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Dedicated to
The 10th International
Symposium On Important
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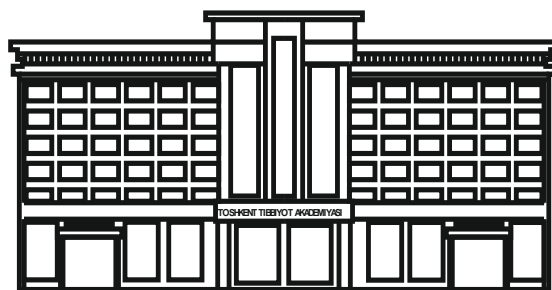
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OCCURRENCE OF RISK FACTORS IN PATIENTS WITH CORONARY HEART DISEASE IN OUTPATIENT SETTINGS

Akhmedova D.T., Mahmudova M.S.

AMBULATORIYA SHAROITIDA YURAK ISHEMIK KASALLIGI BO'LGAN BEMORLARDA XAVF OMILLARINING UCHRASHI

Ahmedova D.T., Mahmudova M.S.

ВСТРЕЧАЕМОСТЬ ФАКТОРОВ РИСКА У ПАЦИЕНТОВ С ИШЕМИЧЕСКОЙ БОЛЕЗНЬЮ СЕРДЦА В АМБУЛАТОРНЫХ УСЛОВИЯХ

Ахмедова Д.Т., Махмудова М.С.

Tashkent Medical Academy

1 7,3 million deaths [1] – 31,5% of all deaths of the world's population and 45% of all deaths from non-communicable diseases, which include 4 groups of diseases, including cardiovascular, oncological, bronchopulmonary and diabetes mellitus (DM). In Europe, more than 4 million people die annually from CVD, of which 1,4 million are under the age of 75 years, which is 45% of all deaths (40% among men and 49% among women) [2]. At the same time, in a number of developed European countries there has been a significant decrease in mortality from CVDs, and they have lost their leading positions among the causes of mortality: according to the latest data, in 12 countries of Western Europe, men die more often from cancer than from CVDs [2].

Coronary heart disease (CHD) continues to remain one of the most important problems of modern healthcare [1-2]. This is due to the wide prevalence of coronary heart disease and the associated high mortality rate, which in different regions differ significantly [3-4]. Some countries have achieved positive results in stabilization efforts mortality from ischemic heart disease, which are explained primarily by the implementation of extensive preventive measures to limit animal fats in the diet, combat smoking and abuse alcohol and, most importantly, the prevention and treatment of arterial hypertension (AH). It is generally accepted that the effect of prevention is determined by early detection and reduction of risk factors (RF). That is why it seems appropriate to study the epidemiology of RF and their significance in shaping the prevalence of IHD and mortality from it in each specific region.

The global burden of cardiovascular disease (CVD) continues to increase despite progress made in recent decades in the development and implementation of preventive and therapeutic strategies. Heart disease and stroke will lead to approximately 24 million annual deaths worldwide by 2030. Continued therapeutic innovation to prevent and treat cardiovascular disease remains an important medical need. An increasingly important factor in atherosclerotic cardiovascular disease is the increasing prevalence of obesity and its metabolic manifestations such as insulin resistance, type 2 dia-

betes mellitus, non-alcoholic fatty liver disease and hypertriglyceridemia. In developing parts of the world, the prevalence of hypertriglyceridemia is even higher than in Western countries. This trend is expected to continue due to the impending diabetes pandemic and its associated metabolic manifestations predicted by population-based studies.

Cardiovascular diseases (CVD) caused by atherosclerosis remain the most pressing health problem in most countries of the world, including ours, despite significant progress in recent decades in the field of diagnosis and treatment of cardiovascular pathology. Experts from the World Health Organization (WHO) predict a further increase in cardiovascular morbidity and mortality, both in developed and developing countries, due to the aging population and the spread of type 2 diabetes mellitus (T2DM) and obesity [5,8]. Cardiovascular diseases (CVD) begin to develop long before the appearance of the first clinical symptoms; their development is closely associated with lifestyle characteristics and associated risk factors, which, interacting with hereditary predisposition, can accelerate the development of diseases and lead to premature mortality, including including the mechanism of sudden cardiac death [2,3,10].

Purpose of the study

To determine the occurrence of risk factors in people with a family history of coronary heart disease in outpatient settings.

Materials and methods

The study examined 60 patients of both sexes, aged 45-75 years. Patients with coronary artery disease and cardiovascular risk with a complicated medical history divided into 2 groups:

The first group of 30 patients who will receive monotherapy with statins.

The second group of 30 patients who will undergo combination therapy with statins and fibrates.

All patients underwent general clinical examinations: general blood count, general urinalysis, biochemical blood test (ALT, AST, urea, creatinine, blood sugar), ECG, echocardiogram, blood lipid profile, coagulogram.

Determination of blood pressure, pulse, BMI and total cardiovascular risk using the SCORE scale. The pri-

mary medical examination was carried out in the morning on an empty stomach and included questionnaires, instrumental and biochemical methods. Instrumental methods included: blood pressure measurement, anthropometry and ECG. Arterial hypertension (AH) was recorded at systolic blood pressure >140 mmHg, and di-

astolic blood pressure >90 mmHg, and also regardless of blood pressure indicators, if the subject took antihypertensive drugs.

Results and discussion

All patients were divided into 2 groups. All patients underwent laboratory and instrumental examinations.

Characteristics of patients included in the study

Table 1.

