

ЎЗБЕКИСТОН РЕСПУБЛИКАСИ СОҒЛИҚНИ САҚЛАШ ВАЗИРЛИГИ
ТОШКЕНТ ТИББИЁТ АКАДЕМИЯСИ

2024 №3

2011 йилдан чиқа бошлаган

TOSHKENT TIBBIYOT AKADEMIYASI
AXBOROTNOMASI



В Е С Т Н И К

ТАШКЕНТСКОЙ МЕДИЦИНСКОЙ АКАДЕМИИ

Тошкент



Выпуск набран и сверстан на компьютерном издательском комплексе

редакционно-издательского отдела Ташкентской медицинской академии

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Учредитель: Ташкентская медицинская академия

Издание зарегистрировано в Ташкентском Городском управлении печати и информации

Регистрационное свидетельство 02-00128

Журнал внесен в список, утвержденный приказом № 201/3 от 30 декабря 2013года

реестром ВАК в раздел медицинских наук

Рукописи, оформленные в соответствии

с прилагаемыми правилами, просим направлять

по адресу: 100109, Ташкент, ул. Фароби, 2,

Главный учебный корпус ТМА,

4-й этаж, комната 444.

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Формат 60x84 1/8. Усл. печ. л. 9,75.

Гарнитура «Cambria».

Тираж 150.

Цена договорная.

Отпечатано на ризографе редакционно-издательского отдела ТМА.

100109, Ташкент, ул. Фароби, 2.

Вестник ТМА №3, 2024
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ASSESSMENT OF FEATURES OF THE CLINICAL COURSE OF GOUT IN ELDERLY WOMEN

Nabieva D.A., Tashpulatova M.M.

ОСОБЕННОСТИ КЛИНИЧЕСКОГО ТЕЧЕНИЯ ПОДАГРЫ У ЖЕНЩИН ПОЖИЛОГО ВОЗРАСТА

Набиева Д.А., Ташпулатова М.М.

KEKSA AYOLLARDA PODAGRANING KLINIK KECCHISH XUSUSIYATLARINI BAHOLASH

Nabiyeva D.A., Tashpulatova M.M.

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Цель: изучение особенностей подагры в ее дебюте у женщин пожилого возраста. **Материал и методы:** под наблюдением были 50 больных с первичной подагрой (25 мужчин и 25 женщин) на основании критериев S. Wallace и соавт. Больных разделили на 2 группы: 1-я – 27 больной старше 60 лет, 2-я – 23 больных моложе 60 лет. Средний возраст дебюта подагры в 1-й группе составил $55 \pm 4,2$ года, во 2-й – $45 \pm 5,0$ года. **Результаты:** длительность заболевания в обеих группах в среднем составляла 6 лет. Артрит I плюснефалангового сустава в дебюте болезни в 1-й и во 2-й группах диагностирован соответственно в 75 и 65% случаев. Хронический артрит в 1-й группе диагностирован у 14 (50%) пациентов, во 2-й – у 10 (45%). Топфусы при обследовании выявлены соответственно в 21 и 37%. Диуретики принимали 14 (50%) и 11 (47%) больных. Артериальная гипертензия выявлена у 6 (25%) обследованных 1-й группы и у 17 (40%) – 2-й. Число больных с ожирением в двух группах было сопоставимо (41 и 43%). **Выводы:** основные клинические особенности подагры свойственны пожилым так же, как и более молодым пациентам. Сердечно-сосудистые заболевания в дебюте подагры чаще отмечаются в пожилом возрасте.

Ключевые слова: подагра, пожилой возраст, артериальная гипертензия, острый инфаркт миокарда, хроническая почечная недостаточность.

