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ЗБІРНИК МАТЕРІАЛІВ НАУКОВИХ КОНФЕРЕНЦІЙ СТУДЕНТІВ ТА ЛІКАРІВ-ІНТЕРНІВ, ПРОВЕДЕНИХ НА БАЗІ КАФЕДРИ ВНУТРІШНЬОЇ МЕДИЦИНИ №1

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EFFICACY OF ANTIPLATELET THERAPY IN PATIENTS WITH CORONARY ARTERY DISEASE

Abhilash Mesh, Zaichenko O.E.

The close interrelation of atherogenesis and thrombosis processes makes pathogenetically justified the conduct of long-term antiplatelet therapy for the purpose of secondary prevention of cardiovascular complications.

The aim of the work was to study the dynamics of indicators of the morphofunctional state in patients with coronary artery disease with clinical manifestations of stable (CCH) angina pectoris against the background of antiplatelet therapy.

Materials and methods. In the course of the work, 55 patients aged 40 to 65 years (36 men and 19 women) with CLO of the II-III functional class were examined. The control group consisted of 20 healthy volunteers, matched by sex and age. All patients received basic therapy and aspirin at an initial dosage of 325 mg / day. (1st reception), with the subsequent transition to 100 mg / day. The survey was conducted on the 1st, 10th and 30th day of treatment. The morpho-functional state of platelets was assessed using the original method (A.S. №1357845).

Results. When assessing the functional activity of platelets in the CLO group, there was an initial increase in the specific number of mega-platelets (5.1 ± 0.6) associated with a decrease in the "lifetime", accelerated updating of the pool of platelets in the bloodstream and the appearance of young platelets with a higher reactivity . Against the background of antiplatelet therapy with aspirin, by the 10th day, the number of discocytes in the CSN group (69.2 ± 3.1)% increased. At the same time, there was a significant decrease in the active forms of cells - spherocytes (8.7 ± 0.8) and mega-platelets (2.6 ± 0.8) and a decrease in the aggregated (9.1 ± 1.4) and degranulated (6.2 ± 0.5) forms. On the 30th day of therapy, with clinical signs of stabilization of the condition in patients with CLS, the specific number of these cells was significantly higher than in the control group. This dictates the need to continue long-term anti-platelet therapy until platelet hemostasis stabilizes, despite the improvement in the patient's clinical condition.

DIAGNOSTICS OF PULMONARY EMBOLISM BASED ON CLINICAL PICTURE

Abugheddeh A. M., Abugheddeh A., Vizir M.

Introduction: Venous thromboembolic (VTE) diseases includes Deep Vein Thrombosis (DVT) and Pulmonary embolism (PE); They are diseases that occur as a result of coagulopathy and might lead to partial or complete vessel occlusion resulting in acute ischemia or infarction. PE is rapid-progressing life threatening complication of DVT. It is difficult to diagnose because symptoms associated with PE are unspecific.

Aim:Survey multiple cases of patients with confirmed diagnoses of Pulmonary Embolism in an attempt to find a recurring clinical picture that will help suspect Pulmonary Embolism without the need of lab tests current algorithms.

Methods:Review of 47 cases, 12 of which provided by journals and 35 provided by a study, these patients belong to different age groups and belong to different risk groups. The most common thing amongst these patients is the confirmed diagnosis of PE

Results: Symptoms:

Chest pain was in 25% (12) of patients, Dyspnea was in 89% (42) of patients, Cough was in 12% (6) of patients and Syncope was in 19% (9) of patients. Fever was in 10% (5) of patients.

Examinations:

ECG: Sinus tachycardia 80% (38). Chest X-ray (CXR): Normal CXR observed in 75% (36), Lung changes observed in 25% (12). Echocardiography (35): Pulmonary arterial hypertension 85.7% (30), RV dysfunction 88.5% (31) Thrombus in pulmonary arteries, RV 16.7% (4). V/Q scan (16): Perfusion defect present 75% (12), No perfusion defects 25% (4). CT pulmonary angiogram (27):

Thrombus in main and lobar arteries 81% (22) thrombus in subsegmental arteries 19% (5). Venous Doppler of lower limbs: Evidence of DVT 68% (32). D-dimer (37): Positive 97% (36).
Predisposing factors(s):
Immobilization was in 21% (10) of patients, Malignancy was in 6% (3) of patients. Deep Vein Thrombosis was in 68% (32).
Conclusion:
According to the results, the symptoms of PE are neither specific nor sensitive, thus further investigations are required to proceed with the diagnosis.
The next step for the clinician is assessment based on the two-level PE Wells score followed by recommended tests; Low risk (score<4) D-dimer, High risk (score>4) CT Pulmonary Angiogram (CTPA) or V/Q SPECT if CTPA is not available.

THE ETHOLOGICAL FACTORS OF OCCURRENCE OF COMA IN ELDERLY PEOPLE

Agyapong M., Vizir M.

BACKGROUND: Coma is a major problem in elderly people. Most often people get into coma on sudden situations without any previous diagnostics or screening which shows any risk to coma. This has made the issue about coma a very sensitive one in the society which requires proper innovations and researches to be able to manage coma in the society especially the elderly people.
PURPOSE: This research is to evaluate the ethological factors of occurrence of coma in elderly people
METHODS: Online data were taken from intensive care units of two main hospitals, thus; TOURE Teaching Hospital, Mali and Korle-bu teaching hospital, Ghana. A total of 200 cases recorded from both hospital (100 from each hospital) was reviewed from 1 April to 1 May 2018.This data is being used to establishment the pathways and major causes leading to coma in the elderly people.
RESULTS: During the period of review, it was observed that 128 persons (64%) were older persons and the remains g number of people represented those of the younger class.93 out of the 128 elderly persons were males representing 72% of the elderly population whiles the remaining number which is 35 were females representing 28%. Hypertensive patients accounted for 65% of all cases of coma in the elderly. In 25% of cases was coma due to cardiovascular reasons due to different reasons and the remaining 10% was due to metabolic disturbances in the body.
CONCLUSION: In conclusion, due to the difficulties in diagnosis of coma related disease, the incidence of coma tends to be on the higher side. Elderly people are more affected with coma due to their degradation in their health status and also the lateness in diagnosing of coma associated diseases. Men tend to have coma at an increased rate than women due to these statistics and it is seen that hypertension is the leading cause of coma among the elderly since diagnosis of hypertension is also seen when patient have been observed over a given period of time.

INFLUENCE OF THE VISCERAL PATHOLOGY ON OSTEOCHONDROSIS OF THE LUMBAR REGION

Amritha Ashok Nair, Zelena I.I.

The problem of osteochondrosis of the spine itself a common chronic illness of a person and his clinical polymorphism is one of the most urgent in modern medicine, which goes far beyond the framework of such specialties as neurology, orthopedics and rheumatology.
Meanwhile, the causal link of the pain syndrome with the pathology of the spine so firmly rooted in consciousness doctors, which often results in erroneous diagnostics and unwarranted surgical interventions. Even with the strongest pain in the sacrum and lumbar region, often irradiation in the lower limbs, osteochondrosis can to be in a stage of deep, prolonged remission. The lack of clear correlations between clinical severity manifestations and degree of morphological changes vertebral

and neural structures according to neuroimaging in many respects due to the complexity of interaction compensatory and pathogenetic mechanisms with vertebrogenic pathology.
The vertebral motor segment receives at the same time afferentation from scleroderma of the vertebrae, internal organs, as well as from certain metameric zones of the body and extremities. Correspondingly, efferent reflex influences can also be of a widespread nature, causing diverse localization and character of the reaction from the part of the musculoskeletal system and the internal ones organs It is important to note that the pain syndrome with SO is no just not so much the manifestation of a local degenerative- dystrophic pathology and its surrounding formations, but a disease of the whole organism.
If prevail biochemical and microcirculatory, autoimmune sanogenetic reactions and physiological emergence adaptation to overloads of the PDS, then the disease can flow latently. In such cases, detected with the help of CT or MRI hernias, protrusion disks, sequesterers, osteophytes and other pronounced degenerative-dystrophic changes are a random find and not have a clinical manifestation. With weakening, and even more so the decompensation of the trophic systems to the loads arises. Clinic of osteochondrosis and, above all, local and reflected pain syndrome. An important role in its development and formation the accompanying visceral pathology plays, since. At the same time, conditions for change are formed reflexively trophies of the muscles, appearance of myofascicular hypertonia (foci of neuro-osteophyrosis) in the thickness of the skeletal muscles, formation functional blockade PDS are in turn a source of reflex influences on interoreceptors visceral organs.
Such an approach to the problem of local and reflected pain Syndrome with SO significantly changes the clinical a picture of the traditional diagnosis "vertebrogenic (discogenic) lumbalgia / lumboisyalgia "and necessitates it its pathogenetic concretization and therapeutic correction.

ACUTE MYOCARDIAL INFARCTION IN YOUNG PATIENTS

Anmol Gupta, Zaichenko O.E.

Currently, the number of hospitalizations of young patients under 40 years of age with a diagnosis of acute myocardial infarction (MI) is increasing. This category of patients has different risk factors, complications and prognosis than the elderly.
The purpose of the study is to assess the characteristics of risk factors and course of MI in young people
35 patients with myocardial infarction with Q wave were examined, 18 of them were patients under the age of 40 and 17 were older than 40 years of the male sex. Patients were examined, clinical and instrumental examinations, ECG, echocardiography was performed.
Results: among the risk factors in young (95%) patients, hereditary burden prevailed compared with older patients (60%). 80 risk factors such as smoking (90%), alcohol abuse (60%), drug use (6%), nervous stress (85%) and obesity (65%) were more common in the young (15% in the elderly, 10%, 0%, 30%, 20%, respectively). Elderly risk factors were hypodynamia (90%), arterial hypertension (85%), diabetes mellitus (65%). In young people, these factors were found respectively 10%, 15%, 0%. Hypertriglyceridemia and elevated levels of LDL and lower HDL levels were equally common in both groups (85%, 80%, 90%). On ECG, localization of myocardial infarction in the young in the anterior septal area 45%, anterior prevalent 20%, anterior-lateral 20%, posterior wall 15%, and in the elderly respectively 25%, 45%, 10%, 15%, circular MI % Echocardiographic parameters in the elderly differed by a decrease in myocardial contractility in terms of the left ventricular ejection fraction (average values in the elderly were 45% ± 2.2%, in the young 60% ± 1.2%). Of rhythm disturbances, ventricular premature beats are equally common in both groups (in young people 55%, in elderly 60%). Ventricular tachycardia, atrial fibrillation, ventricular fibrillation, AV blockade were more common in the elderly (respectively 55%, 40%, 25%, 20%, in the young 20%, 25%, 5%, 10%). In 2 young patients, due to non-observance of bed rest, left ventricular aneurysm

developed. Cardiogenic shock, acute left ventricular failure, pulmonary edema were more common in the elderly (50%, 55%, 30%).
Conclusion. Heredity, stress, and bad habits are major risk factors for young patients. In the elderly, the main risk factors were hypodynamia, hypertension and diabetes. Impaired blood lipid composition is equally common in both young and elderly. The contractility of the myocardium of the left ventricle in the elderly with myocardial infarction is sharply reduced compared with the young. Severe complications are more common in the elderly due to lesions of several coronary arteries. Extensive myocardial infarction is more common in the elderly. Frequent localization of MI in both groups is noted in the anterior wall of the LV. The course of myocardial infarction in the elderly is more difficult due to serious complications and life-threatening arrhythmias

REVIEW OF EFFECTS OF MORINGA OLIFERA EXTRACTS ON BLOOD PRESSURE OF HYPERTENSIVE SUBJECTS NOT UNDER ANY ANTI HYPERTENSIVE THERAPY

Rohilla A., Vizir M.

INTRODUCTION
Hypertension is an iceberg disease following the rule of halves.
only half of hypertensive subjects in general population of developed nations are aware of their condition. Of these only half are being treated and of these half only half are adequately treated.
This disease is usually asymptomatic and may require life long therapy making its patients prone to non compliance to treatment.
The extract obtained from leaves of Moringa Olifera belonging to moringaceae family also known as benoil tree have been known to possess many antioxidants like: DPPH, H202, ascorbic acid and other free radical scavengers along with phylloquinone, nitrate glycosides; the IV administration of which has been known to cause reduction in blood pressure of anaesthetised rats.
toxicological studies on the extracts from this plant have shown no evidence of severe hepatotoxicity, organ damage and no major changes in biochemical parameters in rats, making this a good candidate for clinical trials and studies on humans.
AIM
To survey the effects of extracts from moringa olifera leaves in human hypertensive subjects as an alternative natural remedy for patients reluctant to initiate medical anti hypertensive treatments and those non compliant to therapy.
METHODS
Review of 35 cases from various studies conducted in male subjects of clinically diagnosed stage I hypertension of age groups 35 to 55 years belonging to different risk groups. With subjects serving as self controls. The intervention applied in these subjects was 100ml of moringa leaf extract offered twice daily for 30 days.
RESULTS
The pre intervention Systolic blood pressure of subjects being 140±20 showed a decline to a level of 110±10 post intervention
while the pre intervention Diastolic blood pressure of subjects being 95±15 showed a decline to a level of 80±10 post intervention
CONCLUSION
Extracts from the leaves of moringa olifera are efficacious in significant reduction of both systolic and diastolic blood pressure of subjects who are not under any anti-hypertensive drug therapy. Thus, making it a valuable natural method for control of blood pressure in cases of stage I hypertension in patients who are non compliant to medical therapy or are not willing to initiate treatment.

TROPONIN AS A CARDIAC ENZYME

Asibey A.G, Bonsu S. K., Vizir M.O.

Introduction

Numerous researches have connected a relation of troponin levels to myocardial infarction. It is said that it is a specific cardiac marker for myocardial infarction and that the higher level there is in the blood the bigger the infarct in the myocardium

Purpose

To investigate the interelation between elevated troponin levels and the the size of myocardial infarction and also the prognosis of myocardial infarction (MI).

Method

Troponin levels were measured in 300 patients with ST elevation on the ECG in different researches made by the European Society of Cardiology. Serum troponin was measured by ELISA on admission and three days after admission. 34 ng/mL for men, 16 ng/mL for women was taken as a diagnostic threshold. The trial showed that 99% of the patients after using the diagnostic threshold had myocardial injury but only one- third of these patients had been diagnosed with MI. It also showed that these patients had consequent cardiovascular death after one year.

Another study by the Apple et al. using a newer version of troponin called Hs troponin I to determine acute MI in patients. The clinical sensitivity and specificity in these patients who had symptoms suggestive ischemic heart disease was 69% and 78% respectively. This results increase to 94% and 84% after 6 hours. It was seen that patients with high increase in troponin levels had adverse cardiovascular effect after a one year follow up was made.

Results

It was seen from the first research that each patient with ST elevation had an average of 0.09ng/ml increase in troponin levels. It was seen that the levels were significantly higher in all patients from the research group.

It was also seen in the second research that the graver the condition of the patient the higher increase of troponin there is. And that the patients with very high elevation of troponin had adverse cardiovascular effects/

Conclusion

From the a fore- mentioned researches it is safe to say that the level of troponin in a patient with myocardial infarction is highly related to the size of injury there is. And also those with higher troponin levels stood the risk of very unfavorable outcomes.

CATALASE AS A MARKER OF CHANGES IN THE ANTIOXIDANT PROTECTION SYSTEM DURING FORMATION OF A PEPTICAL DUODENAL ANCER

Balan Shobhana Beena, Zhelezniakova Natalia

Objective: to establish the degree of changes in catalase activity during the formation of peptic duodenal ulcers.

Materials and methods: 49 patients with peptic duodenal ulcer and 20 healthy individuals were examined. The diagnosis was established when evaluating a complex of complaints, anamnesis and instrumental methods of research - video esophagogastroduodenoscopy with a targeted biopsy and subsequent histological examination of the biopsy. The presence of Helicobacter pylori was determined using the Stool Antigen Test for H. Pylori. Blood catalase activity was determined spectrophotometrically with H_2O_2 substrate according to S. Chevary et al. Statistical data has been performed on workstation by means of software “Microsoft Excel” and “Statistica 8.0”.

Results. During the formation of a peptic duodenal ulcer, significant deviations were observed in the activity of the antioxidant defence system in comparison with the indices of practically healthy individuals, and the differences were significant. The level of catalase in patients with peptic

duodenal ulcer was 189.5 ± 11.6 IU mg / Hb. In practically healthy individuals, the level of catalase reached 237.5 ± 12.4 IU mg / Hb ($p < 0.05$).
Conclusion. The formation of peptic duodenal ulcers was accompanied by a significant inhibition of the antioxidant defence system, which was manifested by a significant decrease in catalase activity.

CARDIOVASCULAR DISEASES IN STUDENTS MEDICAL HIGHER EDUCATION: RISK FACTORS

Filianin S.I., Ovcharenko L. I.

