiographic indices in the elderly were characterized by a decrease in the contractility of the myocardium in terms of the left ventricular ejection fraction (mean values in the elderly were $45\% \pm 2.2\%$, in young people $60\% \pm 1.2\%$). Of the rhythm disturbances, ventricular extrasystole was equally common in both groups (in young people 55%, in the elderly 60%). Ventricular tachycardia, atrial fibrillation, ventricular fibrillation, AV blockade were more often detected in the elderly (55%, 40%, 25%, 20%, young 20%, 25%, 5%, 10%, respectively). In 2 young patients, left ventricular aneurysm developed because of non-compliance with bed rest. Cardiogenic shock, acute left ventricular failure, pulmonary edema were more common in the elderly (50%, 55%, 30%).

The conclusion. Heredity, stress and bad habits are the main risk factors among young patients. In the elderly, the main risk factors were inactivity, hypertension and diabetes mellitus. Violation of lipid composition of blood is equally common in young and elderly people. The contractility of LV myocardium in the elderly with myocardial infarction is sharply reduced in comparison with the young. Severe complications are more often observed in the elderly due to the defeat of several coronary arteries. Extensive myocardial infarction is more often recorded in the elderly. Frequent localization of MI in both groups is noted in the area of the anterior wall of the LV. The course of MI in the elderly is harder due to serious complications and life-threatening rhythm disturbances.

МНОЖИННИ ЛЕНТИГО: СИНДРОМ LEOPARD

Прокопенко М.С., Лапшина Е.А.

Дана стаття присвячена синдрому LEOPARD - дуже рідкісного спадкового захворювання, чия діагностика представляє велику складність для клініцистів із-за складності диференційно-діагностичного пошуку та недостатньої інформованості про даний синдром.

Синдром LEOPARD - рідкісне аутосомно-домінантне захворювання з високою пенетрантністю і різноманітною експресивністю. LEOPARD -

акронім, що відображає основні прояви захворювання: Lentigines - множинні лентіго, Electrocardiographic abnormalities - електрокардіографічні порушення, Ocular hypertelorism - гіпертелоризм, Pulmonary stenosis - стеноз легеневої артерії, Abnormalities of genitalia - крипторхізм, гіпоспадія, Retardation of growth - затримка росту, Deafness - глухота .

Найбільш часто спостерігається лентіго (більше 85%), що виявляється плоскими або злегка підносяться плямами жовто-коричневого або майже чорного кольору діаметра 1,5-3 см, дисименовані по всьому тілу, включаючи обличчя, склери (рис.1). Лентіго частіше проявляється відразу після народження, з віком їх кількість збільшується.

Ураження серцево-судинної системи спостерігається у 75% хворих: стеноз легеневої артерії спостерігається в 40% пацієнтів, гіпертрофічна кардіоміопатія спостерігається в 80% (частіше асиметрична і вражає лівий шлуночок), з інших проявів відзначають - пролапс мітрального клапану, дефекти атріовентрикулярних перегородок. Гіпертелоризм присутній майже у всіх пацієнтів, плоска спинка носа і низько посаджені вуха спостерігаються у 85%, серед інших аномалій відзначають дисморфії черепа, високе небо, птоз. У третини хворих є затримка фізичного і розумового розвитку. Скелетні аномалії можуть включати деформації грудної клітки, аномалії ребер, кіфосколиоз, синдактилії, затримки розвитку або агенезія постійних зубів, і виявляється в 75% випадків. Аномалія сечостатевої системи в 50% випадків включає двосторонній крипторхізм, гіпоспадію. Нейросенсорна глухота спостерігається в 15-25% і виявляється відразу після народження або протягом перших років життя.

На сучасному етапі діагностика базується на наступних дослідженнях:

1. ЕКГ. Можливі наступні ознаки: відхилення осі серця, поява патологічних зубців, блокада ніжок пучка Гіса, ознаки гіпертрофії лівих половин серця.