Maqsad: keksa ayollarda paydo bo'lgan podagraning xususiyatlarini o'rganish. **Material va usullar:** S.Wallace va boshqalarning mezonlari asosida birlamchi podagra bilan kasallangan 50 bemor (25 erkak va 25 ayol) kuzatildi. Bemorlar 2 guruhga bo'lingan: 1-chi – 60 yoshdan oshgan 27 nafar bemor, 2-chi – 60 yoshgacha bo'lgan 23 nafar bemor. 1-guruhda podagraning o'rtacha boshlanish yoshi $55 \pm 4,2$ yil, 2-guruhda $45 \pm 5,0$ yil. **Natijalar:** ikkala guruhdagi kasallikning davomiyligi o'rtacha 6 yil. 1 va 2-guruhlarda kasallikning boshlanishida birinchi metatarsofalangeal bo'g'imning artriti mos ravishda 75 va 65% hollarda tashxis qo'yilgan. 1-guruhdagi surunkali artriti 14 (50%) bemorda, 2-guruhda - 10 (45%) bemorlarda aniqlangan. Tekshiruv davomida mos ravishda 21 va 37% da tofi aniqlangan. Diuretiklar 14 (50%) va 11 (47%) bemor tomonidan qabul qilingan. 1-guruhda tekshirilganlarning 6 tasida (25%), 2-guruhda 17 tasida (40%) arterial gipertenziya aniqlangan. Ikki guruhdagi semiz bemorlarning soni o'xshash edi (41 va 43%). **Xulosa:** podagraning asosiy klinik belgilari keksa bemorlarga ham, yosh bemorlarga ham xosdir. Podagra boshlanishida yurak-qon tomir kasalliklari ko'proq keksalikda kuzatiladi.

Kalit so'zlar: podagra, qarilik, arterial gipertenziya, o'tkir miokard infarkti, surunkali buyrak yetishmovchiligi.

Gout is a systemic tophi disease with the deposition of monosodium urate crystals in various tissues and their inflammation in individuals with hyperuricemia (HU) caused by environmental and/or genetic factors [1]. According to population studies, humanity entered the 3rd millennium with a significant burden of rheumatic diseases, and their prevalence tends to increase [4]. One such disease is gout.

Scientific experience allows us to consider gout in the context of the current pathology of modern society, despite its long history and vivid clinical picture. To traditional risk factors (RFs), such as male gender, consumption of red meat and alcohol, were added an increase in life expectancy, components of metabolic syndrome (MS), the use of diuretics, primarily loop diuretics, low doses of acetylsalicylic acid (ASA), cyclosporine, the presence of chronic kidney diseases. A. Luk and P. Simkin [13] note that gout has become “more democratic”, affecting representatives of various socio-economic groups. The well-known features of its pathogenesis are changing in modern realities: along with a proven increase in prevalence, some age-related features of gout are noted. These include obvious sex dif-

ferences, the greater clinical significance of excessive alcohol intake, a frequent association with renal failure and the predominance of hypoexcretion compared with overproduction of uric acid (UA), frequent tophi forms [5], multiple nature of arthritis [7], possible prodromal phenomena [9], localization of tophi in the area of Heberden's nodes. In addition, in elderly patients, differential diagnosis with septic arthritis is often necessary, which may require emergency hospitalization in a surgical hospital before the diagnosis is verified [10].

It should be noted that there are few scientific works on the study of the characteristics of the course of gout in different age categories, and their data are vague and contradictory.

The purpose of this study is to determine the characteristics of gout in its onset in old aged female patients.

Materials and methods

The study included 50 patients with primary gout (25 men and 25 women) based on the criteria of S. Wallace et al. [15]. The patients were divided into 2 groups: 1st - 27 patients over 60 years old, 2nd group - 23 patients under 60 years old. The average age of onset of

gout in group 1 was 55±4.2 years, in group 2 - 45±5.0 years.

All patients were questioned on such parameters as taking diuretics (regardless of the drug and dose), small doses of ASA, the presence of arterial hypertension (AH), 2 type of diabetes mellitus (2DM), obesity, chronic renal failure (CRF), coronary heart disease (CHD), chronic heart failure (CHF), previous myocardial infarction (MI).