Untimely diagnosis and correction of risk factors is one of the main causes of high prevalence of cardiovascular diseases. The effectiveness of the prevention of cardiovascular diseases among young people largely depends on the identification and elimination of the maximum number of known risk factors. This leads to research on the prevalence of risk factors, as well as their gender characteristics among the designated contingent.
The purpose of this intelligence is to study the spread of risk factors, the assessment of the structure and distribution of cardiovascular diseases among boys and girls.
Material and methods. In the course of the study, a preventive medical examination and evaluation of cardiovascular risk factors among students of Kharkiv medical universities in September-October 2018 were conducted.
Results Among the 382 students examined, cardiovascular disease was diagnosed in 82 (21.6%) students. The prevalence of cardiovascular disease was distributed as follows: the mitral valve prolapse was observed in 24 students (6.3% of all examined, 29.2% of cardiovascular diseases), hypertensive illness - in 4 students (1% of all examined, 4.9 % of cardiovascular diseases), vegetative vascular dysfunction - in 53 students (14% of all examined, 64.6% of students with cardiovascular diseases), heart defects - in 5 students (1.3% of all examined, 6.1% from cardiovascular diseases), rhythm disturbances and metabolic syndrome - 1 student (0.3% of all examined, 1.2% of cardiovascular disease) udynnyh diseases). In 5 students, there were 2 cardiovascular diseases, 1 to 3 cardiovascular diseases. Hereditary predisposition was 108 (28.5%) students. 81 (21.4%) of the examined student smokes or burns in the past, 48 (12.7%) use more than 50g of ethanol per week, 92 (24.3%) are sedentary. To undergo chronic stress 80 (21,1%) students, 37 (9,8%) prefer salty food. Tachycardia was observed in 32 (8.4%) students, overweight and obesity - 78 (20.6%). Arterial hypertension was found in 15 (3.5%) students.
Conclusion. In a random sample of students, 21.6% have cardiovascular disease. The most significant influence on the increase of the risk of cardiovascular diseases is hereditary predisposition (28.5% of students). Among the modified risk factors, hypodynamia (22.8%), smoking (21.4%), chronic stress (21.1%), and overweight (20.6%) are more common.
By warning and influencing the most commonly identified risk factors for cardiovascular diseases, we can reduce the prevalence of cardiovascular diseases among young people.

ACUTE CARDIOVASCULAR EVENTS IN INTERNIST PRACTICE

Imran Khan, Zaichenko O.E.

The occurrence of diseases of the cardiovascular system is increasing daily, both in Europe and in Ukraine. The cause is the lack of consciousness of the population about their health and ignorance of the consequences of these conditions.
Objective: To study the awareness of the population about the presence of pathology on the part of the cardiovascular system.
Materials and methods: 136 hypertensive patients were examined (79 women and 57 men), aged from 46 to 75 years. The patients were divided into 3 groups.

Results: The first group consisted of patients with pathology of the cardiovascular system who knew about the occurrence of this pathology in their history. These violations were confirmed by instrumental methods of research (ECG and ultrasound of the heart). This group accounted for about 16% of patients. Among the disorders of the cardiovascular system were: 16% - arterial hypertension with atrial fibrillation (12%) or ventricular extrasystole (4%). The second group was 17.5%, who were partially aware of the occurrence of pathology in the cardiovascular system. In 9.7% of cases, patients were aware of the presence of atrial fibrillation, but did not know about arterial hypertension; in 7.8% of cases they knew about the occurrence of hypertension in them, but did not know about atrial fibrillation. The third group consisted of patients with cardiac pathology who did not know about the occurrence of heart disease. This group included about 66.5% of patients. Among the lesions of the cardiovascular pathology were noted: 22.8% of cases - atrial fibrillation; 14.6% - atrial fibrillation in combination with other rhythm disorders; 12.1% - other rhythm disturbances (atrial or ventricular premature beats); 17.0% - arterial hypertension in combination with arrhythmias.
Conclusions: the main causes of the growth of cardiac complications in the examined patients were atrial fibrillation, arterial hypertension, extrasystole and their combination. More than 65% were patients who did not know about the occurrence of pathology in the heart, which is why they did not receive the necessary therapy in a timely means. Effective methods are: early detection, adequate antihypertensive therapy, antiarrhythmic therapy.

CHANGES IN THE ACTIVITY OF SUPEROXIDDISMUTASE IN PATIENTS WITH A PEPTIC DUODENAL ULCER

Indranil Dey, Zhelezniakova Natalia

Objective: to determine the degree of activity of superoxide dismutase in patients with peptic duodenal ulcer.
Materials and methods: 49 patients with peptic duodenal ulcer and 20 healthy individuals were examined. The diagnosis was established during the evaluation of a set of complaints, anamnesis and instrumental methods of research - video oesophagogastroduodenoscopy with a targeted biopsy and subsequent histological examination of the biopsy. The presence of Helicobacter pylori was determined using the Stool Antigen Test for H. Pylori. The activity of blood superoxide dismutase was determined by a spectrophotometric method according to the degree of inhibition of the reduction of nitro-blue tetrazole (S. Chevari, I. Chaba and J. Sekei). Statistical data has been performed on workstation by means of software “Microsoft Excel” and “Statistica 8.0”.
Results. When determining the activity of the antioxidant enzyme - superoxide dismutase in patients with peptic duodenal ulcer, its significant decrease was detected compared with a group of practically healthy individuals. The level of superoxide dismutase in these patients was 1.48 ± 0.03 units of activity for 1 min. per g Hb. while in healthy individuals, the level of superoxide dismutase reached 2.2 ± 0.14 units of activity for 1 min. per g Hb ($p<0.05$).
Conclusion. The process of formation of peptic duodenal ulcers was associated with the suppression of the activity of the antioxidant defence system, which was manifested by a significant decrease in the activity of its enzyme link, namely, the inhibition of superoxide dismutase.

INVESTIGATION OF PATIENT HISTORY OF GILBERT'S SYNDROME

Kalyuzhniy Ye., Ovcharenko L.I.

Gilbert's syndrome (GJ) - benign prostatitis occurs in the elimination of indirect bilirubin in the liver associated with a decrease in the level of UDFGT-1A1, which leads to an increase in indirect bilirubin within the range of 20-90 mmol / l. The syndrome is based on the mutation of the UGT1A1 gene. The syndrome has an autosomal dominant type of inheritance. Prevalence - 3-7% in

the population. The presence of SC increases the risk of cholelithiasis (indirect bilirubin due to its hydrophobicity and lipophilicity can serve as the basis for the formation of pigmentary (black) stones). Also, during the exacerbation period, asthenic syndrome (toxic effect of bilirubin on the hypothalamus) is characteristic.
The aim of the study. Evaluate clinical manifestations and determine the relevance of Gilbert syndrome in clinical medicine.
Materials and methods. History of diseases of patients with Gilbert's syndrome. Literature data.
Research results. A retrospective analysis was carried out of 20 stories of illnesses of students with Gilbert syndrome that were screened and treated at the Kharkiv City Student Clinic No. 20, from 2007 to 2016. The distribution by gender is 15 men, 5 women, and 18-25 years old. In most cases, the symptoms of the syndrome developed in patients over the age of 12 years, in the history of viral hepatitis in all cases are absent. Heredity was detected in 20% of patients (parents). Main complaints of patients with admission: severity in the right hypochondrium (65%), dyspeptic phenomena (75%), asthenic syndrome (80%), subfibrilitis (55%). In general, in all, jaundice of varying intensity was observed from a slight ictericity of sclera (80%) to severe jaundice (35%). The level of bilirubin was 25-80 μmol / l. Other biochemical parameters: total protein, protein fractions, aminotransferases (AST, ALT), thyme sample, cholesterol, were unchanged. With ultrasound of the liver, in 40% of cases, increased liver was detected. Liver of normal consistency, painless, smooth. Spleen is normal. After 2 weeks of treatment, Barzanov noted improvement. It was recommended to use UDCA to prevent the development of housing and communal services.
Conclusions CJ - hereditary condition, which is characterized by jaundice, asthenic syndrome, high risk of housing and communal services. Having evaluated the history of diseases, we can say that SC is really common in the practice of a Ukrainian doctor. This condition almost does not affect the quality of life of patients. For patients who have been diagnosed with SC, it is advisable to recommend: diet, UDCA, stress reduction, exercise limitation. It is important to remember about the existence of SF during the diagnosis of other diseases and the appointment of drugs in the metabolism of which UDFGT is involved.

INTERACTION OF LIPID EXCHANGE DISORDERS AND HYPERURICEMIA WITH ANTROPOMETRIC INDICATORS IN PATIENTS WITH METABOLIC SYNDROME

Klimenko MI, Shaposhnikova Yu.M.

Objectives: To evaluate the relationship between lipid metabolism and hyperuricemia with anthropometric indicators and risk factors for cardiovascular disease (CVD) in patients with MS.
Materials and methods: The study included 60 patients with MS, whose average age was 45.7 + 1.4 years. The average body mass index (BMI) was 37.6 + 3.3 kg / m2, in 14 patients it was diagnosed with GC I in the 36th - II centuries, besides, in 28 patients, hyperuricemia was diagnosed over 420 mmol / l . Anthropometric parameters were determined for all patients, daily blood pressure monitoring was performed, blood serum levels were determined, glucose content was measured on an empty stomach, and the lipid blood spectrum was estimated by immunoferment method.
Results and discussion: It should be noted that in patients with MS obesity I st. - was detected in 15 patients (25%), II st. - in 40 (66.6%), III century. - in 5 patients (8,3%); Heredity for CVD - the presence of GC in one or both parents - registered in 28 patients (46.6%). A statistically significant relationship was found between age, duration of GC, BMI, OT, maintenance of glucose on an empty stomach and level of uric acid. We found that hyperuricemia, an increase in BMI and OT is accompanied by an increase in the mean daily blood pressure (SDAT) of systolic and pulsed AT (PAT). As a result of the correlation analysis, it was proved that the level of uric acid is closely interconnected with the parameters of abdominal obesity in patients with MS, which is confirmed by statistically significant positive correlation dependencies with OT (r = 069; p = 0.001), ITS (r = 0, 58; p = 0.001), BMI (r = 062; p = 001), as well as for SDAT (r = 0.498; p = 0.012) and PAT (r = 0. 59; p = 0.001). At the same time, patients with MS and hyperuricemia revealed a significant

increase in high values of ZHS (p = 0.046) and LDL cholesterol (p = 0.032), accompanied by a tendency to lower HDL contents.

THE DYNAMICS OF ADIPOCYTOKINES AFTER SIX MONTHS OF TREATMENT WITH SARTANS IN PATIENTS WITH OBESITY AND ARTERIAL HYPERTENSION. IN PATIENTS WITH OZHIRINNYM AND HYPERTENSION

Klimenko N.I., Molodan V.I.

Currently, adiponectin and leptin, which are the most common adipocytokines with opposite effects on the sensitivity of peripheral tissues to insulin, regulation of endothelial function and systemic inflammation activity, are considered as the main linkages between obesity and the development of carbohydrate and lipid metabolism disorders. More and more attention is drawn to the group of angiotensin II receptor blockers (ARBs), especially the representatives of the group, successfully combining both the properties of the RAAS blockers and the ability to cause partial activation of PPAR-γ receptors, which leads to an increase in the effects of the effect on various components of the MS including the synthesis of adipocytokines.

The purpose of the study was to assess the effect of 24 weeks of telmisartan therapy in comparison with candesartan on the secretion of adiponectin and leptin, as well as on the metabolic profile of patients with MS.

Materials and methods. The study included 105 people (60 men and 45 women) aged 36-79 years (mean age 64 ± 2 years) with MS. All patients were evaluated for clinical and antihypertensive efficacy of therapy, somato and anthropometry. The main parameters of fat and carbohydrate metabolism (lipidogram, glycated hemoglobin (HbA1c), immunoreactivity of insulin, glucose), as well as indicators of secretory activity of ST (leptin, adiponectin) were investigated. All patients were randomized to 2 groups: patients of the 1st group (n = 55) received telmisartan (40-80 mg 1 time per day), 2 groups (n = 50) - candesartan (8-16 mg once daily) .

Results and discussion. During the entire observation period, clinical efficacy and reduction in CAD and IGT in both groups of patients did not have clinically significant differences. Both treatment regimens were associated with a significant reduction in total cholesterol and LDL cholesterol compared to baseline. 24 weekly therapy with telmisartan (60%, p <0.01) and, to a lesser extent, candesartan resulted in increased secretion of adiponectin. In this case, the content of leptin was virtually unchanged in the use of candesartan (p <0.05), and decreased when telmisartan was used. Only in patients from the 1st group there was a significant decrease in glucose (P <0.05), and glycated hemoglobin (p <0.05), on an empty stomach.

Conclusion. The results of the study have shown that telmisartan, as a partial PPAR-γ receptor agonist and, to a lesser extent, candesartan, improves metabolic profile and increases the secretion of adiponectin in patients with MS.

EFFECTS OF LOSCARTAN AND KANDESTRAN ON INDICATORS OF ADIPONECTIN AND LEPTIN IN PATIENTS WITH EXTRAORDINARY WEIGHT, HYPERTONIC DISEASE, AND DISORDERS OF TOLERANCE TO GLUCOSE

Klymenko N.I., Zaichenko O.E.

The purpose of the study was to investigate the effect of 6-month losartan therapy versus candesartan on the secretion of adiponectin and leptin, and on the metabolic profile of hypertensive patients, obesity, and cartilage tolerance.

Materials and methods. The study included 44 people (18 men and 26 women) aged 36-70 years (mean age 56 ± 2 years). All patients were evaluated for clinical and antihypertensive therapy, somato and anthropometry (BMI). The main parameters of fat and carbohydrate metabolism (lipidogram, glycosylated hemoglobin (HbA1c), glucose, immunoreactivity of insulin) were

studied, as well as indicators of secretory activity of adipose tissue (leptin, adiponectin), as well as the study of fundus fundus. All patients were randomized to 2 groups: patients of the 1st group (n = 18) received losartan (50 mg once a day in the morning), 2 groups (n = 26) - candesartan (16 mg in the morning 1 time per day).
Results and discussion. During the entire observation period, clinical efficacy and a reduction in systolic and diastolic pressure in both groups of patients did not have clinically significant differences. Both treatment regimens were associated with a decrease in total cholesterol and LDL cholesterol compared to baseline. 6-month therapy with losartan (60%, p <0.01) and, to a lesser extent, candesartan resulted in increased adiponectin secretion. In this case, the content of leptin increased with the use of losartan (p <0.05) and decreased with the use of candesartan. Along with this it should be noted in patients with group 1 there was a decrease in glucose (P <0,05), and glycosylated hemoglobin (p <0,05), on an empty stomach. At the fundus day there was a decrease in convulsive vessels,
Conclusion. The results of the study showed that losartan, as a partial PPAR-γ receptor agonist, and to a lesser extent candesartan, improve the metabolic profile and increase the secretion of adiponectin in patients with hypertension, obesity, and carbohydrate tolerance. Losartan is indicated to patients with a disturbance of carbohydrate tolerance and an increase in glucose levels, since, it contributes more to lowering glucose levels in serum and reduces the manifestations of retinopathy.

ANTROPOMETRICAL PARAMETRES AND CLINICAL MANIFESTATION FEATURES IN NAFLD PATIENTS WITH NON-ALCOHOLIC STEATOHEPATITIS

Lapshyna K., Kydin I.

Nonalcoholic fatty liver disease (NAFLD) is one of the most common causes of chronic liver diseases in both developed and developing countries. The prevalence of the disease is estimated by statistics at 25-30%.
Objective: assessment of the trophic status and clinical manifestations in patients with NAFLD in stage of non-alcoholic steatohepatitis (NASH).
Materials and Methods: The study involved 30 patients with NAFLD in NASH stage. The average age of the patients was (47,60 ± 3,7) years, participated 16 (53%) men and 14 (47%) women. All patients were diagnosed with NAFLD in NASH stage, traditional clinical and laboratory studies, assessment trophological status and lipid metabolism were done.
Results: The body mass index (BMI) in the examined patients was 29.6 kg / m^2, while 36% (11) were diagnosed with
first degree of obesity. Also the ratio of WC/HC was increased in patients with NAFLD and was 1.02 ± 4.6, indicating a tendency to abdominal obesity.
Analysis of clinical manifestations characteristic of diseases of the gastrointestinal tract in patients with NAFLD showed that 40% (18/30) of the patients complained of flatulence, 47% (14/30) reported a discomfort in the abdomen, 30% (9/30) patients were disturbed by propensity to constipation and pain in the upper right quadrant.
Conclusions: patients with NAFLD in the stage of NASH, BMI corresponded with a stage of fattening, and in a third of cases obesity was found in first degree of obesity. Also, for patients with this pathology is characterized by the presence of abdominal obesity. Analysis of clinical manifestations revealed the prevalence of such symptoms as flatulence, discomfort in the abdomen, propensity to constipation and pain in the upper right quadrant.

NON COMPACT LEFT MYOCARDIAL VENTRICLE: AN EXAMPLE OF A RARE DISEASEIN CLINICAL PRACTICE

Lola N.V., Panchenko G.Y.

Noncompact myocardium of the left ventricle (NMLV), or "spongy" myocardium, is one of the rare primary cardiomyopathy, which is characterized by excessive the development of trabeculae with the formation of deep niches, communicating with the cavity of the left ventricle (LV), but not with coronary arteries. It's genetically caused myocardial damage, manifesting manifestations of heart failure (HF), arrhythmias, thromboembolism and concomitant high risk of sudden cardiac death. As a separate nosological form of NMLV singled out relatively recently. This pathology occurs in children much more often than in adults. The first description of LVHL appeared in the literature. in 1986, the authors reported that a 33-year-old woman preserved ventricular sinuses, characteristic for the heart in the prenatal period, the presence of which accompanied by severe cardiomyopathy with lethal outcome that was confirmed at autopsy. By 1990, 8 cases of this diseases, its definition is given and the abbreviation is introduced LVNC (left ventricular non-compaction). It is believed that the main cause of NMLV, is an imperfect embryogenesis, as a result of which normal development is disrupted myocardium. The disease can debut as in the neonatal period, and at a later age. Patients with LVV may experience abnormalities. rhythm, symptoms of LV failure, less often thromboembolism. Cyanosis is also described in childhood. poor weight gain and dysmorphic symptoms. Quite a lot of cases of NMLV diagnosed during the examination of families of patients with NMLV or as an accidental find during routine examination hearts. The diagnosis of NMLV is established by the results echocardiography (echocardiography), another reference The method of its diagnosis is magnetic resonance tomography of the heart. With EchoCG, LV sponge is represented by trabeculae, Which h correspond in density to densitymyocardium and move synchronously with LV myocardium during his cuts]. The basis of therapeutic tactics in patients with spongy myocardial prophylaxis and treatment of HF, disorders heart rate and thromboembolic complications. Some patients are recommended heart transplant, sick with "malignant" rhythm disorders show the implantation of a cardioverter-defibrillator. I would like to note that the isolated spongy LV myocardium - a rarely occurring disease, leading to the development of HF. In the literature there are evidence of hereditary character this pathology, in particular, that non-compact heart muscle may be the result chromosomal aberration (chromosome X, q28). Since there are clinically healthy individuals, which reveals a characteristic picture of "spongy" myocardium, apparently, this pathology is predisposing to the development of chronic HF in the presence of additional factors (intoxication, maximum physical activity, etc.).