2. Холтер-ЕКГ: наявність шлуночкової і надшлуночкової ектопічної активності.

3. Ехо-КГ: гіпертрофія лівих половин серця, візуалізація стенозу легеневої артерії, наявність мітральної регургітації, діастолічна та систолічна дисфункція.

4. Рентгенографія органів грудної порожнини: ознаки застою в легенях, збільшення лівих половин серця.

5. Коронароангіографія.

6. Комп'ютерна томографія.

7. Генетична консультація.

Специфічного лікування даної нозології немає, терапія має симптоматичний і підтримуючий характер. Терапія лентіго в більшій частині не ефективна, але для косметичного ефекту хворим рекомендують кріодеструкцію і лазерне видалення ізольованих плям. Лікування серцевої патології може бути консервативним і включати бета-адреноблокатори, блокатори кальцієвих каналів, антиаритмічні препарати та ін. Стеноз легеневої

артерії усувають хірургічно при високому ступені обструкції. Також оперативному методу підлягає усунення аномалій сечостатевої системи.

Синдром LEOPARD є рідкісним і важким захворюванням, і вимагає точно етіологічної діагностики виявлених порушень. Своєчасна діагностика, уточнення генезу кожного синдрому особливо важливі, тому що дозволяють знайти оптимальний підхід до лікування цих станів, а також попередити повторне виникнення спадкових хвороб в уражених сім'ях шляхом медико-генетичного консультування. Це диктує необхідність лікарям різних спеціальностей бути поінформованими в галузі генетичних захворювань.

STATINS IN PATIENTS WITH ACUTE CORONARY SYNDROME

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The aim of the study was to study the effect of atorvastatin on the indices of systemic inflammation in acute myocardial infarction (AMI) and evaluate its complex corrective effect on the clinical course of the disease.

38 patients were examined in the acute period of myocardial infarction with ST segment elevation without concomitant chronic pathology. The mean age of the examinees was (49.0 ± 5.4) years. Complex therapy included atorvastatin 40 mg / day during hospital and early rehabilitation periods (an average of 6 weeks). The control group included patients who had contraindications to the administration of statins ($n = 12$).

The levels of C-reactive protein, tumor necrosis factor α and interleukin-6 (respectively, by 14.6, 9.4 and 6.5%, $p < 0.005$) significantly decreased in comparison with the control group with atorvastatin, which indicates a decrease manifestations of systemic inflammation.

Against the background of prescribed antianginal therapy, episodes of painful ischemia did not occur in patients, however, with 24-hour ECG monitoring (on the 3rd day of the disease, at discharge from hospital and after 6 weeks of treatment), episodes of painless myocardial ischemia were recorded in both groups of patients. In the atorvastatin group, the number and total duration of these episodes were lower during the day than in the control group (respectively, by 17.5 and 16.9%).

Consequently, the positive effect of atorvastatin is primarily due to its lipophilicity and ability to accumulate in the vessel wall, to suppress the inflammatory response and thereby to correct the sensitivity of the endothelium to vasomotor factors.

Thus, the use of atorvastatin from the first day of treatment of patients with STEMI with ST elevation significantly influences the course of the disease - improves the state of blood supply to the myocardium, stabilizing the clinical course of the disease.

FEATURES OF DIAGNOSTICS OF BEHÇET'S DISEASE

Ядав Джітеш, Зайченко О.Є., Панченко Г.Ю.

Behçet's disease (BB) is a systemic chronic idiopathic inflammatory disease of unknown etiology with a recurring course, manifested as a characteristic triad: recurrent aphthous stomatitis, ulcerous changes in the mucous membrane and genital skin, inflammatory damage to the eyes. In addition, it is possible to defeat other organs - often arthritis, thrombophlebitis, colitis, neurological symptoms.

Men predominate among the patients. The most common debut of the disease is observed at the age of 30-40 years. Thus, epidemiological studies suggest that the development of the disease affects both genetic and external factors.