Using a questionnaire, the joints involved in the first attack of gout were determined. All patients underwent a clinical blood test, urine test, 24-hour urine test, and the glomerular filtration rate (GFR) was calculated using the formula (GFR, ml/min = minute diuresis, ml/min • creatinine in urine, μmol/l • 1000/creatinine in serum, μmol/l).

During clinical examination, the number of affected joints and tophi was determined.

Statistical analysis of the data was carried out using the Statistica 8.0 application package (StatSoft. Inc., USA). The results are presented in the form of means and standard deviations (M±SD) for quantitative characteristics that have a normal distribution, in other cases - in the form of median and quartile range (Me [Q1; Q3]). To compare two independent groups, the nonparametric Mann-Whitney test was used; qualitative indicators in the groups were compared by analyzing contingency tables using the χ² method using a two-sided Fisher test.

Results and discussion

The duration of the disease in group 1 was 6.0 [3.0; 9.0] years, in group 2 - 5.0 [2.4; 7.6] years (p=0.31).

There were no significant differences in the prevalence of most of the studied parameters in the groups. Thus, the debut in both groups was the first metatarsophalangeal joint, traditional for this pathology: in the 1st group in 14 (50%) patients, in the 2nd in 10 (45%). The number of tophi forms during examination in both groups did not differ significantly: in 21% patients in group 1 and in 37% in group 2. The proportion of chronic gouty arthritis was also comparable with the onset of the disease at the age of over 60 years and before 60 years: 50 % and 45%. The number of people taking non-steroidal anti-inflammatory drugs also did not differ significantly: 23 (86%) and 12 (51%) in groups 1 and 2, respectively.

Patients of group 1 took low doses of ASA significantly more often than patients of group 2 - 20 (79%) and 7 (14%), respectively (p=0.013). In addition, patients in group 1 were also slightly more likely than patients in group 2 to take diuretics - 14 (49%) and 10 (41%), respectively (p=0.11).

Obesity, DM2, and hypertension occurred with equal frequency at onset at ages both younger and older than 60 years (see table).

Table

Clinical characteristics of patients with gout, %

Parameters	1st group, n=27	2nd group, n=23	p
Taking diuretics	49	35	0,11
Taking NSAIDs	45	33	0,14
Taking ASA	37	14	0,0079
AH	45	33	0,14
IHD	77	31	0,00001
History of MI or stroke	35	12	0,0095
CHF	45	18	0,0053
Obesity	41	43	1,0
DM-2	15	10	0,55
Chronic renal failure	26	18	0,47
Debut in I joint - metatarsophalangeal	77	61	0,089
Chronic arthritis	37	39	1,0
Presence of tophi forms	21	37	0,12

Note. Data are presented as the absolute number of patients, %.

Significant differences were obtained by comparing the frequency in patients with coronary artery disease, heart failure and cardiovascular complications (MI, stroke). Thus, in the 1st group, 77% of 27 patients had coronary artery disease, in the 2nd group - in 31% of 23 (p<0.0001). Similar data were obtained when comparing the prevalence of CHF: in the 1st group in 45%, in the 2nd in 18%; p=0.001, as well as previous MI or stroke: in the 1st group in 35% patients, in the 2nd in 12%; p=0.009).

Discussion

As noted above, few works have been devoted to a comparative analysis of the characteristics of gout in elderly and young patients; This is mainly a description of individual clinical cases, for example, in the work of P. Dieppe [8].

The influence of age on the course of gout was studied in the most detail in the study by V.G. Barskova et al. However, it did not analyze the age of patients at the onset of gout [2].

The duration of gout in both groups in our work turned out to be comparable, which made it possible to more clearly compare the studied parameters. One of the most interesting data from our study is that the number of patients taking diuretics in both groups was comparable at the onset of gout in both elderly and middle age.