MYOCARDIAL REMODELING AND CHANGES IN BIOCHEMICAL PARAMETERS IN PATIENTS WITH CHRONIC HEART FAILURE AND HYPERTENSION

Maher Z., Shalimova A.S., Prosolenko K.A.

The results of the studies of the last decade have led to the need for a revision of the views on the pathogenesis of chronic heart failure (CHF). It has been proven that the remodeling of the heart and blood vessels, being a pathogenetic component of the regulation of vascular tone and homeostasis under conditions of chronic increase of systemic arterial pressure, becomes a predictor of progression and complicated flow of arterial hypertension (AH), determining the results of the cardiovascular continuum. It has been established that at the subcellular level, the remodeling involves the development of fibrosis, the change in the relative position of cardiomyocytes, the output in the vascular line of proinflammatory cytokines and growth factors, the initiation of apoptosis processes. Manifestations of damage of target organs in AH are hypertrophy (myocardium and vascular walls), dysfunction (systolic and diastolic left ventricular (LV), renal, endothelial) and atherosclerosis. They are interconnected as a single growth factor, as well as by general pathogenetic processes, which ultimately determines the patient's prognosis.

Summing up the above facts it can be noted that the mechanisms of development and progression of CHF in hypertension require further refinement.
The purpose of the work was to optimize the diagnosis of CHF in the context of AH on the basis of establishing the relationship between structural and functional changes in the heart and biochemical parameters in these patients.
The examination was performed on 65 patients with CHF I-IIA stages on the background of 1-2-degree AH (24 patients with 1 degree AH and 41 patients with 2 degree AH). There were 30 (46.2%) men and 35 (53.8%) women aged 38 to 61 years, the mean age (51.45 ± 0.91) years. The control group consisted of 15 practically healthy persons, whose CHF and AH were excluded on the basis of a complex of clinical and instrumental examinations.
As a result of the study, it was found that with an increase in the degree of AH in patients with CHF +AH, the geometry of LV changed due to increased cases of various variants of remodeling, including prognostically unfavorable (eccentric hypertrophy), as well as the progression of the degree of diastolic dysfunction.
In patients with CHF in the background of AH, with an increase in the degree of hypertension, there was a decrease in the C-terminal telopeptide prolactogen-I, an indicator of myocardial fibrosis, which indicates the degree of collagen degradation, as well as an increase in the brain natriuretic peptide (BNP).
Between the value of BNP and echocardiographic parameters, correlations of different orientations were established: direct - with the maximum speed of the early atrial filling and the ratio of filling rates, reverse - with the ejection fraction and the time delay of the velocity of the early diastolic flow.
It was established that at CHF on the background of AH, the level of BNP is substantially related to the CHF stage and to a small extent with the type of transmitral blood flow.

ACTIVITY OF DIEN CONJUGATES IN PATIENTS WITH PEPTIC DUODENAL ULCER

Monika Rani, Zhelezniakova Natalia

Objective: to determine the degree of changes in the indices of free radical oxidation of lipids in patients with peptic duodenal ulcer on the activity of diene conjugates.
Materials and methods: 49 patients with peptic duodenal ulcer and 20 healthy individuals were examined. The diagnosis was established during the evaluation of a complex of complaints, anamnesis and instrumental methods of research - video esophagogastroduodenoscopy with a targeted biopsy and subsequent histological examination of the biopsy. Helicobacter pylori was determined by urease and enzyme immunoassay tests, as well as by histological examination of the biopsy. The blood levels of diene conjugates were determined spectrophotometrically by the method of B.V. Gavrilova and M.I. Mishkorudnoy. Statistical data has been performed on workstation by means of software “Microsoft Excel” and “Statistica 8.0”.
Results. It was revealed that the active phase of peptic duodenal ulcer was accompanied by an increase in the content of the primary products of lipid peroxidation compared with the indices of practically healthy individuals. Thus, the level of diene conjugates in patients with peptic duodenal ulcer was 20.3 ± 1.2 μmol / l, in patients. While the indicators of practically healthy individuals reached only 9.2 ± 0.7 μmol / l. Differences in performance were statistically significant.
Conclusion. The presence of active peptic duodenal ulcer is manifested by impaired free radical oxidation of lipids, which is accompanied by a significant increase in diene conjugates, which are its primary products.

RARE SYNDROMES AND DISEASES

Namrata Pal, Zelena I.I.

Rare (or orphan) diseases are a large group of pathologies, the prevalence of each of which in the general population does not exceed 1 patient per 2000 people (this is the criterion adopted in the European Union). In Russia, rarely, it is proposed to consider the diseases "with a prevalence of no more than 10 cases of the disease per 100 thousand population" (i.e., 1 patient per 10 thousand people). Here are some examples of rare and atypically leaking diseases

Rare and atypical manifestations of rheumatism: vasculitis, pneumonia, pleurisy, peritonitis, gastrointestinal disorders, spleen, pancreatic and liver damage, endocrine pathology (thyrotoxicosis, impaired sexual function, damage to the pituitary gland)

Joint illnesses: Bechterew's disease, intermittent hydrathritis, Titus's syndrome, toxic allergic polyarthritis caused by a specific infection (Tuberculosis-allergic polyarthritis of Grocco-Ponce, syphilitic, gonorrhea, post salmonellosis polyarthritis, dysenteryal arthritis, joint damage in patients with Crohn's disease, viral hepatitis, influenza) , alkaptonuria and ochronez, Knist's syndrome, Pellegrini-Stidy's syndrome, Leven's disease, Hoff syndrome, Morton's disease, congenital arthropathy and unknown etiology (Timan's disease, periarthrosis Hooke, Kenig's disease), zygote arthritis, arthropathy in blood diseases (hemarthrosis in hemophilia, arthritis with myeloma, thrombocytopenic purpura), arthropathy in endocrine diseases (acromegalic arthropathy, Recklinghausen's disease in the parathyroid gland adenoma), arthropathy in pulmonary diseases, paraneoplastic, medicinal arthropathies.

Systemic connective tissue diseases:

Mixed connective tissue diseases (Sharp syndrome), cross-linked forms of systemic connective tissue diseases (systemic scleroderma and polyomyosis, systemic scleroderma and rheumatoid arthritis, rheumatoid arthritis and systemic lupus erythematosus, etc.)

Significant difficulties in the diagnosis of this group of diseases arise when the most commonly occurring manifestations of the disease are absent (skin changes - with systemic lupus erythematosus, skin and subcutaneous tissue - in scleroderma, joints - in rheumatoid arthritis), and there is only an isolated lesion of the internal organs . These include, for example, defeat of the esophagus in scleroderma, isolated lesion of the heart, liver with systemic lupus erythematosus, etc.

Rare forms: Duplia syndrome, Timan-Fleischner syndrome, keloidosis, diffuse eosinophilic fasciitis

Doctors of any specialty in their practice can face both rare diseases and with atypical manifestations of a fairly common pathology. Thus, the surgeon may be confronted with an atypical nature of the pain syndrome with acute appendicitis in the case of a pelvic location of the appendix; the gastroenterologist or therapist may experience atypical manifestations of gastroesophageal reflux disease (coma feeling in the throat, cough, heart rhythm disturbances), cardiologist with atypical pain syndrome Myocardial infarction (pain in the region of the mandible, in the upper abdomen). In connection with this, the task of the doctor of any specialty is the timely recognition of these atypical and rare syndromes and the definition of further tactics of conduct.

UNUSUAL DISEASES OF THE HEART AND BLOOD VESSELS

Nitesh Sharma, Zelena I.I.

In nature there is a huge number of diseases that occur in the human population. Many of them are very dangerous and lead to death. Find out all about rare, truly unusual heart disease and vascular diseases that sometimes come across in our lives. What symptoms do they have and how do they affect human health?

Congenital absence of pericardium. Fainting heart, in which there is a complete or partial absence of an ocular-bearing bag. This is due to the wrong bookmark in the fetal period. Etiology is unknown. Prevalence: about 300 cases worldwide. Clinic: pain sensations in the chest area without

exercise, often accompanied by ischemic attacks, heart rhythm failures. Treatment: the creation of an artificial ocheroserdechnoy handbag. Forecast: Untreated treatment.
Cerebral amyloid angiopathy Amyloid is a protein that is normally absent in the body. With prolonged current diseases, it develops and setstles in the internal organs, causing even more problems. Including on the walls of the vessels of the brain, which leads to their closure. Blood flow is disturbed and stroke develops. Most often this pathology occurs in the elderly. Prevalence: up to 1% of the population. Clinic: non-specific (from transient ischemic attacks and headaches to stroke). Treatment: not developed. Forecast: unfavorable.
Cardiovascular syphilis In rare cases, the syphilitic infection affects the cardiovascular system in isolation. It can affect both the walls of the aorta and the valves. Often syphilis affects the conducting system of the heart and coronary arteries. Prevalence: up to 5% of all patients with syphilitic infection. Symptoms: frequent manifestations include cardiac arrhythmias, valve failure, angina attacks, left ventricular insufficiency. Treatment: long-term antibiotic therapy (penicillins, tetracyclines). Forecast: at a slow course and timely initiated treatment is favorable.
Generalized atherosclerosis Formation of atherosclerotic plaques in vessels of different sizes in different organs and tissues. The main reason lies in metabolic disorders, due to which excessive accumulation of cholesterol in the vascular wall occurs. Prevalence: up to 2% of the population. Clinic: Depends on the place where the atherosclerotic plaque forms. Infections of organs are observed in the zone of defeat. Treatment: balanced nutrition and taking drugs that lower blood cholesterol. Forecast: with timely detection and treatment favorable. Most perechyslennыh rarely boleznej heart and vessels formyruyutsya eschë in the embryonic period, Therefore beremennым How Everybody Need a trail for svoym Health and ustranyat all vrednые factors.
Cairns-Seyra Syndrome Represents mitochondrial cardiomyopathy, based on the mutation of DNA genes. The debut of the disease falls under the age of 20 years. He has no addiction to race or sex, and there are no known risk factors. Prevalence: 1 per 10,000 people. Clinic: lowering the eyelids, retinopathy and heart rhythm disturbances in the type of elongation of the P-R interval, symptoms of cardiac blockade. Treatment: not developed. Forecast: with a mild course favorable.

SOME USEFUL ISSUES OF THE INTERNET OPPORTUNITIES IN THE MEDICAL EDUCATION

Oladjide T., Prosolenko K.O.

The use of Internet resources in medical education today is a generally accepted and highly effective learning tool. This primarily concerns the use of the Internet as sources of useful (often free) literature, the use of special, thematic sites, participation in webinars, etc.
At the same time, modern standards for the diagnosis and treatment of diseases of the internal organs dictate the need to use special indicators, both for the diagnosis of diseases, and for determining the prognosis of the disease. One of the most important diagnostic indicators is the glomerular filtration rate (GFR), which is to be expected in a large number of patients with a therapeutic profile, primarily in patients with chronic kidney disease and hypertension. Without defining this parameter, the correct formulation of the diagnosis in this group of patients is impossible. Indicator GFR is determined by several complex formulas (Cockroft-Golt formula, MDRD, CKD-EPI and others). Calculation of this indicator can be difficult for a doctor without the use of special computer programs and can lead to an incorrect diagnosis.
An example of a "prognostic" ratio may be the Model for End-Stage Liver Disease (MELD), which was developed and published in 2001 by experts from the famous Mayo Clinic. The indicator was developed for patients with chronic liver disease, primarily liver cirrhosis, and today its use is necessary for a correct assessment of the prognosis of the disease and included in the current international protocol of patient management. The calculation formula is also quite complex: MELD = 10 × (0.957 Ln (creatinine level) + 0.378 Ln (total bilirubin level) + 1.12 (INR) + 0.643 × X), where X = 0 for alcohol or cholestatic etiology, X = 1 for other cause of the disease); INR - is

an international normalized ratio. Interpretation of MELD Score in hospitalized patients is carried out in the context of 3-month mortality, which is: at the rate of 40 or more - 71.3%, at 30-39 - 52.6%, at 20-29 - 19.6%, at 10-19 - 6.0% , with <9 - 1.9% mortality.
It should be noted that today physicians have no problems with the availability of mobile Internet devices such as smartphones and tablet computers. Most medical sites that contain online calculators have mobile versions and the doctor can use them even while on the move in the department. An important point in using these and other indexes is the source (website) of information. Validated sites must be used to calculate the indicators.
Thus, the use of diagnostic and prognostic ratio in the management of therapeutic patients is recommended. Using online calculators to determine these indicators can optimize the cure of therapeutic patients.

IDIOPATHIC VENTRIC FIBRILLATION INDUCED BY VAGUS ACTIVITY

Ostah O.V., Panchenko G.Y.

Idiopathic ventricular fibrillation (VF) in patients without signs of organic heart disease is found in 4-10% of all cases of VF. In the foreign literature, due to the presence of a computer data bank, information on this problem is quite widely represented. Despite this, the available literary data today are very controversial, and the causes of such arrhythmias, often fatal, remain unclear. Three different variants of idiopathic VF are described that do not exclude the relationship between them: 1. In 1922, Brugada P. first described the syndrome, which included an ECG picture of a complete blockade of the right bundle of His and an ST segment elevation in the right chest leads (V1-V3). To date, about 200 such cases have been described. There are observations of asymptomatic patients for a long time with this ECG phenomenon, who subsequently had VF registered. In addition, latent Brugada syndrome with intermittent ECG signs that appear suddenly or after drug stimulation has been described. Ongoing research in this direction suggests the presence of genetic defects in Na-channels. It is believed that Brugada syndrome is a type of arrhythmogenic dysplasia of the right ventricle. 2. In the early 60s, there were mentions of sudden death syndrome in men from Japan, Laos, the Philippines, and Thailand. The community of racial origin, the exposure of this disease exclusively to young (25–40 years old) men, and death during sleep have made it possible to isolate this disease into a separate form, the cause of which is also not completely clear. The assumption of an acquired defect of the LQTS gene associated with thiamine deficiency remains controversial. 3. Finally, idiopathic VF with an unchanged ECG occupies the third place in this classification. This variant of VFs constitute 1% of all cases of VFs that occurred on an outpatient basis. About 14% of them are patients younger than 40 years old, among which both men and women are found with the same frequency. Sudden death caused by VF is usually the only and in most cases a fatal manifestation of this disease. Many patients survived only due to the fact that cardiac arrest occurred in the intensive care unit shortly after the development of the first arrhythmic syncope. Repetitions of paroxysms after a different number of years are described, but the so-called “arrhythmic storms”, which are numerous episodes of VF, often develop in the first 24 hours from the moment of hospitalization (25% of cases), that is, from the moment of the first loss of consciousness. It has been observed that in many cases, single ventricular ectopic complexes with a very short adhesion interval initiate rapid polymorphic ventricular tachycardia (VT), which is then transformed into VF. However, pause-dependent polymorphic arrhythmias have also been described. Most authors are inclined to believe that the re-entry mechanism is the basis of the pathogenesis of idiopathic fibrillation. It has been suggested that the focus of arrhythmogenesis is located in the anterior wall and the outlet part of the right ventricle.

APPLICATION OF DIABETON MR IN PATIENTS WITH ARTERIAL HYPERTENSION WITH COMORBIDITY

Ovcharenko L. I., Milko A. Yu.

Topicality. Diabetes mellitus (diabetes mellitus) is a common pathology whose frequency is steadily increasing in the world. Data from international studies indicate that patients with type 2 diabetes have an increased risk of developing diabetic nephropathy (DN) and cardiovascular disease, leading causes of mortality in patients with diabetes and a major factor in the development of chronic renal failure. The main purpose of the treatment of type II diabetes is to achieve the target values of glycemia.

Goal. On the basis of the analysis, determine the presence and effectiveness of the protective effect of Diabetic MR on vascular endothelium and renal function.

Materials and method of research. Retrospective analysis of disease histories of 25 patients with compensated type II diabetes (I-III stage moderate and moderate arterial hypertension), a comparison group - 20 patients with hypertensive disease (GC) without diabetes, and a control group of 10 healthy individuals. All patients in the main group and the comparison group received baseline antihypertensive therapy with the use of an ACE inhibitor perindopril from 2 to 8 mg per day. All patients with diabetes were prescribed diabetic MR in a dose of 30 to 90 mg per day, depending on the level of glucose in the blood, treatment was performed for 1 year. The concentration of albumin in urine and the activity of elastase, the concentration of cathepsin G, the elastase-inhibiting activity of α-1-proteinase inhibitor (α-1-IP) in serum in dynamics was determined by the immunoassay method. The content of nitrite in plasma of venous blood was determined by photometric method after the reaction of Gris.

Results and discussion. In all patients with diabetes, under the influence of treatment with Diabetic MR, a gradual dose-dependent decrease in the level of glycemia was noted to 6.1 + 1.2 mmol / L. There was a decrease in the activity of elastase in patients with diabetes mellitus type II with DN than in patients with GC II st. The content of nitrite in the blood plasma of patients with diabetes with an increase in the duration of the disease significantly decreased, especially in the stage of proteinuria. Perindopril was prescribed, there was a positive effect on the endothelial function, which was expressed in increasing the content of nitrite and reducing the content of the amount of nitrite nitrate. By incorporating glyclazide into the treatment regimen in the above-mentioned doses, we have received additional positive effects on the endothelial function (further increase in the content of nitrite and the reduction of the content of the amount of nitrite + nitrate). The most expressive effect was observed in patients with normal nervous system normoproteinuria under conditions of use of the combined treatment regimen (decrease by 39%, $p < 0,05$). It was determined that diabetic MR had an additional nephroprotective effect when compared with perindopril treatment. Approximately 68% of the patients examined with microalbuminuria after a year of taking the drug, microalbuminuria was not determined.