Gene studies in Japan and Turkey have identified associations of HLA-B51 with BB. Along with this, a relationship of BB with other antigens (not belonging to the main histocompatibility complex), interleukin 10 (IL10), and the receptor for IL23 is noted. J. Kappen et al. suggested the role of the 6th chromosome in the development of BB and its possible association with the 18th chromosome.

Pathogenesis is the development of systemic vasculitis of the immune complex nature. The main pathogenetic links of the process are: a decrease in the activity of T-lymphocytes-helpers and an increase in circulating autoantibodies to mucosal cells; the appearance of circulating T-lymphocytes, which have cytotoxicity with respect to the epithelium of the oral mucosa; decrease in the number of interleukin-2 receptors on T-lymphocytes; decrease in the concentration of secretory IgA in saliva; high chemotactic and phagocytic activity of segmented nuclear neutrophils. All these factors contribute to damage to the vascular endothelium in Behçet's disease. The histological picture of tissue damage is often represented by perivascular lymphocytic infiltration, vasculitis. Possible damage to blood vessels of both arterial and venous bed.

Behçet's disease is characterized by a triad of clinical signs: aphthous stomatitis, ulcerous changes in the mucous membrane and genital skin, eye damage in the form of uveitis or iridocyclitis. The formation of ulcers in the oral cavity is noted in all patients and is considered one of the earliest symptoms, often outstripping the development of systemic manifestations for months and even years. Eye damage is the first symptom of the disease in about 10% of patients, but more often develops after ulcerative stomatitis. Patients with eye injuries present various complaints, among which the most frequent are vagueness of visual objects, pain in the eyes, photophobia, lacrimation, periorbital hyperemia. Joint damage occurs in about half of patients and is characterized mainly by mono- or oligoarthritis of large joints; fewer patients develop polyarthritis. The defeat of the organs of the gastrointestinal tract manifests by pain in the abdomen and diarrhea. Possible the development of intestinal bleeding and intestinal perforation. The ileocecal part of the intestine is most often affected, the esophagus, the transverse and ascending colon are less often involved. Chronic progressive lesion of the central nervous system is noted in 10-20% of patients. Possible manifestations of pulmonary lesions include aneurysms of the pulmonary arteries, arterial and venous thromboses, lung infarction, recurrent pneumonia, bronchial asthma obliterans, pleurisy. The defeat of

the kidneys in Behcet's disease is marked significantly less often than with other vasculitis and less severe. Sometimes proteinuria, hematuria, and insignificant renal failure are detected. The defeat of the heart develops rarely and can be represented by pericarditis, myocarditis, coronary disease, endocarditis, mitral valve prolapse, etc. Small-vessel vascular lesions underlie many pathological processes in Behcet's disease and are observed in 7-38% of cases. A typical symptom is thrombosis of the superficial and deep veins. International diagnostic criteria for Behçet's disease (Internal Study group for Behcet's disease, 1990). These criteria include:

- Recurrent ulcers of the mouth - small and / or large aphthae, herpetiform ulceration, recurring at least 3 times during the year, identified by a doctor or patient.
- Recurrent ulcers of the genitals - aphthous or scarring ulcers, identified by a doctor or patient.
- Eye damage - anterior uveitis, posterior uveitis, cells in the vitreous body when examined by a slit lamp, retinal vasculitis detected by an ophthalmologist.
- Skin lesion - erythema nodosum, pseudofolliculitis, papulopustular eruptions, acne-like nodules, diagnosed by a doctor in patients with post-pubertal development using glucocorticoids.
- Positive test of paternity - evaluated by a doctor in 24-48 hours.

In accordance with these criteria, the diagnosis is considered reliable if ulcerative stomatitis is combined with two of the following: recurrent genital ulcers, eye damage, skin lesion, or positive paternity test.

Thus, the clinical diagnosis of Behcet's disease is formulated on the basis of the preliminary diagnosis data (established in accordance with international criteria), the revealed features of the course of the disease and the effectiveness of therapy in accordance with treatment protocols.

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