It is known that taking diuretics is an independent risk factor for the development of gout. So, according to M.S. Eliseeva et al., this risk factor is observed very often even in young patients, especially in women [3]. The most commonly taken diuretic drugs in women are loop diuretics (almost 50% of the women examined took furosemide), while 10 out of 29 women had no indications for their use: diuretics were taken independently for the purpose of body correction and weight loss. Men were more likely to take thiazide and thiazide-like diuretics.

The clinical significance of the hyperuricemic effect of diuretics was proven in a study involving more than 1000 people over 65 years of age: the average levels of uric acid concentration in the blood serum were significantly higher in those who regularly took diuretics compared to those who did not use drugs of this group (0.361 and 0.281 mmol/l respectively). In addition, according to the data obtained, of 107 patients with HU, 82% took diuretics [6].

Thus, the definition of clear indications for prescribing diuretics as a risk factor for the development of gout, and educational work among patients about severe side effects are relevant at the present time [11].

Despite the fact that the use of diuretics is considered one of the main factors in the increase in the incidence of gout, there is also an opposite opinion. Thus, H. Janssens et al. [12] believe that the risk factors for the development of gout, which practitioners need to pay attention to, are rather pathological conditions for the treatment of which diuretics were used - hypertension and other cardiovascular diseases (CVD). An increase in sUA levels, even if it does not lead to the development of gout, is associated with an increased risk of the onset and progression of hypertension [16]. Moreover, the presence of headache in patients with gout turned out to be significantly higher in old age than in other age categories [7].

However, there are diametrically opposite data: the risk of developing hypertriglyceridemia against the background of HU is more pronounced in young people and women [14]. Our study confirmed the connection between gout and the presence of hypertriglyceridemia, regardless of the age at its onset. Since the order of occurrence of these diseases has not been studied chronologically, we cannot accurately determine which of them has a greater impact on the development of the other, but, of course, this is mutual influence.

IHD, a history of myocardial infarction, and CHF were 2-3 times more common in representatives of group 1, which corresponds to data obtained by other authors [5]. However, there is evidence of the effect of HU on the development of CVD in younger patients [6].

The use of small doses of ASA as an antiplatelet agent is significantly higher in the group of elderly patients. Antiplatelet agents, in particular ASA, are an essential component of the treatment of diseases associ-

ated with atherosclerosis and lead to a decrease in the functional activity of the kidneys [10].

MK acts not only as an independent predictor of IHD and overall mortality in patients at risk of developing CVD [9], but also as a marker of preclinical atherosclerosis in individuals without CVD [4]. Despite the abundance of data on the frequent presence of coronary artery disease in gout sufferers, the question of the true nature of this relationship still remains open: whether HU has a direct effect on the development of IHD or whether it is indirect and due to the influence of HU on the development of hypertension and atherosclerosis [11]. On the one hand, UA provokes endothelial damage, platelet adhesion and the development of atherosclerosis, leading to CVD [3], on the other, an increase in the level of UA, which is an antioxidant, is considered in the literature as a protective mechanism that prevents lipid peroxidation in conditions of the development of CVD [11]. In this case, HU, which is a consequence of the presence of CVD, can explain the higher prevalence in patients with the onset of gout in old age and with concomitant diseases.

Gouty arthritis is also associated with an increased risk of developing myocardial infarction, which is independent of the presence of factors such as metabolic syndrome, diuretic use, and CVD [7]. Thus, among older Canadians, a high risk of developing MI in women suffering from gout has been noted [10].

According to our study, CHF is significantly more common with the onset of gout in old age, and obesity was equally common (49 and 43%, respectively) in both groups. It should be noted that obesity has been associated with gout for many centuries, and now, along with type 2 diabetes, hypertension, and hyperlipidemia, it is considered one of the important factors causing the increase in the incidence of this pathology. In our recent study, it turned out that obesity as a risk factor for the development of gout was observed equally often, regardless of the age of the patients at its onset [5].

ZDM was equally common in our groups, as in the authors [6], but in contrast to the data of other researchers [1].