Conclusions Diabetic MR except for a significant hypoglycemic effect has a positive effect on the exchange of nitric oxide (nephroprotective effect) and should be used as the first line drug for the treatment of diabetes mellitus.

FEATURES OF THE PROTECTION OF DISEASE DIAGNOSIS IN SICKNESS SYNDROME

Ovcharenko L.I., Batalina D. D.

Topicality. At present, the significance of Gilbert syndrome is very low. But research shows that in recent times the frequency of encounter is increasing every year. So, according to recent data: In Asian countries, 16-33%, in some ethnic groups in Africa exceeds 50%, in countries of Europe 35-40%. The prevalence of males and females is 4: 1, respectively. This syndrome occurs due to a genetically determined defect of the gene encoding the enzyme, which plays a major role in the metabolism of bilirubin (uridinidophosphate-glucuronyltransferase).

The purpose of the study. Determination of peculiarities of biliary tract disease in patients with Gilbert's syndrome ..
Materials and methods. To address this issue, a group of 80 people (age + - 25) with Gilbert syndrome was examined. All patients had the following examinations: a general blood test, a general urine test, a biochemical analysis (ALT, AST), an ultrasound examination of the abdominal cavity, etc.). All correlation coefficients were calculated using Pearson's linear pairwise correlation method.
Results and discussion. During the study we were able to determine the incidence of biliary tract disease in patients with Gilbert's syndrome. (60-65%). The jaundice in them was constant and accompanied by a dashing skin itching. The feeling of all has always been bad. In the course of this study, it was found that both women and men between 20 and 30 years of age with Gilbert's syndrome dominated the hypothalamic type of gallbladder dysfunction than the Oddi sphincter dysfunction or the hypermotor type of the gallbladder dysfunction.
Conclusion. This survey helped establish that the most frequent in patients with Gilbert's syndrome are biliary tract disease. This is due to the functional connection between the biliary tract, the liver, the upper parts of the gastrointestinal tract, and also the violation of the rheological properties of bile and its composition (which is characteristic of Gilbert's syndrome). At the moment, the problem that we are considering should be taken into account by all doctors, because its significance is very low. But, unfortunately, complications are getting bigger and the incidence of syndrome is increasing.

COMBINED TREATMENT OF PATIENTS WITH HYPERTONIC DISEASE AND COMBINING STATE

Ovcharenko L.I., Polikov G.O.

Topicality. The problem of combining hypertension (GC) and type 2 diabetes mellitus (CDII) is relevant to modern medical science. The risk of cardiovascular complications (MDS) exceeds 2-5 times. It is expected that with preservation of the existing rates of growth of morbidity by 2025, there will be 380 million patients with diabetes, 90% of which will be patients with diabetes II. The combination of these two pathologies accelerates the diffuse lesion of the vascular bed from capillaries to major vessels. Particular attention is paid to insulin-like growth factor-1 (IGF-1).
The purpose of the study. Determination of the effect of combination therapy on the parameters of cardiovascular remodeling in patients with GHTATs II type.
Materials and methods. Retrospective analysis of the history of the disease in 39 patients with GC and type 2 diabetes: 18 (46%) men and 21 (54%) women. Patients ranged from 45 to 69 years. The average duration of GC - 13,5 (1,6) years, the average duration of type II diabetes - 7,9 (0,9) years. Antihypertensive treatment was performed using perindopril in a dose of 10 mg and amlodipine in a dose of 5-10 mg. As a hypolipidemic agent, atorvastatin was used in a dose of 10-20 mg. Depending on the type of antidiabetic treatment, the patients were divided into two groups: 21 patients received metformin at a dose of 1000-2000 mg and 18 patients - metformin at a dose of 1000 mg in combination with a long-acting gliclazide in a dose of 30-90 mg.
Results and discussion. After 12 months of combination therapy, there is a significant decrease in blood pressure (BP). Thus, the average indicators of systolic blood pressure (SAT) decreased from 200.4 to 140.3 mm Hg. Art., average diastolic blood pressure (DAT) - from 117.1 to 90.3 mm Hg. Art. ($p < 0.05$). Target blood pressure was achieved in 30 patients (77%). The use of metformin combination therapy was accompanied by a significant decrease in the level of IGF-1 - 70.7 ng / ml before treatment and 125.0 ng / ml in the dynamics of therapy. With the combination of metformin and gliclazide, no reliable changes in the level of IGF-1 in the blood in the patient after 12 months of treatment have not been established.
Conclusion. Combination therapy in patients with type II gCTDs, perindopril, amlodipine, atorvastatin and antidiabetic drugs - metformin or a combination of metformin with gliclazide,

showed a marked antihypertensive effect, inhibited cardiovascular remodeling. Treatment of patients with type 2 diabetes with the use of metformin resulted in a significant decrease in the level of IGF-1 in the blood.

MODERN APPROACHES TO TREATMENT OF PATIENTS ON RHEUMATOID ARTHRITIS

Ovcharenko L.I., Zavgorodniy A.C.

Relevance. Rheumatoid arthritis (RA) is a chronic systemic disease with a complex autoimmune pathogenesis, a predominant affection of small joints and systemic inflammatory lesions of internal organs. The genetic predisposition plays an important role in the development of RA (HLA DRB1, PTPN 22, CTLA4 b, etc.). Among the population, the prevalence of RA exceeds 1.0%.
Purpose: on the basis of a retrospective analysis and analyzed literary sources, to indicate the main modern approaches to treatment of RA. The purpose of treatment of RA is to minimize the symptoms of cumulative inflammation based on early diagnosis and early aggressive treatment with biological anti-inflammatory drugs (BP).
Materials and methods: BPVP can be used as the first and second line of therapy in patients with high activity and adverse prognostic factors. According to EULAR and ACR recommendations, methotrexate is used as a starting drug in monotherapy or in combination with other essential antirheumatic drugs. Combination therapy with methotrexate and BPVP is better for achieving remission than monotherapy methotrexate.
In recent years, IL-6 has attracted the attention of the researchers - the pleiotropic cytokine, which is synthesized by many cells (T- and B-lymphocytes, fibroblasts, endothelial cells, monocytes, etc.) that are involved in the development of inflammation, and manifests a wide range of pro-inflammatory biological effects. The first humanized blocker of IL-6 tocilizumab has been approved for use in Europe after a long study and several studies that demonstrated clinical efficacy in patients with inadequate response to PPV and anti-FNP-α drugs.
Results: AMBITION study was conducted to evaluate the efficacy and safety of tocilizumab (8 mg / kg) as compared to methotrexate in patients with active RA. The study showed that considerably more patients achieved ACR20 after the 24-week treatment when compared with methotrexate (70% vs. 53%). Other biological products do not exhibit advantages over methotrexate in this important clinical setting. In addition, in the treatment of tocilizumab in monotherapy, remission was achieved approximately 3 times more often (34% vs. 12% of cases) than in patients receiving methotrexate alone.
Conclusions: Early aggressive therapy, aimed at controlling the symptoms of RA, allows for remission. The emergence of biological therapy has provided the solution to this problem in 50% of patients during the first year of the disease. Other 50% of the inability to achieve remission is associated with an inadequate response to therapy, contraindications to aggressive treatment, drug resistance, and serious adverse reactions.

SECRETS OF "PERIODIC" OR "ARMENIAN" DISEASE

Panchenko G.Y.

Clinical manifestations of the disease are due to the abuse of alcoholic beverages and alimentary poisoning, as well as climatic factors.One of the most mysterious diseases today is the "periodic" illness, also called "Armenian" or "Yerevan" disease."Armenian" disease is characterized by periodic acute attacks of severe abdominal pain, sometimes in the chest and joints, and fever. After an attack lasting 2-3 days, the patients quickly recover, recover fully able to work. The disease is chronic and can last for dozens of years.

Clinical manifestations of the disease are due to the abuse of alcoholic beverages and alimentary poisoning, as well as climatic factors. For example, residents of Russia may experience exacerbations during the off-season.

An ancient illness

There is a popular opinion that once the disease is called "Yerevan" or "Armenian", it is only found among Armenians. But this is a delusion, because this disease is susceptible to representatives of peoples with "ancient" genes.

The name "Armenian" was due to the fact that it is mostly found in representatives of nationalities, whose ancestors lived in the Mediterranean basin - especially Armenians, Jews, Arabs. Among other nationalities, this rare genetic disease, sometimes also referred to as the "Mediterranean family fever", is rarely seen in only 6% of cases.

Armenian experts say that calling this disease "Yerevan" is incorrect, since it has nothing to do with the Armenian capital.

A bit of statistics

As a whole, there are more than 20 thousand people living in Armenia today who suffer from "Armenian" illness. Moreover, according to the Republican Center for Children's Periodic Disease at the Arabkir Medical Center, over 2700 children under the age of 18 with a "periodic" illness have been registered. The dynamics of morbidity is quite significant: annually new cases of "periodic" illness are detected in about 300-500 children.

Symptoms of periodic illness

Most often, the onset of a "periodic" illness starts suddenly: acute and painful pains arise in the abdominal cavity and spread throughout the body. At the time of the attack, the patient can not clearly outline his condition. Sharp pain may be accompanied by high fever, chills, feelings of depression, restraint, sometimes aggressive reactions are possible, the skin darkens, dark circles are formed under eyes, the patient's pulse is felt weakly, in extreme cases it is possible loss of consciousness.

The condition of the patient can be somehow eased - warming drink helps, the patient can hide, help him warm up. If the patient has urges to vomit, you should not use antiemetic drugs - if he is released from "excess" in the body, this will not only not hurt, but will also ease the condition at times.

The treatment of "Mediterranean fever" is most often medication. In any case, "periodic" illness is not a verdict. The most important thing is to set yourself up for proper treatment in time, because the unconscious person does miracles.

LEVEL OF MALONDIALDEHYDE IN PATIENTS WITH PEPTIC DUODENAL ULCER

Pooja Magendra, Zhelezniakova Natalia

Objective: to determine the degree of changes in the indices of free radical oxidation of lipids in patients with peptic duodenal ulcer.

Materials and methods: 49 patients with peptic duodenal ulcer and 20 healthy individuals were examined. The diagnosis was established during the evaluation of a complex of complaints, anamnesis and instrumental methods of research - video esophagogastroduodenoscopy with a targeted biopsy and subsequent histological examination of the biopsy. Helicobacter pylori was determined by urease and enzyme immunoassay tests, as well as by histological examination of the biopsy. The content in the blood of malondialdehyde without initiation, as well as with the initiation of NADPH2 and ascorbate, was estimated by the method of Yu.A. Vladimirova and O.I. Archakova. Statistical data has been performed on workstation by means of software “Microsoft Excel” and “Statistica 8.0”.

Results. In patients with active peptic duodenal ulcer, a significant increase in the content of malondialdehyde was found in comparison with the indices of practically healthy people. The levels of malondialdehyde without initiation in these patients amounted to 9.6 ± 0.5 μmol / l, and

malondialdehyde with initiation of NADPH2 - 12.9 ± 0.8 μmol / l. In healthy individuals, the following results were obtained - malondialdehyde without initiation 7.00 ± 0.22 μmol / l, malondialdehyde with initiation of NADPH2 8.24 ± 0.23 μmol / l. The differences between the groups were significant.

Conclusion. The phase of exacerbation of peptic duodenal ulcers was associated with impaired lipid peroxidation, which was manifested by a significantly more pronounced increase in its primary products, namely malondialdehyde.

JAUNDICE IN HEPATITIS B VIRUS INFECTION

Rakhmanov R., Shahab A. M., Vizir M. O.

Background

Yellow staining of the skin and sclera as a result of abnormally high bilirubin levels in blood. Bilirubin is a yellow-colored product that remains in the bloodstream after the catabolism of iron (heme) to remove it from the blood. The conjugated bilirubin is a product of combination of bilirubin with glucuronic acid facilitated by enzyme glucuronyltransferase inside the liver, this substance is water soluble.

The pathogenesis of hepatitis B virus (HBV) is due to the interaction of the virus and the host's immune system, which leads to liver injury and, potentially, cirrhosis and hepatocellular carcinoma. Patients can have either an acute symptomatic disease or an asymptomatic disease.

Icteric hepatitis is associated with a prodromal period, during which a serum sickness–like syndrome can occur.

Purpose

Hepatitis B virus infection is a dominant and leading public health problem worldwide; roughly 30% of the world's population show serological evidence of current or past infection. The aim is to find and existing correlation between jaundice and hepatitis B virus infection.

Methods

Reviewed 107 cases based on scientific researches conducted by the Dhaka Parishahar Clinic in Bangladesh. These patients had jaundice caused by HBV with different race, age and sex.

According to patients' anamnesis of life, it was uncoevered that most of the patients 83 (77%) were infected with HBV through sexual contact, 11 (10%) patients were drug addicts and infected by using shared and used needles multiple times, 11 (10%) patients were infected by medical, surgical and dental procedures, 1 (1%) patient was infected through tattooing, 1 (1%) patient through nail polishing.

Levels of bilirubin, and serological markers namely HBsAg, HBeAg, HBcAg were used to determine the presence of jaundice and hepatitis. Since jaundice is the main syndrome in hepatitis and can be detected through bilirubin levels, and hepatitis can be detected most accurately with the aid of serological markers.

Results

All 107 (100%) patients presented with jaundice. Level of bilirubin detected is > 3mg/dL.

Serology: 99 (92%) detected with Hepatitis B surface antigen (HBsAg); 72 (67%) detected with Hepatitis B e antigen (HBeAg); 15 (14%) detected with Hepatitis B core antigen (HBcAg)

Conclusion

Cessation of the tests revealed that patients infected by HBV presented with jaundice, due to hepatocellular failure. The first serologic marker of infection to appear is HBsAg, which was established in a majority of the patient group. HBeAg is often present during the acute phase and indicates a highly infectious state. HbcAg never presents itself in blood, it can be found only in hepatocytes by biopsy, which was performed in 15 patients.

EFFICACY OF ROSUVASTATIN IN PATIENTS WITH UNSTABLE ANGINA

Ravi Kumar, Zaichenko O.E.

The aim of the study is to study the effect of rosuvastatin on the functional activity of platelets in patients with coronary artery disease with unstable (progressive) angina pectoris.

Materials and methods

47 patients with coronary artery disease with clinical manifestations of PSN were examined. The average age is (49.3 ± 3.7) years. The control group (K) consisted of 10 healthy individuals aged 35–50 years.

The patients were divided into two groups: the first group (n = 23) received aspirin 75 mg + clopidogrel 75 mg per day, low molecular weight heparins, ACE inhibitors, beta-adrenergic blockers, the second (n = 24) - additionally rosuvastatin at a dose of 20 mg. Platelet aggregation activity was studied by the turbidimetric method, the aggregation rate (CA) was determined and the total aggregation index (SIAT) was calculated using the formula: SIAT = ((E1-E2) / (E1-E_{PPP})) x 100%, where: E1 is the optical density platelet-rich plasma (PRP) prior to aggregation; E2 is the optical density of the PRP after aggregation; E_{PPP}. - optical density of platelet-poor plasma.

The survey was conducted on admission, on the 14th and 30th day from the start of lipid-lowering therapy.

Results: The initial increase of SIAT in ADP-induced aggregation in patients with PSN compared with the control group ($p < 0.05$) was revealed. Already on the 14th day of treatment in group 2, a significant decrease in SIAT was noted compared with group 1 ($p < 0.05$). At the same time, the SA had only a tendency to normalize ($p > 0.05$). On the 30th day of observation, a further decrease in CIAT and aggregation rate was observed ($p < 0.05$).

Conclusions: The administration of rosuvastatin to patients with PSN at a dose of 40 mg per day already on day 14 leads to an increase in the effectiveness of anti-platelet therapy, which may be due mainly to the pleotropic effects of rosuvastatin.

REVIEW OF EFFECTS OF MORINGA OLIFERA EXTRACTS ON BLOOD PRESSURE OF HYPERTENSIVE SUBJECTS NOT UNDER ANY ANTI HYPERTENSIVE THERAPY

Rohilla A., Vizir M.

INTRODUCTION

Hypertension is an iceberg disease following the rule of halves.

only half of hypertensive subjects in general population of developed nations are aware of their condition. Of these only half are being treated and of these half only half are adequately treated.

This disease is usually asymptomatic and may require life long therapy making its patients prone to non compliance to treatment.

The extract obtained from leaves of Moringa Olifera belonging to moringaceae family also known as benoil tree have been known to possess many antioxidants like: DPPH, H202, ascorbic acid and other free radical scavengers along with phylloquinone, nitrate glycosides; the IV administration of which has been known to cause reduction in blood pressure of anaesthetised rats.

toxicological studies on the extracts from this plant have shown no evidence of severe hepatotoxicity, organ damage and no major changes in biochemical parameters in rats, making this a good candidate for clinical trials and studies on humans.

AIM

To survey the effects of extracts from moringa olifera leaves in human hypertensive subjects as an alternative natural remedy for patients reluctant to initiate medical anti hypertensive treatments and those non compliant to therapy.

METHODS

Review of 35 cases from various studies conducted in male subjects of clinically diagnosed stage I hypertension of age groups 35 to 55 years belonging to different risk groups. With subjects serving as self controls. The intervention applied in these subjects was 100ml of moringa leaf extract offered twice daily for 30 days.

RESULTS

The pre intervention Systolic blood pressure of subjects being 140±20 showed a decline to a level of 110±10 post intervention

while the pre intervention Diastolic blood pressure of subjects being 95±15 showed a decline to a level of 80±10 post intervention

CONCLUSION

Extracts from the leaves of moringa olifera are efficacious in significant reduction of both systolic and diastolic blood pressure of subjects who are not under any anti-hypertensive drug therapy. Thus, making it a valuable natural method for control of blood pressure in cases of stage I hypertension in patients who are non compliant to medical therapy or are not willing to initiate treatment.