Indicators	Main group	Control group
Quantity	30	30
Age	59,7 ± 2,9	67,4 ± 3,0
Gender, men / women	14/16	10/20
Body mass index, kg/m ³	34,0 ± 1,2	32,9 ± 1,8
Arterial hypertension, mmHg	142,0 ± 1,7	137,7 ± 3,0
	80,7 ± 0,67	79,3 ± 1,5
Diabetes mellitus type 2, n (%)	18 (60%)	12 (40%)
History of smoking, n (%)	3 (10%)	4 (13,3 %)
Average duration of IHD, years	10,8 ± 2,5	11,2 ± 4,3
Heredity to IHD	15 (50%)	18 (60%)

Clinical characteristics of patients show that in the main group the age of patients was 59,7 ± 2,9 years and in the control group 67,4 ± 3,0 years; body mass index was highest in the main group 34,0 ± 1,2 kg/m³. The average duration of IHD was 11,2 ± 4,3 years in the control group; in the main group 10,8 ± 2,5 years.

ber of patients were with third degree obesity: men – 2 (3%), women – 6 (10%).

Table 2.
Anamnestic and clinical characteristics of patients.

Indicators	Main group, n - 30	Control group, n - 30
Duration AH, years	15 ± 2,0	10 ± 3,2
BMI, classes	4 (13,3%)	5 (16,7%)
1	2 (6,7%)	3 (10%)
2	4 (13,3%)	5 (16,7%)
3	2 (6,7%)	2 (6,7%)
DM	9 (30%)	5 (17%)

The duration of hypertension in the main and control groups differed slightly and amounted to 15 ± 2 and 10 ± 3 years, respectively. The study included individuals with stage 1 hypertension and stage 2 hypertension. Men with 3 degree hypertension were also included in the study.

Based on the results, we can see that the largest number of patients were overweight, the category of women was 11 (18%), and men with excess body weight were 6 (10%). Calculating the BMI of patients, it turned out that obesity of the first degree prevails compared to the second and third degrees: men - 11 (18%), women - 9 (14%), respectively. Obesity of the second degree was: men – 6 (10%), women – 9 (14%). The smallest num-

Innovative nutritional strategies have been developed to correct dyslipidemia. These were based either on changing certain “risky” food components or on encouraging the consumption of “healthy” functional foods and/or nutraceuticals. Nutraceuticals are an innovative way to help low- to moderate-risk patients control LDL-C levels without resorting to lipid-lowering medications drugs as nutritional support for a hypocholesterolemic diet.

Today, red yeast rice preparations have become available. The hypocholesterolemic effect of red yeast rice is associated with a statin-like mechanism, through the inhibition of hydroxymethylglutaryl-coenzyme A (HMG- CoA) reductase, monacolin K, which is a bioactive ingredient. In a large study performed in China on patients with coronary artery disease, red yeast rice extract reduced the incidence of cardiovascular events by 45% [7]. A hypocholesterolemic effect (decrease in LDL cholesterol by 15-25%) is observed with a daily dose of 2,5-10 mg of monacolin K [28].

For timely and adequate prevention of IHD, it is necessary to identify population groups most susceptible to risk factors. To clarify this issue, we studied the dynamics prevalence of risk factors in different age periods. Frequency Smoking decreases with age, but quitting smoking is most intense at older ages 50-59 years old.

Conclusions. According to the results of the study, the majority of patients (18% of men) suffered from type 1 obesity; among women, 18% were overweight. The lowest rates of third-degree obesity were in 3% of men and 10% of women. Smoking history was present in 10% and 13,3% of patients, respectively, by group. There was a preponderance of women in our study. The studied risk factors are interconnected to a certain extent. The presence of any risk factors from among hyper-

tension, BMI is associated with elevated levels of blood pressure, glycemia and lipids, and when combined, their significance increases. Lipid metabolism disorders and

smoking are less important. They are mostly related with the levels of the studied indicators when combined with other risk factors.

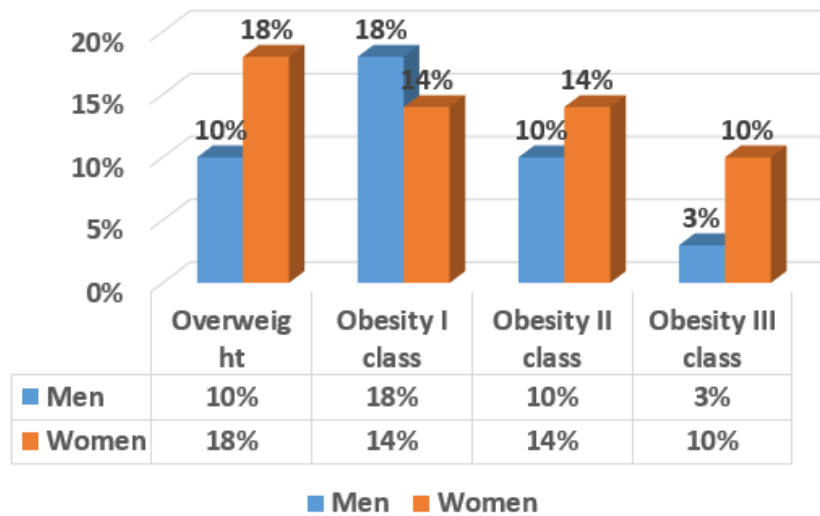


Diagram 1. Distribution of patients depending on body mass index

Table 3. Prevalence of risk factors for cardiovascular diseases

Smoking	10 (16,7%)
Family history of IHD	23 (38%)
Abdominal obesity	8 (13,3%)
Hypercholesterolemia	5 (8,3%)
Low physical activity	15 (25%)
Arterial hypertension	32 (53%)
Diabetes mellitus type 2	14(23%)

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