CRF was slightly more common in patients with the onset of gout at the age of 60 years (26 and 18%, respectively), but the differences were not significant.

Kidney damage in gout is often associated with age, duration of the disease, concomitant pathology, and in some cases determines the prognosis of its course. In the elderly, the functional activity of the kidneys decreases; it is influenced by the use of ASA as a prophylaxis of thrombus formation, hypertension, and hyperglycemia [9].

Chronic gouty nephropathy is not considered to be caused solely by HU. A connection between chronic kidney damage and the presence of diseases associated with hyperuricemia, primarily hypertension, is postulated [8].

However, an experimental model of GU in rats showed the possibility of inducing hypertension, arteriopathy and damage to the interstitial tissue of the kidneys by mechanisms not related to the deposition of UA crystals, but by influencing the synthesis of renin by the juxtaglomerular apparatus, reducing the activity of neuronal NO synthase in the macula densa [4]. In this case,

it is necessary to remember that although GU is an obligate sign of gout, it does not always lead to it. In addition, the in vivo model of HU did not lead to the development of gout. Perhaps, with an increase in the number of observed patients, the ratio of cases of chronic renal failure in the elderly and young will change and will give us the opportunity to more reliably assess this parameter.

It is necessary to emphasize the frequent presence of hypertriglyceridemia, 2 type of diabetes mellitus, and coronary heart disease in gout as part of a multimorbid status, which enhances the manifestation and increases the frequency of gout attacks. According to the literature, the cardiometabolic background in patients with gout increases their risk [16].

Our data indicate approximately the same prevalence of combined pathology in both groups. However, if the presence of several diseases in patients of the 1st group can be explained by age, then the comparable frequency of several forms of pathology, not typical for young people, in the 2nd group, namely obesity, hypertension, 2DM, chronic renal failure, may indicate their connection with gout, as shown abroad [14].

Conclusion

1. Thus, the first joint in both groups was more often the first metatarsophalangeal joint, which certainly facilitates the diagnosis of gout, and the main clinical features of gout are characteristic of elderly patients as well as younger patients. The age of patients at the onset of gout does not determine significant differences in clinical features with a comparable duration of its course in young and elderly patients. The number of tophi forms also did not differ at the onset of gout in both young and old age. Tophi are one of the reliable signs of gout; their presence can be an indicator of both its severity and the lack of systematic treatment. Chronic arthritis was observed equally often in both groups.

2. In addition to the expected conclusion about the high frequency of diuretic use, the presence of hypertension, 2 type of diabetes mellitus, obesity and chronic renal failure, our data suggest the influence of these factors on the course of gout, regardless of the age of the patients. Of course, large population studies are needed to definitively answer the question about the characteristics of the course of gout in different age groups. Currently, gout remains one of the most interesting subjects of study: despite its advanced age, it is more than modern, and the pathology that accompanies it only forces us to pay more attention to its prevention and treatment in both young and old aged women.