ACUTE KIDNEY INJURY AS A GLOBAL MEDICAL PROBLEM

Sultan M., Prosolenko K.O.

Acute kidney injury (AKI) is one of a number of conditions that affect kidney structure and function. AKI is defined by an abrupt decrease in kidney function that includes, but is not limited to, acute renal failure (ARF). It is a broad clinical syndrome encompassing various etiologies, including specific kidney diseases (e.g., acute interstitial nephritis, acute glomerular and vasculitic renal diseases); non-specific conditions (e.g, ischemia, toxic injury); as well as extrarenal pathology (e.g., prerenal azotemia, and acute postrenal obstructive nephropathy). AKI is a global problem and occurs in the community, in the hospital where it is common on medical, surgical, pediatric, and oncology wards, and in ICUs. Using the KDIGO (Kidney Disease: Improving Global Outcomes) definition, 1 in 5 adults (21.6%) and 1 in 3 children (33.7%) experienced AKI worldwide. Higher rates of AKI were observed in critical care settings and after cardiac surgery, identifying these high-risk populations in urgent need for interventions. Irrespective of its nature, AKI is a predictor of immediate and long-term adverse outcomes. AKI is more prevalent in (and a significant risk factor for) patients with chronic kidney disease (CKD). Individuals with CKD are especially susceptible to AKI which, in turn, may act as a promoter of progression of the underlying CKD. The burden of AKI may be most significant in developing countries with limited resources for the care of these patients once the disease progresses to kidney failure necessitating renal replacement therapy (RRT).

Accoding to KDIGO, 2011, AKI is defined as any of the following (Not Graded):

increase in serum creatinine (SCr) by ≥0.3 mg/dl (≥26.5 lmol/l) within 48 hours

or increase in Cr to≥1.5 times baseline, which is known or presumed to have occurred within the prior 7 days or urine volume < 0.5 ml/kg/h for 6 hours.

AKI is one of a number of acute kidney diseases and disorders (AKD), and can occur with or without other acute or chronic kidney diseases and disorders.

Thus, AKI is a multidisciplinary medical problem that requires a certain alertness and timely detection. Treatment activities should be carried out in accordance with modern international and national protocols based on the positions of evidence-based medicine.

UNSUITABLE USE OF ANTIBIOTICS AFTER VIRAL INFECTION OF RESPIRATORY SYSTEM

Talluri Venoy Kumar, Zelena I.I.

The use of antibiotics can be largely limited in the treatment of viral respiratory tract infections. Recently, doctors have the possibility of early and accurate identification of several respiratory viruses (in particular influenza A and B virus, parainfluenza virus, adenovirus and respiratory syncytial virus) with the help of highly sensitive and specific method - PCR.

Due to the fact that excessive use of antibiotics in hospitals leads to the emergence and spread of multiresistant pathogens, the researchers set out to determine why antibiotics are prescribed after diagnosis of viral respiratory infection in adult patients hospitalized in the hospital with symptoms of the respiratory system.

Among all adult patients admitted to 8 hospitals in Kiev from 1 November 2015 to 1 August 2017, 196 people were diagnosed with influenza A or B virus, parainfluenza virus, adenovirus, or PC virus, of which antibiotics were obtained 131 patients, including 125 people, were assigned antibiotics after the detection of the viral etiology of respiratory tract infection.

Of the 52 patients with changes in the chest x-ray, 46 people received antibiotics. As it turned out, changes in the chest X-ray are an independent risk factor for the continuation of antibiotic therapy (a corrected ratio of chances of 4.28, a 95% confidence interval of 1.71-10.77, p = 0.002), with 63% of patients continuing the appointment of antibiotics, despite the normal X-ray.

Infection caused by Clostridium difficile has developed in 8 patients (6%), in whom the use of antibiotics was continued, and in one patient, in whom the prescription of antibiotics continued (p = 0.05). At the same time, the duration of hospitalization and mortality were statistically significantly lower in patients with C.difficile infection.

Overall, in patients receiving antibiotics, higher mortality rates were observed for all causes (10 vs 0 fatal outcomes, p = 0.01) and longer hospital stay (5 vs 3 days) compared to patients who did not receive antibiotics , p = 0.001), indicating that the use of antibiotics does not have any significant positive effect on the clinical outcome. However, due to the small number of observed outcomes, it was difficult to determine whether the use of antibiotics directly affects the mortality and duration of hospitalization.

The limitations of this study also included retrospective design, lack of data, therefore the appointment of antibiotics continued after the establishment of the viral nature of the disease, the impossibility of extrapolation to all departments of the hospital and all categories of patients, excluding patients with positive results of bacteriological examination of respiratory specimens.

DIFFERRENTIATED APPROACH TO THE USE OF β-BLOCKERS IN ACUTE MYOCARDIAL INFARCTION

Thakre Anmol, Zaichenko O.E.

The aim of the study is to determine the effectiveness of β-blockers nebivolol and metoprolol in acute myocardial infarction (AMI) with ST-segment elevation, taking into account the peculiarities of autonomic heart tone.

29 patients with AMI with ST segment elevation at the inpatient stage of treatment were examined. In the 1st group (n = 17), nebivolol was included in the complex therapy of patients; in the 2nd group (n = 12), patients took metoprolol, in the 3rd group (n = 10) no β-blocker was assigned to patients for various reasons.

All patients were given daily ECG monitoring (on the 4-5th day of the disease and on the day of discharge from the hospital) with the determination of the spectral parameters of heart rate variability: high-frequency (HF), low-frequency (LF), very low-frequency (VLF) fluctuations of the heart rhythm, and also the ratio of sympathetic and parasympathetic influences on HRV (sympatho-vagal index - LF / HF).

The output autonomic tone of the heart was characterized by a pronounced sympathetic effect in all groups of patients: the LF ((1313.92 ± 78.00), (1305.91 ± 48.00) and (1115.68 ± 64.00) ms2 significantly exceeded the normal values - respectively in patients of the 1st, 2nd and 3rd groups, P <0.05), VLF ((2108.19 ± 43.00), (2666.63 ± 44.00) and (2803.15 ± 124.00 ms2, P <0.05), the sympatho-vagal index (3.48 ± 0.71, 2.24 ± 0.77 and 3.6 ± 0.20, p <0.05) and the high-frequency component of the spectrum ((581.31 ± 56.00), (583.63 ± 58.00) and (612.9 ± 88.0) ms 2, P = 0.867 remained practically unchanged. In the course of treatment, the activity of the sympathetic nervous system almost did not change in patients of the 1st and 2nd groups and significantly increased in patients of the 3rd group. At the same time, the influence of the high-frequency component of the spectrum increased by 39.89% under the influence of nebivolol and remained almost at the same level in patients of the 2nd and 3rd groups. As a result, there was a pronounced tendency to normalize the sympathovagal index in patients of the 1st group (LF / HF = 3.02 ± 0.12, P = 0.584) and to the progression of vegetative imbalance in patients who took metoprolol or who were not prescribed β -blockers.

Activation of the sympathetic nervous system is an important link in the pathogenesis of AMI. Investigation of the state of autonomic regulation of heart rhythm contributes to the targeted choice of drug therapy. With a significant increase in sympathetic influences on the heart rhythm, the use of the β-blocker nebivolol is more effective than metoprolol.

RARE SPECIES OF PERICARDITIS

Turuta D.O., Panchenko G.Y.

Fungal Pericarditis

Causes: generalized fungal infection, reduced immunity. Features: the clinical picture consists of the symptoms of pericarditis (of any kind), as well as fungal myocarditis (more than 2/3 of the observations). The combination of signs of myocarditis and pericarditis is the basis for suspicion of the fungal nature of the disease, as well as for conducting diagnostic pericardiocentesis with the study of the sample obtained for fungi and for the determination of antifungal antibodies in the blood.

Pericarditis in pregnant women Usually it is a hydropericardium, from mild to moderate, often asymptomatic and detected by chance. Extremely rarely develop cardiac tamponade. The reason is an increase in circulating fluid volume during pregnancy, so hydropericardium is more typical for late pregnancy (III trimester). If a change in pericarditis characteristic on the ECG is detected during this period, it is necessary to prescribe echocardiography. Treatment of pericarditis in pregnant women often does not require (except for general purposes, aimed at reducing the BCC). When tamponade symptoms are treated with nonsteroidal anti-inflammatory drugs. Extremely rarely, in severe cases, refractory to drug therapy, surgical treatment is indicated.

Pericarditis in diseases of the thyroid gland This is usually a hydropericardium. Incidence: 10–30% in patients with thyroid disease. Hypothyroidism occurs twice as often as hyperthyroidism. Features: slow accumulation of fluid (over months and years). Heart tamponade with this type of hydropericardium - casuistry. Treatment of thyroid disease is usually sufficient to reduce the amount of fluid in the pericardium.

Drug and toxic pericarditis The most common causes are serum sickness, reaction to a foreign substance, lupus response.Types of medicinal and toxic pericarditis can be any: acute and chronic pericarditis, constrictive pericarditis, cardiac tamponade. Treatment includes, in addition to conventional methods, the initial determination and elimination of the initiating agent.

Hilopericard Observed when a message appears between the intrathoracic lymphatic duct and the pericardium. The most common cause of this message is chest injuries, as well as tumors of the lymphatic system with localization in the mediastinum. The main methods confirming the diagnosis: pericardiocentesis, computed tomography, lymphography. The liquid obtained from the

pericardium during pericardiocentesis, opalescent, milky white, with a high content of triglycerides and protein. Treatment of the chilopericardium depends on the cause of it.
Radiation pericarditis Features: it may occur at a time that is significantly remote from t e time of exposure therefore, for the diagnosis of this type of pericarditis, anamnesis is of paramount importance. The severity and shape depend on the radiation source, the radiation dose, the volume of the irradiated tissue and the age of the patient. The incidence of fibrinous and constrictive pericarditis is high.

NIEMANN-PICK DISEASE AS A POSSIBLE CAUSE OF HEPATOSPLENOMEGALY IN ADULTS

Udoch A., Prosolenko K.O.

The disease was first described by the German pediatrician A. Niemann in 1914, and L. Pick in 1927 summarized the results of clinical and pathoanatomical observations of several patients and determined the characteristic histological criteria inherent in this disease.
There are three types of Niemann-Pick disease (NPD). For adults, the actual types are type B and type C. NPD has an autosomal recessive type of inheritance. The approximate frequency of NPD types A and B is 1: 100,000 and type C - 1: 150,000. The disease is found in different ethnic groups, but predominantly (in 30-50% of all cases described) in Ashkenic Jews.
The development of type B XNP is associated with mutations in the sphingomyelin phosphodiesterase I gene (SMPD-I), which encodes the enzyme acidic sphingomyelinase. For type B, CNS sphingomyelin accumulates mainly in the internal organs and is practically not deposited in the brain.
The development of the C-type NPD causes a violation of the structure of the transmembrane protein that is involved in the transfer of exogenous cholesterol associated with mutations in the NPC1 gene (locus 18q11-q12 chromosome 18) and in the NPC2 gene (locus 14q24 chromosome 14) and lead to the accumulation of non-esterified cholesterol (cholesterol) in the cells.
For type B the main clinical manifestations develop later than for type A. Splenomegaly appears at the age of 2-6 years, later the liver and lungs are affected. Symptoms of CNS lesion are absent, on the contrary, in some cases high intellectual abilities are marked. Life expectancy is not reduced, that is, these patients continue or, in case of untimely treatment, begin to be treated by therapists and gastroenterologists.
Type C more often manifests itself in 1-2 years and is characterized neurovascular disorders. Systemic C-type CNS generally include hepatopenomegaly and associated symptoms. Pulmonary infiltration with foam cells is usually observed only in patients with early onset of disease or in patients with mutations in the NPC2 gene. Type C NPD can be manifested by liver disease in childhood. Patients with pre / perinatal forms of this type of CNS have one or more of the following symptoms: fetal abundance, ascites, neonatal cholestasis, hepatosplenomegaly and / or hepatic insufficiency.
Hepatosplenomegaly in patients with a history of disease at an older age is usually asymptomatic and is often not clinically recognized, which requires, in cases of suspicion of type C NPD, an abdominal ultrasound examination. According to the literature, it is presumably absent or minimal in about 15% of all patients with type C NPD and in almost half of patients with an onset of the disease in adolescence / adulthood. The published data probably lowers the prevalence of hepatosplenomegaly, as ultrasound examination of the abdominal cavity is often not performed. When conducting an ultrasound study in one cohort, the proportion of patients with splenomegaly (with or without hepatomegaly) was close to 90%. Although splenomegaly is almost always observed with type C NPD, hepatomegaly is less common in adults.
At a pathomorphological study, macroscopically, an increase in the size and density of the liver, spleen, and lymph nodes is noted. The surface of the spleen appears yellowish-pink, and the lymph nodes and the liver are yellow. When light microscopy is detected in many organs and tissues cells

with lipid inclusions. The cytoplasm of the cells looks foamy at the expense of many vacuoles. In studies of the liver and spleen, the accumulation of sphingomyelin and non-esterified cholesterol are detected.
Neurological symptoms develop on the background of defeat of the internal organs, muscular hypotonia, increased deep tendon reflexes, which are replaced by spastic paralysis, as well as intentional tremor, moderate ataxia, seizures. In adult patients with this type of NPD often present symptoms of psychosis, circulatory disorders, depression, atypical schizophrenic disorders and / or other psychiatric symptoms, including attention deficit disorder.
To confirm the diagnosis, the activity of sphingomyelinase in the culture of skin fibroblasts and leukocytes (for type A and B) is determined, accumulation of unterified cholesterol in the culture of skin fibroblasts (for type C), search for genetic defects in 11, 14, 18th chromosomes is indicated.
The puncture of the bone marrow in such patients reveals specific "foamy" Niemann -Pick cells (they look like they are due to the accumulation of fats).
To sum up, NPD is rare but probable cause of hepatosplenomegaly in adults and should be present in the differential diagnosis list.

INTERLEUKIN-6 IN PATIENTS WITH NON-ALCOHOLIC FATTY LIVER DISEASE

Varun Rana, Zhelezniakova Natalia

Objective. The purpose of this study was to examine the relationship between serum levels of interleukin-6 in patients with non-alcoholic fatty liver disease.
Materials and methods. For this purpose, 39 individuals with non-alcoholic fatty liver disease (main group) and 20 healthy individuals randomized by gender and age (control group) were examined. All patients were determined by the level of proinflammatory cytokine IL-6 in the serum by ELISA using standard reagent kits. Statistical data has been performed on workstation by means of software “Microsoft Excel” and “Statistica 8.0”.
Results. Analysis of the level of the studied cytokine showed that the presence of non-alcoholic steatohepatitis is accompanied by an increase in the level of interleukin-6 and reaches 49.36 ± 3.27 pg / ml in comparison with the figures of practically healthy individuals. In turn, the indicators of the control group amounted to 15.2 ± 1.68 pg / ml. Differences between main and control groups were significant ($p < 0.05$).
Conclusion. In patients with non-alcoholic fatty liver disease, activation of pro-inflammatory immunity was observed, which was manifested by a significant increase in the level of interleukin-6.

RARE AND ORPHAN LUNG DISEASES

Vorona Y.M., Panchenko G. Y.

A rare disease is a disease that affects less than one person out of every 2000. It may seem that this is a very small number, but with a population of 700 million people in Europe, one “rare” disease can hit up to 350,000 Europeans - and this is almost equal to the population of Malta. Examples of rare lung diseases are cystic fibrosis and alpha1-antitrypsin deficiency. There are many rare lung diseases, so it is likely that millions of people suffer from them. This is essential. problem, since many rare diseases are serious and long lasting, and often dangerous for
of life.
Orphaned ’are those diseases that are insufficiently studied and / or are incurable, and this leads patients to feel ‘orphans’ in the world of health. Patients may experience *t*he difficulty of finding an experienced doctor dealing with the disease, and the diagnosis often takes longer. Many rare diseases are orphan ’, although some of orphan’ diseases are not rare (for example, some parasitic diseases in poor countries).

These can be diseases that affect only the lungs. (such as idiopathic pulmonary fibrosis), and other parts of the body and / or organs along with the lungs (for example, al factors have not yet been established. A large number of diseases caused by defective genes. This means that they can be transmitted from parents to children, although the occurrence of the disease can be arbitrary, being a consequence of gene damage. Other diseases may be caused by malfunction of the body's immune system. Sometimes 'orphan' diseases cease to be 'orphan' as scientists begin to devote more attention to their study. In the past few years, this has happened with idiopathic pulmonary hypertension.

Some orphan lung diseases.

Lymphangioleiomyomatosis is often called LAM for short. It strikes practically exclusively women of childbearing age. Abnormal cells invade tissue lung, including the respiratory tract, and can form cysts, destroying healthy tissue and leading to holes in the lungs.

Idiopathic chronic eosinophilic pneumonia, abbreviated as ICEP, represents an accumulation of white blood cells called eosinophils. Origin of this the disease is unknown. IHEP occurs in women twice as often as men, about half she has already suffered from asthma and allergic rhinitis (allergy-induced irritation nose and eyes).

Idiopathic pulmonary fibrosis (often called ILF) is a disease that usually
starts at the age of 50 to 75 years. Deep inside the lungs, the tissue becomes scarred and thickened. This means that it becomes more difficult for the body to get enough oxygen, especially during exercise. The cause of the disease is unknown, but others forms of pulmonary fibrosis can be caused by drugs, asbestos dust, or concomitant diseases.

In recent years, partly due to the development of the Internet, the number of patient organizations has increased significantly. Dedicated to individual rare lung diseases. Often these organizations work with patients only in one country, largely because of the language barrier. A good resource to start looking for an organization helping the people with a specific disease is the European Alliance of Rare Patient Organizations diseases (EURORDIS).

КЛИНИЧЕСКИЙ СЛУЧАЙ ПЕЧЕНОЧНОЙ ЭНЦЕФАЛОПАТИИ У БОЛЬНОЙ С ЦИРОЗОМ ПЕЧЕНИ

Афанасенко Д.М., Молодан В.И., Лапшина Е.А.

Актуальность: печеночная энцефалопатия (ПЭ) - потенциально обратимое нарушение функции мозга, возникающее в результате острой печеночной недостаточности, хронических заболеваний печени. В связи с клиническими проявлениями поражениями центральной нервной системы ПЭ является основной причиной преждевременного прекращения трудовой деятельности у пациентов с циррозом печени и встречается примерно у 60% пациентов с этим заболеванием. Необходимо подчеркнуть, что при ПЭ нет строго последовательного перехода одной стадии в другую, она может манифестировать сразу острейшей симптоматикой, вплоть до отека мозга, внутреннего кровотечения, эндогенной печеночной комы.

Цель: изучить клиническую картину проявлений ПЭ, проанализировать диагностику и лечение, тяжесть и прогноз ПЭ.

Клинический случай: Пациентка О., 36 лет. Жалобы на резкое увеличение размеров живота, массивные отеки голеней и стоп, тяжесть, тошноту, метеоризм после еды, повышение температуры до фебрильных цифр, слабость, бессонницу, онемение пальцев рук и ног, тупые головные боли, изменение почерка, шаткость в походке. Из анамнеза: больная считает, что заболела около 3-ех месяцев назад, когда впервые появились многократная рвота, тошнота, повышение температуры до субфебрильных цифр. За неделю до госпитализации возникли жалобы на многократную рвоту с примесью желчи, массивные отеки нижних конечностей, невозможность самостоятельно передвигаться. Объективно: общее состояние средней тяжести, сознание ясное, присутствует возбуждение и

двигательное беспокойство. Живот увеличен в размерах и напряжен за счет асцита, при пальпации безболезненный. Печень +3-4см, селезенка +4-5см. Переферические отеки, диурез 1000мл. Полиневропатия. КТ органов брюшной полости – печень 22*33*20см, контуры неровные, бугристые. Жировой гепатоз, цирроз печени. Асцит. Селезенка 150*70см. Гепатоспленомегалия. В брюшной полости, во всех ее отделах свободная жидкость. Клинический анализ крови: СОЭ -70мм/ч, лейкоциты 17,4г/л., эритроциты 2,5 г/л., НВ – 91. тромбоциты 298г/л. Биохимический анализ крови: АсАТ – 114ед/л., АлАТ – 25ед/л., мочевая к-та – 470мкмоль/л., общий холестерин – 3,4ммоль/л., триглицериды – 1.8ммоль/л., альбумины – 41г/л. Диагноз: цирроз печени в исходе хронического гепатита, токсической этиологии, с высокой активностью класса С по Чайлд-Пью, портальная гипертензия III ст, асцит стадия декомпенсации, печеночная энцефалопатия I ст. Для уменьшения проявлений печеночной недостаточности и ПЭ было назначено следующую терапию: реосорбилакт 200 мл/сут в/в кап, трисоль 100 мл/сут в/в кап, глутаргин 40% 5,0 в/в кап, диалипон 600 мг в/в кап, трифас 40 мг в/в стр, флуоцин 500 в/в кап; В1 3,0 в/м, В12 1000 в/м, дексаметазон 8 мг в/в, порталак 15,0 х 3р/сут. Важным компонентом лечения ПЭ является применение портолака (лактулозы), что позволяет уменьшить образование азотсодержащих токсических веществ в толстом кишечнике и снижает их всасывание в систему полой вены.

Выводы: в результате проведенного лечения данной патологии наблюдалась положительная динамика. У больной значительно уменьшились признаки ПЭ: восстановились почерк, походка, сон, отсутствуют признаки общего возбуждения и двигательного беспокойства, больная не предъявляет жалоб на головную боль и онемение пальцев рук и ног. Также у пациентки значительно уменьшились отеки нижних конечностей, что дало возможность самостоятельно передвигаться; уменьшились в размере живот и селезенка. Данный клинический случай показывает, как важно своевременно диагностировать и назначить патогенетически обоснованное лечение, направленное на устранение проявлений и осложнений ПЭ, т.к. эта патология на начальных стадиях является обратимой.

МОРФОФУНКЦІОНАЛЬНИЙ СТАН СЛИЗОВОЇ ОБОЛОНКИ СТРАВОХОДУ У ХВОРИХ НА ГЕРХ З ПІДВИЩЕНИМ ІНДЕКСОМ МАСИ ТІЛА

Гальчінська В.Ю., Фролова-Романюк Е.Ю

Метою роботи було визначення гістологічних і морфометричних змін слизової оболонки (СО) у хворих на ГЕРХ з підвищеним індексом маси тіла (ІМТ).

Матеріали та методи

Під наглядом перебували 57 хворих на ГЕРХ з нормальним ІМТ (18,5-24,9 кг/м^2) - 1 група (n=24) та підвищеним ІМТ (більше 25 кг/м^2) - 2 група (n=33).

Для морфологічного дослідження використовували біопсійний матеріал, який отримували під час ВЕГДС із СО дистального відділу стравоходу на 3 см вище умовної циркулярної лінії, що сполучає проксимальні кінці складок шлунку.

Для гістологічного аналізу застосовували забарвлення гематоксиліном і еозином та пікрофуксином за Ван-Гізон. Подальше дослідження проводили на препаратах СО з ознаками рефлюкс-езофагіту та порівнювали їх з препаратами незміненої СО стравоходу (контрольна група).

Результати та їх обговорення

Дослідження гістологічних характеристик біоптатів стравоходу хворих на ГЕРХ з нормальним та високим ІМТ виявили суттєве порушення стану СО стравоходу в обох групах. В більшості випадків відзначались реактивні зміни багатошарового епітелію слизової оболонки стравоходу, які найчастіше проявлялись паракератозом, проліферацією базальних клітин та акантозом.

Крім того, в набряклому підепітеліальному просторі спостерігалась різного ступеню лімфо-гістіоцитарна і лейкоцитарна інфільтрація з переходом запального інфільтрату на покривний

багатошаровий плоский епітелій. У випадках ерозивного езофагіту – лейкоцитарна інфільтрація СО стравоходу досягала максимуму, аж до формування мікроабсцесів.
Запальний інфільтрат більшою мірою представлений клітинами лімфо-гістіоцитарного ряду. Інфільтрати розташовувались як в області сосочків, так і в більш глибоких шарах під епітелієм, провокуючи розшарування колагенових волокон та м'язових клітин. Клітинний склад інфільтрату був поліморфний з переважним домінуванням моноцитів, плазматичних клітин, лімфоцитів, макрофагів та фібробластів. Базальна мембрана епітелію нерівномірно потовщена, гомогенна.
При морфометричному дослідженні виявляється суттєве збільшення товщини базального шару епітелію та висоти сосочків ($p<0,05$) (Табл.1).
Таблиця 1- Морфометрична оцінка стану слизової оболонки
дистальної частини стравоходу у хворих на ГЕРХ

Групи	Морфометричні показники, мкм				
	Загальна товщина епітелію	Товщина базального шару епітелію		Висота сполучнотканинних сосочків	
	M ± m	M ± m	%	M ± m	%
Контроль	267,4±7,6	27,8±0,9	10,4	77,4±2,1	28,9
1 група	331,3±12,5*	54,2±2,8*	16,4*	124,3±7,8*	37,5*
2 група	308,9±11,9	57,6±3,8*	15,4*	129,8±8,3*	38,1*

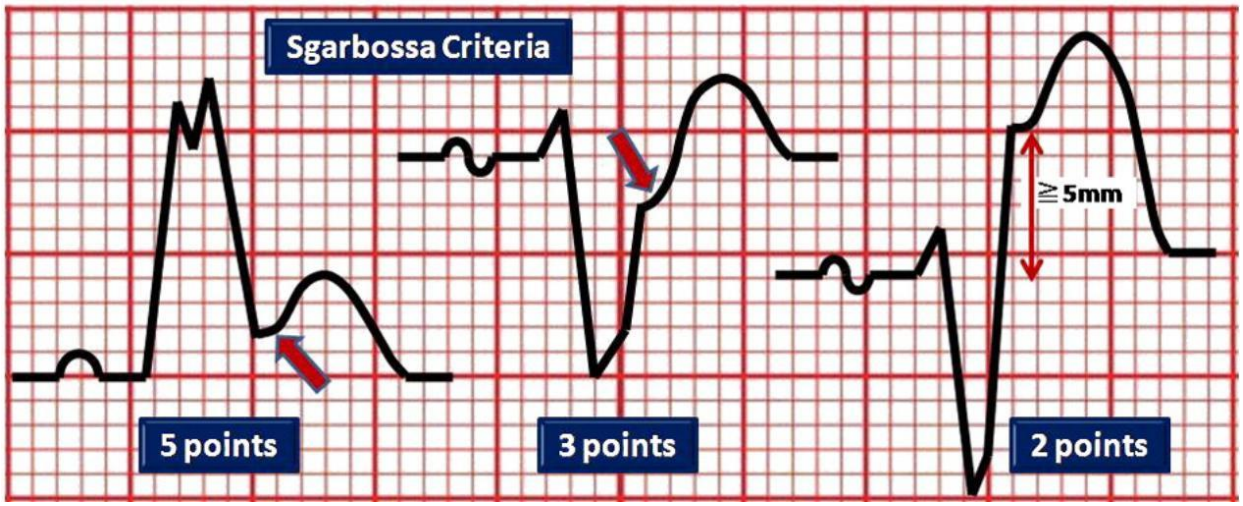
Примітка. * - вірогідність відмінностей в порівнянні з незміненою СО стравоходу.
Висновки Збільшення товщини базального шару може відображати саме підвищення проліферації його клітин. Довжина сполучнотканинних сосочків сягала до 75 % епітеліального пласта, а її зростання скоріш за все обумовлюється виділенням при запаленні медіаторів, що стимулюють проліферацію фібробластів, ендотелію та гладеньком'язових клітин.
При цьому слід відзначити що вірогідних відмінностей в морфометричних показниках гістологічного стану СО стравоходу у хворих на ГЕРХ з нормальним та високим ІМТ не виявлено.

ОСОБЛИВОСТІ ЕКГ-ДІАГНОСТИКИ ІНФАРКТУ МІОКАРДА ПРИ ПОВНІЙ БЛОКАДІ ЛІВОЇ НІЖКИ ПУЧКА ГІСА

Гончаренко С.С., Молодан В.І.

Актуальність: повна блокада лівої ніжки пучка Гіса значно ускладнює ЕКГ-діагностику інфаркту міокарда, що може впливати на вибір правильної лікувально-діагностичної тактики або приводити до проведень необґрунтованих коронарографій.
Ціль: дослідити ефективність високоспецифічних критеріїв ЕКГ-діагностики інфаркту міокарда у хворих з повною блокадою лівої ніжки пучка Гіса(ЛНПГ).
Клінічний випадок: Хвора 49 років, жінка. Скарги на різку слабкість, появу холодного липкого поту, блідність шкірних покривів, відчуття задухи. Вважає себе хворою приблизно 1,5-2 годин, коли вперше з′явилися вказані скарги. Напередодні був перенесений стрес, самостійно ліків не приймала. З анамнезу ІХС(ішемічна хвороба серця), ГХ (гіпертензивна хвороба) ІІ ст. 2 ст. більше 5 років. Постійно приймає Бісопролол 5 мг. Об-но: при тямі, шкірні покриви бліді, тони серця ритмічні, глухі. АД-100/90 рт.ст., ЧСС-68 уд/хв., пульс слабкий, ниткоподібний. Результати обстежень на догоспітальному етапі: на ЕКГ ЧСС-69 уд/хв. Ознаки блокади ЛНПГ. Підозра на інфаркт міокарда передньої стінки. Попередній

діагноз: ІХС, гострий(?) Q-негативний передній інфаркт міокарда, повна блокада ЛНПГ, ГХ II ст. 3 ст. СН III. До результатів ЕКГ були застосовані критерії Sgarbossa завдяки яким було встановлено елевацію сегмента ST- 2 мм і конкордантність комплексу QRS. Данні критерії є 90% показниками гострого інфаркту міокарда на фоні повної блокади ЛНПГ.



Таблиця. Бальна система оцінки критеріїв Sgarbossa у діагностиці ІМ

Критерії	**Бали**
Конкордантна до основного зубця комплексу QRS елевація сегмента ST ≥1 мм хоча б в одному відведенні	5
Конкордантна до основного зубця комплексу QRS депресія сегмента ST ≥1 мм у відведеннях V_1, V_2, V_3	3
Дискордантна до основного зубця комплексу QRS елевація сегмента ST ≥5 мм хоча б в одному відведенні	2

Хворому введено аспірину 325 мг, Клопідогрель 300 мг, нітрогліцерин 1 мг, Арикстра 1 ин′єкція внутрішньовенно, Пропранолол 80 мг.
Клінічний діагноз: ІХС, гострий Q-негативний передній інфаркт міокарда, повна блокада ЛНПГ, ГХ II ст. 3 ст. СН III, ризик 3. Пацієнтку госпіталізовано до реанімаційного відділення НАМН ім. Л.Т. Малої для подальшого проведення коронарографії зі стентуванням.
Висновки: Настороженість у відношенні розвитку ГІМ повинна бути у всіх випадках повної блокади ЛНПГ. За даними літератури діагностичні критерії Sgarbossa дозволяють зі специфічністю більше 90% встановити діагноз ІМ на фоні повної блокади ЛНПГ. Це дозволяє обрати правильну діагностично-терапевтичну тактику, що значно покращує прогноз захворювання, та уникнути проведення необґрунтованої коронарографії у пацієнтів з повною блокадою ЛНПГ.

КЛИНИЧЕСКИЙ СЛУЧАЙ БОЛЬНОГО С РАННИМ ПОСТИНФАРКТНЫМ ПЕРИКАРДИТОМ

Гунько А.В., Молодан В.И.

Актуальность: На сегодняшний день, перикардит - наиболее распространенная причина возникновения боли в груди у больных, перенесших инфаркт миокарда (ИМ). Частота его развития по разным литературным данным оценивается от 7-41%. Мужчины в возрасте 16-

65 лет более склонны к развитию раннего пост-ИМ перикардита, чем женщины. Трудности в диагностике данной патологии обуславливают важность осведомленности врачей для своевременной оценки ситуации и постановки диагноза.

Цель: анализ клинико-диагностических мероприятий и лечебной тактики ведения больного с острым ИМ, осложненного перикардитом.

Клинический случай: Больной Н., 64-х лет поступил в НИТ НАМНУ с жалобами на общую слабость, дискомфорт за грудиной. Из анамнеза: заболел остро, когда ночью появились вышеперечисленные жалобы. Бригадой СМП диагностирован ОИМ, больной доставлен в ГУ «ИОНХ им. В.Т. Зайцева НАМНУ», где была проведена коронарография и выполнено стентирование ПМЖВ ЛКА стентом без лекарственного покрытия. Для дальнейшего лечения с учетом тяжести состояния, переведен и госпитализирован в ОРИТ НИТ НАМНУ им. Л.Т. Малой. В последующие 24 часа пациент стал предъявлять жалобы на общую слабость, давящие боли в области сердца, усиливающиеся на высоте вдоха. Объективно: общее состояние средней тяжести-тяжелое, сознание ясное. Кожа и видимые слизистые чистые, обычной окраски. Над легкими выслушивается ослабленное дыхание, хрипов нет. Тоны сердца приглушены, ритмичны, над прекардиальной областью выслушивается шум трения перикарда. АД=150/100 мм.рт.ст, ЧСС=98 уд/мин, ЧДД=20 в мин, SpO2=82%. Живот мягкий, безболезненный. Печень у края реберной дуги, селезенка не пальпируется. Симптомы раздражения брюшины отрицательны. Отеков нет. Стул и мочеиспускание не нарушены. Назначено лечение: бриллинта 90 мг 2р/д, кардисейв 75 мг 1р/д, бисопролол 2,5 1р/д, лимистин 80 мг 1р/д, тритаце 2,5 мг 1р/д, проксиум 40 мг 1р/д. Согласно рекомендациям ESC по диагностике и ведению пациентов с заболеваниями перикарда 2015, аспирин и НПВС являются основными препаратами для лечения острого перикардита. Колхицин рекомендуется в низких дозах для лучшего ответа на медикаментозную терапию и предотвращения рецидивов.

В данном случае в качестве дополнения к плановой терапии назначено инфузии нитроглицерина, бета-блокаторы, ингаляция кислорода, с целью купирования болевого синдрома – наркотические анальгетики. Дополнительные методы исследования: ОАК: нейтрофильный лейкоцитоз со сдвигом лейкоцитарной формулы влево, лимфоцитопения; ОАМ: в пределах нормы; биохимический анализ крови: повышение трансаминаз, уровня холестерина, ЛПНП и коеффициента атерогенности. ЭХОкг: фиброз створок аортального и митрального клапанов, гипертрофия миокарда левого желудочка (ЛЖ), гипокинезия передне-перегородочной, верхушечной области ЛЖ, сократительная функция несколько снижена. ЭКГ: синусовый ритм, замедленная эволюция переднего ИМ с зубцом Q без отрицательной динамики. На основании полученных данных установлен диагноз: ИБС: острый передний распространенный ИМ с зубцом Q. Стенозирующий коронаросклероз. Стентирование ПМЖВ ЛКА стентом без лекарственного покрытия. Гипертоническая болезнь III стадии, 2 степени. Риск очень высокий. СН по Killip I. Осложнение: Острый перикардит. На фоне проведенной терапии антитромбоцитарными, гипотензивными, кардиопротекторными, гиполипидемическими средствами уменьшилась выраженность симптомов, ангинозные боли не рецидивировали. Больной переведен в отделение ИБС на 6-й день болезни.