References

1. Атаханова Л.Е., Цурко В.В., Булеева И.М. и другие. Подагра: от этиологии и патогенеза к диагностике и рациональной терапии // *Соврем. гевматол.* – 2007. – Vol. 1. – P. 13-18.
2. Барскова В.Г., Кудаева Ф.М., Якунина И.А., Насонова В.А. Клинические особенности подагры у пожилых людей // *Клин. геронтол.* – 2006. – №2. – С. 11-14.
3. Елисеев М.С., Чикаленкова Н.А., Денисов И.С., Барскова В.Г. Факторы риска подагры: гендерные различия // *Науч.-практ. ревматол.* – 2011. – Vol. 6. – P. 27-30.
4. Bieber J.D., Terkeltaub R.A. Gout: on the brink of novel therapeutic options for an ancient disease // *Arthritis Rheum.* – 2004. – Vol. 50. – P. 2400-2414.
5. Chen S.Y., Chen C.L., Shen M.L. Manifestations of metabolic syndrome associated with male gout in different age strata // *Clin. Rheumatol.* – 2007. – Vol. 26. – P. 1453-1457.
6. Choi H.K., Atkinson K., Karlson E.W., Curhan G. Obesity, weight change, hypertension, diuretic use, and risk of gout in men: the health professionals follow-up study // *Arch. Intern. Med.* – 2005. – Vol. 165. – P. 742-748.
7. De Scheerder I.K., van de Kraay A.M., Lamers J.M. et al. Myocardial malondialdehyde and uric acid release after short-lasting coronary occlusions during coronary angioplasty: potential mechanisms for free radical generation // *Amer. J. Cardiol.* – 1991. – Vol. 68. – P. 392-395.
8. Dieppe P.A. Investigation and management of grief in the young and elderly // *Ann. Rheum. Dis.* – 1991. – Vol. 50. – P. 263-266.
9. Fam A.G. Gout in the elderly. Clinical presentation and treatment // *Drugs Aging.* – 1998. – Vol. 13, №3. – P. 229-243.
10. Geiderman J.M. An elderly woman with a warm, painful finger // *West J. Med.* – 2000. – Vol. 172, №1. – P. 51-52.
11. Hootman J.M., Helmick C.G. Projections of US prevalence of arthritis and associated activity limitations // *Arthritis Rheum.* – 2006. – Vol. 54. – P. 226-229.
12. Janssens H.J.E.M., van de Lisdonk E.H., Janssen M. et al. Gout, not induced by diuretics? A case control study from primary care // *Ann. Rheum. Dis.* – 2005. – Vol. 65, №8. – P. 1080-1083.
13. Luk A.J., Simkin P.A. Epidemiology of Hyperuricemia and Gout // *Amer. J. Manag. Care.* – 2005. – Vol. 11. – P. 435-442.
14. Simkin P.A., Campbell P.M., Larson E.B. Brief report: Gout in Heberden's nodes // *Arthritis Rheum.* – 1983. – Vol. 26. – P. 97-104.
15. Wallace S.L., Robinson H., Masi A.T. et al. Preliminary criteria for the classification of the acute arthritis of gout // *Arthritis Rheum.* – 1977. – Vol. 20. – P. 895-900.
16. Zhang W., Doherty M., Pascual E. et al. EULAR evidence based recommendations for gout. Part I: Diagnosis. Report of a task force of the Standing Committee for International Clinical Studies Including Therapeutics (ESCIIT) // *Ann. Rheum. Dis.* – 2006. – Vol. 65, №10. – P. 1301-1311.

ASSESSMENT OF FEATURES OF THE CLINICAL COURSE OF GOUT IN ELDERLY WOMEN

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Objective: To study the characteristics of gout at its onset in elderly women. **Material and methods:** 50 patients with primary gout (25 men and 25 women) were observed based on the criteria of S. Wallace et al. The patients were divided into 2 groups: 1st – 27 patients over 60 years old, 2nd – 23 patients under 60 years old. The average age of onset of gout in the 1st group was 55±4.2 years, in the 2nd group – 45±5.0 years. **Results:** The duration of the disease in both groups averaged 6 years. Arthritis of the first metatarsophalangeal joint at the onset of the disease in groups 1 and 2 was diagnosed in 75 and 65% of cases, respectively. Chronic arthritis in group 1 was diagnosed in 14 (50%) patients, in group 2 – in 10 (45%). Tophi were detected during examination in 21 and 37%, respectively. Diuretics were taken by 14 (50%) and 11 (47%) patients. Arterial hypertension was detected in 6 (25%) of those examined in group 1 and in 17 (40%) in group 2. The number of obese patients in the two groups was comparable (41 and 43%). **Conclusions:** The main clinical features of gout are characteristic of elderly patients as well as younger patients. Cardiovascular diseases at the onset of gout are more often observed in old age.

Keywords: gout, old age, arterial hypertension, acute myocardial infarction, chronic renal failure.