Выводы: Анализируя данный клинический случай, пациенту с целью уменьшения воспалительных изменений в перикарде был показан прием НПВС, в частности, препаратом выбора являлся аспирин. В дополнение к терапии для снятия болевого синдрома назначены наркотические анальгетики.

ДИЛАТАЦІЙНА КАРДІОМІОПАТІЯ

Лапшина К.А., Артеменко А.А.

Дилатаційна кардіоміопатія (ДКМП) – це первинне ураження міокарду, що характеризується вираженою дилатацією порожнин і порушенням систолічної функції шлучночків. Поширення ДКМП невідомо, тому що до сих пір відсутні чіткі критерії її діагностики, що ускладнює проведення епідеміологічних досліджень. Захворюваність по даним різних авторів коливається від 5 до 10 чоловік на 100 тис. населення в рік. ДКМП в 2-3 рази частіше зустрічається у чоловіків, особливо у віці 30-50 років. В генезі ДКМП доказана роль вірусної інфекції, аутоіммунных процесів, спадковості та інших факторів. Є дані про неблагоприятну дію алкоголю на міокард: порушення синтезу скорочувальних білків кардіоміоцитів, пошкодження митохондрій, порушення енергетического метаболізму кліток, критичне зниження скорочувальної здатності міокарда, розширення порожнини сердца та формування ДКМП. На практиці в більшості випадків конкретні причини залишаються невиясненими і ДКМП трактується як ідіопатична форма хвороби. Захворювання тривалий час може протікати безсимптомно, незважаючи на наявність об'єктивних (ехокардіографічних) ознак дилатації шлуночків і порушення їх функції. Зазвичай перші клінічні прояви хвороби пов'язані із серцевою декомпенсацією, застоєм крові в малому, а потім і у великому колах кровообігу і зниженням серцевого викиду.

Ми хочемо представити історію хвороби молодого пацієнта, у якого постанова клінічного діагнозу викликала певні труднощі. Хворий С. (1978 р.н..), 36 років, поступив в кардіологічне відділення зі скаргами на задишку при невеликому фізичному навантаженні (підйом до другого поверху); нечасті, тривалі, стискаючі болі в лівій половині грудної клітини, з іррадіацією в ліву руку, без чіткого зв'язку з фізичним навантаженням; непостійні перебої в роботі серця по типу «завмирань, зупинок ». В анамнезі систематичне зловживання алкогольними напоями, іноді сурогатами. Вважає себе хворим з липня 2014 р коли після чергового алкогольного запою з'явилася і стала наростати задишка, слабкість, запаморочення, набряки на ногах. Госпіталізований в кардіологічне відділення, з діагнозом: інфаркт міокарда з зубцем Q передньо-перегородочний, верхівки, бічної стінки ЛШ. ХСН II Б, ФК III. За даними Ехо-КГ 14.07.14. – очагові зміни серця (МЖП, верхівки), ВКДС, порушення глобальної скоротливості міокарда (ФВ 18%). Виражена мітральна і трикуспидальная недостатність. Ознаки легеневої гіпертензії. У стаціонарі відзначалася гіпотонія, АТ 80 / 60-90 / 60 мм рт. ст. При виписці рекомендовано прийом: аспірин 125 мг, клопідогрель 75 мг, бісопролол 2,5 мг, івабрадін 5 мг 2 р. сут., торасемід 10 мг вранці, Інспра 25 мг, омепразол 20 мг 2 р / добу, симвастатин 20 мг. На тлі лікування зменшилася задишка, зросла толерантність до навантажень, іноді відзначав появу перебоїв в роботі серця. Прийом алкогольних напоїв припинив. Двічі оглянутий кардіохірургом 02.09.14., 18.09.14. - ДКМП? Ішемічна КМП? ІХС. Інфаркт міокарда. рекомендована консультація аритмолога для уточнення показань до ресинхронизируючої терапії. Відлуння-КГ в динаміці 28.10.14. – вогнищеві зміни серця (МЖП, передня і нижня стінки),ВКДС, порушення глобальної скоротливості міокарда (ФВ 32%). ЕКГ 20.11.14. - синусова брадикардія, 50 в хв. Госпіталізація планова з метою уточнення діагнозу і лікування. На час госпіталізації : відхилення електричної осі серця вліво. блокада передньої гілки ЛНПГ. Метаболічні зміни міокарда Холтер-ЕКГ: ритм синусовий з ЧСС 48-70-121 уд / хв. Варіабельність серцевого ритму знижена. ЦІ 1,2. Пауз і пароксизмальних порушень ритму не зареєстровано. Зареєстровано 54 епізоду синусової брадикардії, 93 епізоду синусовой тахікардії. Зареєстровано 116 шлуночкових екстрасистол. Надшлуночкової ектопічної активності не зареєстровано. Діагностично значимого зміщення сегмента ST не зафіксовано. Аорта не розширена, стінки ущільнені. Сепфундаментальні дефекти не візуалізуються. Збільшені всі порожнини серця. Товщина стінок серця в межах норми. МЖП неоднорідне ущільнена. Гіпокінез стінок лівого шлуночка. Відсутнє фізіологічне звуження ЛШ до верхівки. У порожнині лівого шлуночка візуалізуються додаткові трабекули в середньому, апикальному

відділах. Висновок: Дифузні зміни серця з ділатаєю порожнин і порушенням глобальної скоротливості лівого шлуночка. Ознаки легеневої гіпертензії (36 мм рт. Ст.). Проведена коронарографія: правий тип кровотоку. Виписаний з поліпшенням, зберігається синусовий ритм з ЧСС 60-66 в хвилину, перебої в роботі серця не турбують, зменшилася задишка при навантаженні, набряків немає, болі в грудній клітці турбують рідше, АТ на рівні 110-120 / 70-80 мм рт. ст. З огляду на виражений кардіоділатаціонний синдром діагноз перенесений інфаркт міокарда сумнівний.

Таким чином, представлений клінічний випадок характеризує особливість перебігу ділатаціційної кардіоміопатії у молодого пацієнта. Особливістю даного клінічного випадку є діагностичні труднощі, які виникли при постанові діагнозу - систематичне вживання в анамнезі алкоголю, перенесений інфаркт міокарда в 2014 році. На сьогоднішній день терапія даного захворювання потребує ендоваскулярного лікування хронічної серцевої недостатності і імплантацією ресинхронізуйочого пристрою а також - оперативного втручання-трансплантації серця.

ВІЛ-ІНФЕКЦІЯ: АКТУАЛЬНІ ЕПІДЕМІОЛОГІЧНІ ДАНІ В ХАРКІВСЬКІЙ ОБЛАСТІ.

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Актуальність. За даними ЮНЕЙДС з початком епідемії ВІЛ-інфекції в світі 76,1 млн людей були інфіковані ВІЛ, понад 35 мільйонів населення - померли від причин, пов'язаних з ВІЛ і ще більше ніж 37 мільйонів живуть з ВІЛ. Згідно офіційним даним статистики «Центру громадського здоров'я МОЗ України» з 1987 по 2017 рік було офіційно зафіксовано 315 618 випадків ВІЛ-інфікування, в тому числі 102205 випадків захворюваності на СНІД та 45074 смертельних випадків від захворювань, викликані СНІДом. За оціночними даними в Україні на початку 2018 року проживало 241 тисяч ВІЛ-інфікованих. Рівень поширеності вірусу в віковій групі від 15 до 49 років становив 98%. Саме тому ВООЗ була поставлена мета, ліквідувати епідемію ВІЛ до 2030 року. Повністю елімінувати вірус з організму не можна, але можна попередити його передачу і зупинити розмноження в організмі.

Мета: оцінити епідемічну ситуацію в Харківській області в період з 2016 по 2017 рік.

Матеріали та методи дослідження: проаналізовано захворюваність на ВІЛ-інфекцію в Харківській області за 2016, 2017 відповідно даних «Центру громадського здоров'я МОЗ України».

Результати. Згідно з даними «Центру громадського здоров'я МОЗ України», спостерігається нерівномірне поширення ВІЛ-інфекції на території України. Більш інтенсивно реєструються випадки захворюваності в Дніпропетровській, Київській, Чернігівській області. На початку 2018 року в Харківській області було зафіксовано 4113 випадків ВІЛ-інфікування та 1011 хворих на СНІД. У 2017 році в Харківській області кількість нових випадків ВІЛ-інфікування зросла, зареєстровано 655 хворих проти 618 за 2016 рік, темп приросту захворюваності знизився і склав 7% (2016 року - становив 8%), інтенсивний показник склав 24,8 проти 22, 8 на 100 тис. населення в попередньому році. У структурі шляхів передачі ВІЛ спостерігається підвищення рівня статевого шляху інфікування (63,6% проти 61,6% в 2016 році) і парентерального (23% проти 21,9% в 2016 році). За 2017 рік діагностовано 276 випадків СНІДу проти 271 в 2016, показник захворюваності склав - 10,2 на 100 тис. населення (2016 р. - 10,0 на 100 тис. населення). Темп приросту знизився і склав 2,0% (2016 року - становив 18%). У минулому році померли від СНІДу 78 осіб, що на 15 більше, ніж в 2016, показник смертності - 2,9 на 100 тис. нас. проти 2,3 на 100 тис. нас. в попередньому році. Темп приросту збільшився і склав 26% (2016 р.- становив 9.5%). Туберкульоз - основна причина смертності ВІЛ хворих в Україні, кожен другий з діагнозом СНІД помирає від даної патології. Наприкінці 2017 року за медичним контролем перебувало 4028 ВІЛ-інфікованих, поширеність ВІЛ-інфекції - 150,2 на 100 тис. населення (2016 р.- 134,3 на 100 тис. населення)

та 980 хворих на СНІД, поширеність СНІДу - 36, 5 на 100 тис. населення (2016 р. - 30,9 на 100 тис. населення).
Висновки. Для зниження нових випадків захворюваності на ВІЛ, потрібно своєчасно виявляти ВІЛ-інфікованих осіб, що не знають про свій позитивний статус. Саме вони підтримують активність епідемічного процесу в Україні. Проводити агітаційну політику, добровільного консультування і тестування на ВІЛ. Оскільки підвищення показників захворюваності на ВІЛ, пов'язані зі збільшенням нових вперше виявлених ВІЛ-інфікованих пацієнтів. Посилити заходи щодо попередження інфікування ВІЛ статевим і парентеральним шляхом. Своєчасна діагностика, лікування (АРТ), підтримка та догляд хворих, поліпшить їх якість життя і знизити рівень смертності від СНІДу.

БРОНХОЕКТАТИЧНА ХВОРОБА. АТИПОВІ УСКЛАДНЕННЯ.

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Вступ. Бронхоектатична хвороба - це захворювання, що характеризується хронічно гнійним процесом в необоротно змінених (розширених, деформованих) і функціонально неповноцінних бронхах переважно нижніх відділів легень. У 50% випадків захворювання двостороннє, локалізується найчастіше в нижніх частках легень, супроводжується запаленням стінки бронха. Хворіють переважно в дитячому і молодому віці, частіше чоловіки.
В Україні дане захворювання також поширене. Кількість хворих сягає 2-3% на рік. Бронхоектатична хвороба може бути як вродженою патологією так і набутою. У багатьох хворих знайден ген що впливає на розвиток муковісцидозу, його назва 621+1G>T, мутація в гені CFTR . У деяких випадках можливий розвиток раку легенів, що призводить до бронхоектазів та легеневої обструкції.
Мета: дослідження хворого з атиповими ускладненнями бронхоектатичної хвороби. Існує ряд ускладнень - емфізема легенів з розвитком дихальної недостатності, хронічне легеневе серце, амілоїдоз нирок, бронхіальна астма, септицемія з розвитком абсцесу легень та мозку, рак легенів.
Клінічний випадок. Хворий 27р. поступив у терапевтичне відділення, зі скаргами на сильний кашель з виділенням гнійного мокротиння та прожилками крові. Кашель виникає у ранкову та вечірню годину. Біль у грудній клітці та задишку. Хворий спостерігає підвищену t^0 тіла 39^0С, та загальну слабкість.
Анамнез: . Почав хворіти з дитинства після перенесеної пневмонії, почав сильно кашляти, виділялася мокрота до 50 мл на день. Хворий приймав антибіотики: цефтриаксон, тетрациклін. Багато палить, до 2 пачок сигарет на день. Місце праці – машинобудівельний завод.
Об’єктивно: стан хворого важкий. Шкіра бліда, ціаноз губ, пальці у вигляді барабанних паличок, нігті у вигляді стекла годинника.
Діагностика: клінічний аналіз крові: лейкоцитоз, прискорення ШОЕ, анемія. Аналізі мокротиння – атипові клітини. Спірометрія – зниження ЖЕЛ. Аускультативно: нижній долі правої легені – середньопузирчаті хрипи. Інструментальне дослідження – рентгенограмма гомогенне затемнення нижніх часток правої легені, округлої тіні. Бронхографія – звуження просвіту бронха з бугристими контурами. КТ органів грудної клітини – виявлення малюнку бджолиних сот, щільний м’якотканний вузол у нижній частці правої легені.
Діагноз: Бронхоектатична хвороба. Дихальна недостатність II ступеню.
Хворий був направлений до клінічного онкологічного центру для подальшого обстеження та лікування.
Прогноз для одужання, життя та працездатності: відносно несприятливий
Висновок: Отже в нашому випадку, у хворого на фоні бронхоектатичної хвороби почався процес малігнізації легеневої тканини. Існує думка, що зміни виникли внаслідок спадкових

факторів, здатність до метаболічної активації канцерогенів у тканинах організму. Також, мають місце хронічні запалення легень, тютюнопаління, праця у приміщенні з забрудненим повітрям, не дотримання повноцінної медикаментозної терапії. Отже для профілактики бронхоектатичної хвороби та її ускладнень необхідно вести здоровий спосіб життя, дотримуватися дієти, працювати в гарних умовах, займатися фізкультурою і більше часу проводити на свіжому повітрі.

ДИАБЕТИЧЕСКИЙ КЕТОАЦИДОЗ У БОЛЬНОГО САХАРНЫМ ДИАБЕТОМ 2 ТИПА

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Актуальность: Сахарный диабет (СД) на сегодняшний день является важной медицинской, экономической, социальной проблемой, в разных странах доля больных СД составляет от 4 до 7%. Развитие диабетического кетоацидоза (ДК) более характерно для больных СД 1 типа, при СД 2 типа ДК встречается гораздо реже, что может приводить к несвоевременной диагностике этого опасного осложнения СД.

Цель: проанализировать случай ДК у больного с СД 2 типа, определить факторы риска его возникновения и методы профилактики.

Клинический случай: Пациентка А., 1951 г. р. (67 лет), госпитализирована машиной скорой помощи (МСП) ургентно в токсикологическое отделение КНП «ГКБ №2 им. проф. А.А. Шалимова» ХГС 07.10.2018 14:20 с жалобами на сухость во рту, жажду, боли в животе, в поясничной области, потерю массы тела за последний месяц на 3 кг, сонливость, резкую общую слабость за последние 2 дня до госпитализации, тошноту, трехкратную рвоту. Страдает сахарным диабетом в течении 5 лет, были назначены пероральные сахароснижающие препараты (ПССП), которые больная отказывалась принимать. Диету не соблюдала, злоупотребляла углеводами. За последний месяц начала терять массу тела, в течении 3-х недель отмечала сильную сухость во рту, жажду. 05.10.2018 появились боли в животе, пояснице, общая слабость, 06.10.2018 начала нарастать сонливость, со слов родственников безучастно лежала в кровати, плохо реагировала на словесные раздражители, была вызвана МСП. Объективно: ИМТ – 27,1. Общее состояние тяжелое, легкое оглушение (шкала Глазго – 14 б.), положение больной вынужденное (в кресле-каталке), говорит с трудом из-за резкой сухости во рту, отмечается запах ацетона изо рта. Кожные покровы, видимые слизистые бледные, сухие, теплые, тургор снижен, следов расчесов, сыпи нет. Отеков нет. t 36.2˚. Тахикардия, тахипноэ. Язык розовый, сухой, обложен белым налетом. При пальпации живот мягкий, безболезненный, доступен глубокой пальпации. Печень у края реберной дуги, безболезненная. Симптом Пастернацкого слабоположительный слева. Мочеиспускание учащено, объём мочи увеличен.

Клинический анализ крови от 07.10.18: Ht – 40%, нейтрофильный лейкоцитоз со сдвигом формулы влево, ускорено СОЭ; в клиническом анализе мочи: моча мутная, глюкоза – 111.02 ммоль/л, кетоновые тела +++. Коагулограмма от 08.10.2018: увеличение протромбинового времени, фибриногена. Глюкоза крови – 25,2 ммоль/л. Консультация уролога – острый пиелонефрит слева. Был поставлен диагноз: Сахарный диабет 2 типа, средней тяжести, стадия декомпенсации (диабетический кетоацидоз). Сопутствующий: Острый пиелонефрит слева. Проведено лечение: раствор 0,9% хлорида натрия 400 мл в/в кап + 40 ЕД инсулина + 8 мл 20% р-ра альбумина, раствор 400 мл 0,9% хлорида натрия №2, раствор 10% глюкозы 400 мл в/в кап. + 12 Ед инсулина, раствор 5% глюкозы 400 мл в/в кап. +6 Ед инсулина, глутаргин 40% 5,0 в/в, витамин В1/В6 3,0 в/в, рибоксин 10,0 в/в, клексан 0,2 п/к, содовое питье, содовые клизмы, сульбактомакс по 1,5 г в/м; грандазол 1000 мг в/в кап. латрен 200,0 в/в капельно.

Выводы: Невыполнение рекомендаций врача по приёму ПССП, отказ от соблюдения диеты, а также возникновение острого пиелонефрита послужили главными факторами развития ДК у данной пациентки, что говорит о важности комплаенса между врачом и пациентом, так как

правильное и своевременное лечение СД является главным методом профилактики острых осложнений СД, и в частности ДК.

КЛИНИЧЕСКИЙ СЛУЧАЙ ВЕДЕНИЯ БОЛЬНОГО С Q-ПОЗИТИВНЫМ ИНФАРКТОМ МИОКАРДА И ОСТРОЙ АНЕВРИЗМОЙ ЛЕВОГО ЖЕЛУДОЧКА

Постолаки М.А, Молодан В.И.

Актуальность: Инфаркт миокарда (ИМ) является одной из главных причин инвалидизации и смертности населения. Постинфарктные аневризмы выявляются с частотой 8,5-34%. В среднем после обширного Q позитивного ИМ аневризма формируется у каждого пятого пациента. У мужчин развитие аневризм сердца встречается в 5-7 раз чаще, чем у женщин. Развитие аневризмы сердца в большинстве случаев приводит к развитию сердечной недостаточности, что ведёт к инвалидизации работоспособного населения. **Цель**: проанализировать клинический случай пациента с Q позитивным ИМ и острой аневризмой левого желудочка для определения дальнейшей тактики ведения таких больных, а также оценить необходимость раннего выявления ИМ до начала развития осложнений.

Клинический случай: Больной П., 57 лет. Поступил в клинику НИТНАМНУ с жалобами на слабость, головную боль, ноющие боли за грудиной. Из анамнеза заболевания известно, что боль за грудиной сохранялась на протяжении 5 дней до поступления в клинику. За медицинской помощью не обращался. В приемном отделении была снята ЭКГ и диагностирован острый Q-позитивный ИМ. Повышение артериального давления (АД) отрицает. Объективно: Состояние больного средней степени тяжести. При аускультации легких дыхание, ослабленное. Тоны сердца глухие, деятельность ритмичная, акцент 2 тона на аорте. АД 140/80 мм.рт.ст. ЧСС 70 в минуту. Печень пальпируется на +2,0 см из-под края реберной дуги, безболезненная. Больной был обследован: в клиническом анализе крови: относительный сдвиг лейкоцитарной формы влево, СОЭ 40 мм/час. В биохимическом анализе крови: СРБ-48 мг/л, коэффициент атерогенности-4,55, ХС ЛПНП-3,58 ммоль/л, протромбиновое время-сгусток. ЭКГ: замедленная эволюция острого с зубцом Q передне-перегородночно-верхушечно-бокового ИМ. Острая аневризма передне-перегородочно-верхушечного отделов левого желудочка. УЗИ сердца: Атеросклероз аортального клапана, фиброз митрального клапана. Левое предсердие увеличено. Фракция выброса снижена-50 %. Гипокинезия передне-перегородочного сегмента ЛЖ. Аневризма левого желудочка. Диастолическая дисфункция левого желудочка 2 типа. Таким образом был поставлен диагноз: ИБС: острый Q-позитивный ИМ передний распространенный ИМ. Острая аневризма левого желудочка. СН II А ст. с сохраненной фракцией выброса левого желудочка. Риск 4. Больному назначено лечение: кардисейв 75 мг, тромбонет 75 мг, лимистин 80 мг, корвазан 6,25 мг, энолазид моно-2,5 мг, пантопрозол 40 мг. На фоне проведенного лечения состояние больного улучшилось, боли за грудиной не рецидивировали. АД 120/80 мм.рт.ст, ЧСС 60 в минуту. Больному рекомендовано проведение коронарографии для решения вопроса о реваскуляризации миокарда.

Выводы: Представленный клинический случай показывает, что позднее обращение пациента с острым инфарктом миокарда за медицинской помощью привело к развитию острой аневризмы левого желудочка. Современная стратеигия ведения пациентов с подъемом сегмента ST включает как можно болшее раннее (первые минуты и часы) применение антиагрегантов, антикоагулянтов, нитратов, b-блокаторов, наркотических анальгетиков, проведение коронарографии для реваскуляризации миокарда при необходимости тромболизис.

ОСОБЛИВОСТІ КЛІНІЧНОЇ ТА ЕНДОСКОПІЧНОЇ КАРТИНИ ГЕРХ У ХВОРИХ НА ЦУКРОВИЙ ДІАБЕТ 2 ТИПУ

Фадєєнко Г.Д., Панченко Г.Ю. , Фролова-Романюк Е.Ю.

Метою нашого дослідження було визначити частоту виникнення типових скарг залежно від наявності ЦД 2 (цукрового діабету) типу та форми ГЕРХ ерозивної чи неерозивної у хворих на ізольовану на ГЕРХ та при поєднанні її з цукровим діабетом 2 типу.

Матеріали і методи Проведено анкетування 107 хворих на ГЕРХ, з яких у 67 ГЕРХ поєднувалась з ЦД 2 типу, та склали основну групу, решта-групу порівняння. Жінок- 66, чоловіків- 41, середній вік –(57,4 ± 7,6) років. У пацієнтів мали місце клінічні та /або ендоскопічні прояви ГЕРХ. Ретельно вивчено анамнестичні дані про тривалість, тяжкість перебігу діабету, ускладнення захворювання, дослідження глікозильованого гемоглобіну (HbA1c), проведення добової pH-метрії, ендоскопічного дослідження стравоходу і шлунку з взяттям біопсії.

Результати та обговорення При аналізі даних визначено, що печія у пацієнтів з ГЕРХ та ЦД 2 типу переважала при ерозивній формі ГЕРХ та зустрічалась у 43% випадків порівняно з неерозивною формою – 61%, тоді як у групі з ГЕРХ – при ерозивних формах спостерігалась у майже 90 % хворих.

Кисле зригування в основній групі з ерозивною формою ГЕРХ було виявлено в 56,6% хворих проти неерозивної – 40%, тоді як у групі порівняння відзначалось у 68% пацієнтів. Дисфагія турбувала 35% пацієнтів основної групи з ерозивною формою ГЕРХ та 46% з неерозивною формою, у контрольній групі ці показники становили 40 та 46,5%. Аналізуючи частоту виникнення другорядних симптомів, гикавка та “комок” в горлі в групі пацієнтів з ГЕРХ та ЦД 2 типу зустрічалась найчастіше – 42% хворих, майже з такою ж частотою виникала відрижка – 40% пацієнтів, неприємний запах у роті та болі за грудиною – 39% хворих. У 37% основної групи зустрічалась осиплість голосу та у 22% пацієнтів одинофагія.

У групі пацієнтів з ГЕРХ відрижка та комок у горлі зустрічались в найбільшої кількості пацієнтів – 37,5%. Осиплість голосу зустрічалась у 32,5% пацієнтів, неприємний запах у роті та болі за грудиною – 22,5% хворих. Одинофагія зустрічалася у найменшого відсотка пацієнтів – 15%.

Встановлено, що у пацієнтів з ГЕРХ та ЦД 2 типу з ерозивною формою ГЕРХ найчастіше зустрічалась гикавка (23%), з нееророзивною – неприємний присмак в роті та “комок” в горлі (16%). Серед пацієнтів з ерозивною формою ГЕРХ у групі порівняння найчастіше зустрічалась відрижка (28%), тоді як при неерозивній формі ГЕРХ переважала гикавка (26,7%).

Висновки

Визначено, що всі основні симптоми переважали у пацієнтів з ізольованою ГЕРХ та в обох групах частота виникнення була вищою при ерозивній формі ГЕРХ.

ПОКАЗНИКИ ДОБОВОЇ РН-МЕТРІЇ У ХВОРИХ ПРИ ПОЄДНАННІ ГЕРХ З ЦУКРОВИМ ДІАБЕТОМ 2 ТИПУ.

Фролова-Романюк Е.Ю., Тітов З.А.

Метою нашого дослідження було визначити показники добової pH-метрії у хворих на ГЕРХ при поєднанні її з цукровим діабетом 2 типу.

Матеріали і методи.

Проведено анкетування 107 хворих на ГЕРХ, з яких у 67 ГЕРХ поєднувалась з ЦД 2 типу. З них 66 жінок, 41 чоловіків, середній вік –(57,4 ± 7,6) років. У пацієнтів мали місце клінічні та /або ендоскопічні прояви ГЕРХ. Ретельно вивчено анамнестичні дані про тривалість, тяжкість перебігу діабету, ускладнення захворювання, дослідження глікозильованого

гемоглобіну (HbA1c), проведення добової pH-метрії за допомогою “Гастроскан-24”, ендоскопічного дослідження стравоходу і шлунку з взяттям біопсії.

Результати та обговорення.

При аналізі даних добового pH-моніторування стравоходу у 31 хворого з кардіальними проявами ГЕРХ виявлено переважання ознаки кислого гастроезофагеального рефлюксу у 22 (70,9%) пацієнтів. Аналіз даних pH-моніторування стравоходу при різних ЛОР-проявах ГЕРХ основної групи свідчить про незначне переваження у 38 (51,4%) кислого рефлюксу з рівнем pH<4, а у решті хворих мав місце патологічний лужний ГЕРХ з pH>7 (не зв’язаний з їжею).

При проведенні хворим 1 групи (хворі на ГЕРХ та ЦД 2 типу) добової pH-метрії, крім оцінки внутрішньостравохідних змін, проводили вивчення внутрішньошлункової кислотності. У даних пацієнтів, в середньому, визначали нормоцидний стан кислотності (pH = 1,82±0,11) на відміну від 2

групи (хворі з ізольованою ГЕРХ), де мала місце помірна гіперацидність (pH = 1,22±0,09),p <0,05.

При аналізі ступеня важкості ГЕРХ, визначеного по показниках добової pH-метрії (градація ступеня важкості рефлюксу по А.В. Медведєву, Е.И. Шмелеву, 2002р), вірогідної різниці між показниками основної та контрольної груп не було. Так, спостерігався рівномірний розподіл хворих основної та контрольної груп на ГЕРХ легкого, середнього та важкого перебігу. Між тим, у хворих з поєднанням ГЕРХ та ЦД 2 типу спостерігалася частота вираженого перебігу ГЕРХ у 12 (18%) хворих проти 10 (25%) хворих , але достовірність різниці p>0,05. Крім того число рефлюксів з pH< 4 тривалістю більше 5 хв за добу та час найтривалішого рефлюксу с pH< 4 достовірно перебільшував у хворих основної групи (p <0,05).

Висновки.

Аналіз показників добової pH-метрії свідчить, що число рефлюксів з pH<4 тривалістю більше 5 хв за добу та час найбільш тривалого рефлюксу з pH<4 вірогідно перебільшував у хворих при поєднанні ГЕРХ та ЦД 2 типу (p <0,05), що саме свідчить про наявність гіпомоторної дискінезії стравоходу.

ЭФФЕКТИВНОСТЬ АБЛЯЦИИ ПРИ ФИБРИЛЛЯЦИИ ПРЕДСЕРДИЙ

Чхун К.К., Молодан В.И.

Актуальность:Фибрилляция предсердий (ФП) — одно из самых распространенных видов нарушения ритма сердца, оно характеризуется некоординированными сокращениями предсердий, что в дальнейшем приводит к неполноценному функционированию сердца в целом. Изучение ФП важно потому, что данная патология значительно увеличивает риск сердечно-сосудистой и общей смертности. Данная патология на сегодняшний день, рассматривается как потенциально летальная аритмия, в связи со значительным нарушением качества жизни, а также с тяжелыми, а иногда, летальными осложнениями. Метод абляции не является методом выбора лечения данного вида аритмий, но считается одним из самых эффективных.

Цель: Посмотреть на эффективность абляции при постоянной форме фибрилляции предсердий.

Клинический случай: Больной М, 65 лет поступил в Национальный институт терапии им. Л. Т. Малой НАМНУ, в отделение ИБС (19.10.18). Больной жаловался на: одышку, чувство перебоев работы сердца, учащенное сердцебиение. Объективно: состояние средней тяжести, сознание ясное. Телосложение правильное, нормостеник. Кожные покровы чистые, естественной окраски. Аускультативно в легких: незначительное количество влажных хрипов в н\долях легких. ЧДД=20 в мин. Данные аускультации сердца: тоны сердце аритмичны, приглушены, акцент II тона над аортой. ЧСС=100 в мин. АД= 135\95 мм рт. ст. Границы относительной сердечной тупости расширены на 1 см влево. Живот при пальпации

мягкий безболезненный. Печень у края реберной дуги, селезенка не увеличена. Симптом Пастернацкого отрицательный с обеих сторон. Стул и мочеиспускание не изменены. Данные лабораторно-инструментальных исследований: б\х (19.10.18) общий холестерин- 6,5 ммоль\л, ТГ-0,8 ммоль\л, ХС ЛПВП -1,5 ммоль\л, ХС ЛПНП-5,0 ммоль\л, коэф. атерогенности-3,3. ЭКГ(19.10.18): отсутствие зубцов Р, наличие волн f. ЭхоКГ (19.10.18): расширение полости левого предсердия, гипертрофия левого желудочка, ФВ=50%. Рентгенография ОГК(19.10.18): признаки застоя в н\долях легких. На основании жалоб и результатов дополнительных методов исследования был поставлен диагноз: Фибрилляция предсердий, постоянная форма, тахисистолический вариант. CHADSWAS3б.HASBLED3б. Гипертоническая болезнь IIст. 2ст. Ранее больной получал антиаритмическую терапию (амиодарон), в анамнезе 3 кардиоверсии, которые не дали положительного эффекта. Больному была поставилена постоянная форма фебрилляции предсердий.
Пациент получал лечение: аспиринкардио 100мг, плавикс 75мг, ксарелто15мг, крестор 40 мг, паноцид 40 мг, трифас 10 мг, бисопролол 5мг, триплексам 10\5\5. На фоне проводимой терапии, состояние не улучшилось, больного продолжали беспокоить перебои в работе сердца и одышка. Было предложено произвести абляцию, которая была проведена больному в национальном институте сердечно-сосудистой хирургии им. Н. М. Амосова. После данной манипуляции ритм больного был восстановлен, жалоб не предъявлял.
Вывод: данный клинический случай отражает эффективность применения абляции при постоянной форме фибрилляции предсердий, особенно в случае, когда она значительно снижает качество жизни пациента или является резистентной к медикаментозной терапии.

КЛИНИЧЕСКИЙ СЛУЧАЙ ЯЗВЕННОЙ БОЛЕЗНИ ЖЕЛУДКА, ОСЛОЖНИВШЕЙСЯ ОСТРЫМ ЖЕЛУДОЧНО-КИШЕЧНЫМ КРОВОТЕЧЕНИЕМ

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Введение: Язвенная болезнь желудка (ЯБЖ) – это патологический процесс со склонностью к прогрессированию, характеризуется воспалением слизистой оболочки (иногда с захватом и под слизистого слоя) желудка с формированием язвенного дефекта. Одними из главных причин, которые приводят к заболеванию ЯБЖ, является инфицирование Helicobacter pylori (H.pylori) прием нестероидных противовоспалительных препаратов, повышенная кислотность. К основным осложнениям ЯБЖ относятся: перфорация язвы, острое желудочно-кишечное кровотечение (ОЖКК), пенетрация, малигнизация язвы. На данный момент, учитывая длительное изучение данного заболевания, не удалось найти способы остановить прогрессирование заболевания или полностью излечить пациента.
Цель: проанализировать клиническую картину и лечение больного с ЯБЖ осложнившуюся ОЖКК.
Клиническая картина: Пациент Х. 69лет поступил в отделение гастроэнтерологии с болью в эпигастральной области, возникшая после приема пищи и которая уменьшались через 1-2 часа после еды, слабость, иногда шум в ушах, отрыжку кислым, тошноту, вздутие. Больным себя считает последние 5 лет, когда впервые появились вышеуказанные жалобы. 10 дней назад у пациента на фоне данного заболевания развилось ОЖКК, и была оказана неотложная помощь в хирургическом стационаре. На данный момент черного кала и мелены не отмечает. Объективно: кожные покровы бледные, язык влажный, обложен белесовато-желтым налетом. При пальпации живота боль в эпигастральной области, вздутие живота. Учитывая жалобы и анамнез заболевания больного, были назначены следующие обследования: Клинический анализ крови и мочи, биохимический анализ крови, УЗИ ОБП, ФГДС с биопсией, рН метрия, ЭКГ. В результате проведенных исследований, отмечается: Клинический анализ крови: RBC 3,2x1012, HB 72, HCT 27% PLT 112x109/l. Заключение: признаки кровотечения, анемия. Клинический анализ мочи: в норме. Биохимический анализ крови: в норме. ФГДС: в антральном отделе желудка имеется язвенный дефект диаметром

0,7 см, на дне фибрин светло-коричневого цвета. Биопсия: в цитограмме из желудка, клетки с признаками лимфоцитарной инфильтрации. Атипичных клеток не выявлено. Учитывая данные исследований, был вынесен диагноз: Язвенная болезнь желудка III стадии, осложненная ОЖКК средней тяжести, период обострения. Постгеморагическая анемия средней степени тяжести.

В условиях стационара было проведено лечение: диета, омепразол 40мг в/в кап, улькавис 240мг х2р, нольпаза 40мг х 2р, нормолакт 15,0 х 3р, креазим 20000ЕД х3р, вит. В1 2,0 в/м, вит.В12 1000 в/м, гино-тардиферон 1т х 2р. На фоне назначенного лечения, на 4 сутки отмечалась положительная динамика, гемоглобин начал повышаться, боли в эпигастральной области уменьшились. Для предотвращения рецидивов кровотечения, необходимо придерживаться диеты, стол 1а, отказ от вредных привычек, своевременное обращение к специалисту при обострении ЯБЖ. При появлении черного стула или мелены необходимо немедленно обратится к врачу.

Вывод: клинический случай демонстрирует протекание ЯБЖ осложнившейся ОЖКК. В лечении такого пациента нужно учитывать данные лабораторных и инструментальных исследований. Необходимо назначать противоанемические препараты для восстановления гемодинамики и препараты для лечения основного заболевания. Важным является акцентирование внимания больного на проведение терапии для профилактики ОЖКК.

ЗМІСТ: