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ОСОБЕННОСТИ ЛЕЧЕНИЯ АНТИТРОМБОТИЧЕСКИМИ И АНТИКОАГУЛЯНТНЫМИ ПРЕПАРАТАМИ У БОЛЬНЫХ С ОСТРОМ КОРОНАРНОМ СИНДРОМОМ БЕЗ ПОДЪЕМА СЕГМЕНТА ST

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АННОТАЦИЯ

В настоящее время в лечении больных с острым коронарным синдромом без подъема сегмента ST (ОКСБПСТ) широко используются антитромботические и антикоагулянтные препараты. В ряде случаев лечение больных с ОКСБПСТ антитромботическими и антикоагулянтными препаратами повышает риск развития кровотечений.

Цель научного исследования, изучить лечению у больных с ОКСБПСТ, имеющийся высокий риск кровотечений и железодефицитной анемии. Проанализировано 112 истории болезней с диагнозом ОКСБПСТ, в отделении Кардиореанимации Республиканского научного центра экстренной медицинской помощи Самаркандского филиала. Мы изучили, течение болезни у больных с анемией. В лечение у 35 больных мы не использовали совместные применение антиромботические и антикоагулянтные препараты.

Ключевые слова: антиромботические препараты, антикоагулянты, острый коронарный синдром, анемия, кровотечение.

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FEATURES OF TREATMENT WITH ANTITHROMBOTIC AND ANTICOAGULANT DRUGS IN PATIENTS WITH ACUTE CORONARY SYNDROME WITHOUT ST SEGMENT ELEVATION

ANNOTATION

Combined treatment with antiaggregants and anticoagulants may constitute a scheduling approach for the treatment of intense coronary disorder without ST fragment height (AC-ST) in patients with a lack of iron deficiency. However, a few of these patients are at high risk of hemorrhagic complications. This work highlights the importance of choosing the restorative procedure for such patients. The review examination of therapeutic cards of 112 patients alluded to the Office of Cardiac Activity with Determination of AC-ST included the estimation of the adequacy and safety of the anticoagulant heparin in the treatment of press insufficiency iron deficiency in terms of the recurrence of thrombotic and hemorrhagic complications and a guess of the result compared with the patients given no anticoagulants. A total of 35 patients were included. Antithrombotic treatment ought to be endorsed for such patients, taking into account the chance of thrombotic complications. The possibility of stall rot loss and frailty in patients with CS-STs requires illustration and evaluation of hemorrhage risk variables (HAS-BLenn scale), the latter of which determine the choice of modality for encouraging treatment.

Keywords: antithrombotic drugs, anticoagulants, acute coronary syndrome, anemia, bleeding.

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O'TKIR KORONAR SINDROM ST SEGMENTI ELEVATSIYASIZ TASHXISLI BEMORLARNI DAVOLASHDA ANTITROMBOTIK VA ANTIKOAGULYANT DORI VOSITALARINING QO'LLANISHI

ANNOTATSIYA

Hozirgi davrda o'tkir koronar sindrom ST segmentini elevatsiyasiz tashxisli bemorlarda antiagregant va antikoagulyantlarni birgalikda qo'llash keng qo'llanmoqda. Biroq, ba'zi hollarda, ST segmentini elevatsiyasiz o'tkir koronar sindrom bilan og'rigan bemorlarda antikoagulyantlarni qo'llash gemorragik asoratlarni xavfni oshiradi. Ishning maqsadi qon ketish xavfi yuqori bo'lgan va temir tanqisligi kamqonligi bo'lgan bemorlarni olib borish taktikasini aniqlashdir. ST segmentini elevatsiyasiz o'tkir koronar sindrom tashxisi bilan kardioreanimatsiya bo'limiga yotqizilgan 112 bemorning anamnezi tahlil qilindi. Trombotik va gemorragik asoratlarning rivojlanish chastotasi, shuningdek antikoagulyantlarni qabul qilishni nazarda tutmaydigan terapiya bilan taqqoslaganda ushbu toifadagi bemorlarning prognozi bo'yicha dastlabki temir tanqisligi anemiyasini davolash fonida geparin bilan etarli antikoagulyant davolashning samaradorligi va xavfsizligi o'rganildi. Ishning prospektiv qismiga 35 bemor kirdi. ST segmentini elevatsiyasiz o'tkir koronar sindrom bilan og'rigan bemorlarda trombotik asoratlarning yuqori darajasi ko'rsatilgan. ST segmentini elevatsiyasiz o'tkir koronar sindromda trombotik asoratlarning yuqori chastotasi va shu bemorlarda antitrombotik terapiyaning muhimligi aniqlandi. ST segmentini elevatsiyasiz o'tkir koronar sindromda temir tanqis anemiyaning ko'p uchraganligi sababli qon ketish xavf omillarini baholash (HAS-BLEND shkalasi) va keying olib borish taktikasini aniqlashni taqozo etadi.

Kalit so'zlar: o'tkir koronar sindrom, temir tanqis anemiya, gemorragik asoratlarni xavfi, geparin.

Introduction. Concurring to cutting edge concepts, the premise for the treatment of intense coronary disorder without ST portion rise (NSTEMI) on the electrocardiogram (ECG) is to affect intravascular thrombus arrangement with the assistance of antithrombotic drugs (All-Russian Logical Commission, 2016; ACC/AHA, 2016). Subsequently, the combined use of antiplatelet specialists and anticoagulants has led to the development of schedules for this illness. Moreover, a few patients with NSTEMI-ACS, including elderly women, with nearness of

unremitting renal disappointment (CRF) have an expanded hazard of hemorrhagic complications (ESC, 2016). In addition, these risk factors concur with those of the HAS-BLEND scale: hypertension, particularly SBP>160 mmHg; labile international normalized ratio (INR); iron deficiency; impeded renal work, defined as creatinine ≥ 200 μmol/l; disabled liver work; diminished platelet count; past stroke; hereditary variables; and high-sensitivity troponin [1].

Table 1

HAS-BLED Bleeding Risk Score

Letter <*>	Clinical characteristics #	Number of points
H	Hypertension	1
A	Impaired liver or kidney function (1 point each)	1 or 2
S	Stroke	1
B	Bleeding	1
L	Labile INR	1
E	Age > 65 years	1
D	Medicines or alcohol (1 point each)	1 or 2
Maximum 9 points		

<*> First letters of English names.

H-hypertension, systolic blood weight > 160 mm Hg. Craftsmanship. A - renal or liver brokenness: dialysis, kidney transplant or serum creatinine 200 mmol/l; unremitting liver illness (e.g., cirrhosis); or biochemical proof of serious liver harm (e.g., bilirubin level at slightest 2 times the upper limit of ordinary in combination with an increase in AST/ALT/alkaline phosphatase more than 3 times the upper restraint standards). S - history of stroke. B - history of dying and/or inclination to dying, for illustration, dying diathesis, frailty, etc. L - labile INR: unstable/high INR or <60% of INR estimations inside the target run. E - aged older than 65 years. D - drugs/alcohol, concomitant utilize of antiplatelet drugs, nonsteroidal anti-inflammatory drugs (NSAIDs) or liquor mishandle.

In intense coronary disorders, the activation calculated for the advancement of dying, as a run the show, may be sudden weakening or dynamic decay within the systolic work of the heart [2]. The resulting ischaemia of the mucous layer of the gastroduodenal locale,

which diminishes defensive components, causes relative hyperacidity of the stomach, against the foundation of which intense erosive and ulcerative wounds (EUP) of the mucous film of the upper gastrointestinal tract (GIT) develop, taken after gastrointestinal dying (GIB), [3-5]. Along with expansive ponderers (Fervor, 1997; ASSENT-3, 2004; CAPRIE, 1996; OASIS-5, 2005), the gastrointestinal tract and the coming about press lack posthemorrhagic frailty, increasing mortality in patients with intense nonacute joint pain by 5 times during the first 30 days and by 1.5 times within the other 5 months [6].

In ponderers by N. Meneveau et al., Press lack frailty (IDA) occurs in 27% of patients with NSTEMI-ACS as a result of gastrointestinal tract complications against the foundation of serious concomitant pathology and causes a 4-fold increase in mortality in these patients [7]. These bleeding events are identified at dissection in 21% of those who kicked the bucket from different shapes of coronary heart illness

(CHD), accounting for 10% of patients with essential necrosis and 54% with rehashed myocardial localized necrosis (MI) [8].

Within the FRAXIS consider (1999) and within the perceptions of I. Anand [10] and K. R. Alexander [9], an increase in the recurrence of gastrointestinal tract diseases was common during anticoagulant treatment.

In agreement with other creators, gastrointestinal tract diseases or a tall hazard of their event in half of the cases indicate that medicine is insufficient for anticoagulant use [11]. At the same time, S. Husted suggested that under these conditions, lower dosages of molybdenum glycol heparin (LMWH) can be used, which prevents backsliding of the infection within the following 1-1.5 months and does not cause damage to the gastrointestinal tract [12]. Hence, the issue of endorsing anticoagulants to patients with intense esophageal dysplasia due to IDA and a tall chance of gastrointestinal tract disease remains important.

The reasons for the differences in the benefits and dangers of these treatments, the inclination to use bunches, the dose regimens used and the timing of antithrombotic treatment have not been fully resolved. The main reason for this belief was to decide on the treatment of patients with non-ST portion rise intense coronary disorder with a lack of iron deficiency and a high risk of gastrointestinal death. The creators assigned themselves to the examination of the frequency of press insufficiency frailty and the structure of complications in patients with intense nonacute stroke. In addition, the reliance of the improvement in hemorrhagic complications on antithrombotic therapy was assessed within the healing center in patients with intense esophageal vascular illness, and the adequacy and safety of anticoagulants were assessed in patients with intense esophageal vascular illness with press insufficiency iron deficiency and a tall hazard of creating the gastrointestinal tract.

Materials and methods The study included 2 stages. At organization I, a review was carried out of 112 case series of patients with NSTEMI-ACS who were conceded to the cardiac serious care unit of the multidisciplinary clinic of the Tashkent Restorative Institute in

2022-2023. Among the 112 patients, 65 (58%) were men and 47 (42%) were women. The average age of the patients was 69.3 ± 12.1 years.

Screening revealed that, in 78 (69%) patients with NSTEMI-ACS, the Hb level and the number of ruddy blood cells were decreased. Additionally, in 92.9% of patients, the color file was less than one, which indicated hypochromic frailty; in 6.2% of patients, the frailty was hyperchromic; and in 0.9%, it was normochromic.

Arrange II - a planned think about the adequacy and safety of treatment for patients with NSTEMI-ACS and IDA and a tall chance of GIB with heparin and press supplements. The inclusion criteria were concurrent nearness within the understanding of NSTEMI-ACS and IDA and the tall hazard of creating the gastrointestinal tract (HAS-BLEND). The control group comprised patients who did not receive anticoagulants.

The consider did not include patients with nearness or appearance on the ECG of signs of transmural ischemia or myocardial rot (ST section height, neurotic Q wave, QS complex, or unused cleared out bundle department piece); dynamic and/or clinically noteworthy death less than 10 days before any localization; advancement of modern extreme dying disarranges; intense renal disappointment; program hemodialysis; anamnestic signs of nearness of resistant heparin-induced thrombocytopenia; signs of constant circulatory disappointment of utilitarian lesson III-IV concurring with NYHA; intense cerebrovascular illness that happened less than 6 months prior; or a history of unfavorably susceptible responses to heparin.

The NSTEMI-ACS was analysed in accordance with the proposals of the All-Russian Logical Committee (2016) and the ACC/AHA (2016). Inveterate IDA was analysed on the premise of complaints, anamnesis information (location of invertebrate blood failure), and information from laboratory blood parameters [diminish within the level of Hb, ruddy blood cells, colour list, haematocrit, serum iron, ferritin, and an increment within the level of transferrin, add up to and idle serum pressure official capacity (IBC)] [13]. Of the 112 patients with NSTEMI-ACSs, 92 individuals met all the fundamental criteria and were included within the advance criteria. All patients underwent common clinical and research facility examinations (Table 2).

Table 2

Frequency of prescribing iron supplements to patients with acute-CSD in IDA

Degree of anemia	Number of patients	Prescription frequency	
		abs.	%
Lightweight	58	19	32*
Average	37	34	91*
Heavy	17	17	100*
Total	112	70	62.5

Note. Here and in the table. 2—5: * p < 0.05.

In accordance with the proposals of the All-Russian Logical Commission and ESC, all patients were endorsed with complex pharmacotherapy, including LMWH.

The level of troponin T was determined upon affirmation and 12 hours after the patient experienced an anginal assault. All research facility strategies utilized to assess the press digestion system and liver and kidney function involved the use of a gadget for examining blood serum.

To prohibit dynamic dying at the beginning of the sedate treatment, all patients with recognized IDA and a tall chance of experiencing GIB were inspected by a surgeon.

From the minute of randomization, patients within the primary bunch (n = 37) were treated with heparin in accordance with the suggested All-Russian Logical Commission and ESC crisis treatment for NSTEMI-ACS [12, 13]. Hence, the patients in the most bunch received a five-day course of treatment with heparin, the day-by-day dosage of which was approximately 20,000 IU per month. When the sedation

began, coagulogram parameters were taken into consideration, as was antithrombotic treatment carried out before the patient was hospitalized.

Patients within the control group (n = 16) were given full-scale therapy for NSTEMI-ACS but without anticoagulants.

Patients in both bunches, in agreement with the proposals of the All-Russian Scientific Commission and the ESC, proceeded to experience treatment for NSTEMI-ACS in full within the conditions of the cardiac serious care unit with advance restoration within the cardiology divisions of the clinic.

Factual preparation of the comes about was carried out in Microsoft Exceed Expectations and Measurements (Form 6.0). The following measurable methods were utilized: calculating the normality of the heart, calculating the standard deviation, calculating centrality and Student's t test, and developing charts and histograms. Contrasts between bunches were considered noteworthy at p < 0.05 (Table №3).

Table 3

Frequency of prescribing anticoagulants in patients with NSTEMI-ACS

Hemoglobin level, g/l	Number of patients	Prescription frequency	
		abs.	%
From 90 to 120	58	57	98*
From 70 to 90	37	34	91*
Below 70	17	7	41*
Total	112	98	62.5

Results and discussion

At stage I, as a result of screening, hypochromic iron deficiency was identified in 98 (92.9%) patients with intense nonacute stroke-related iron deficiency—a total of 90 g/l < Hb < 120 g/l—in 57 (98%) patients; direct iron deficiency (70 g/l < Hb < 90 g/l)—in 34 (91%) patients; and severe iron deficiency (Hb < 70 g/l)—in 7 (41%).

All 112 patients were classified into 4 categories: in 20 (17%) patients, the cause of hypochromic iron deficiency was constant renal disappointment due to arteriolonephrosclerosis against the foundation of hypertension; in 5 (4.4%) patients, there were neoplasms of different locations; and in 43 (38.3%) patients, there were anamnestic signs of different bleeding events, accounting for 36 (32.1%) gastrointestinal tract bleeding events from erosive and ulcerative injuries of the mucous layer of the upper gastrointestinal tract. In 8 (7.1%) patients, it was not conceivable to establish the beginning of hypochromic iron deficiency.

All patients with hypochromic frailty thought about their serum pressure levels. Other pointers of the press digestion system (ferritin, transferrin, add-up to and inactive iron-binding capacity of blood serum) were considered, as they were found in 10 (9.1%) patients. Due to the lack of recurrence of symptoms in the press digestion system, anamnestic signs of blood misfortune, the nearness of threatening neoplasms and kidney harm, as well as identified hypochromia, were considered by the creators to indicate a lack of pressure.

As seen from the table. 2, In patients with NSTEMI-ACS and a lack of pressure tolerance, adjustment for press insufficiency was carried out, as indicated by a noteworthy decrease in Hb levels. The recurrence of patients with gentle hypochromic frailty who were receiving press supplements was lower (32%) (p < 0.05). IDA anticoagulants within the healing center were endorsed by 65 (58%) patients, whereas they were endorsed by 47 patients without iron deficiency—45 (97.1%) patients (Table №1).

As takes after from the table. Second, the recurrence of anticoagulant therapy in patients with intense nonsteroidal iron deficiency and patients with mellow hypochromic iron deficiency was 97.1 and 93.1%, respectively, which was essentially greater than that in patients with direct iron deficiency and extreme press lack iron deficiency (39.9 and 4.3%, respectively) (p < 0.05).

Clinicians were most likely to choose an antithrombotic medication for UFH (88.2%), whereas LMWH was utilized for 9.1% of the patients (p < 0.05). Adjustment of the press lack in 92.3% of the patients was carried out with ferrous press salt arrangements (p < 0.05). Of the 112

patients, acetylsalicylic acid corrosion was used in 72 (64%) patients, clopidogrel was used in 25 (22.3%), and the combination of these two agents was used in 13 (11.6%) patients. Hence, within the cohort of patients with NSTEMI-ACS and a decrease in Hb levels, associated with a destute guess and a high probability of creating antagonistic events within the close future, 1/3 of patients do not receive anticoagulants, and each fifth does not receive antiplatelet therapy. At the conclusion of the primary portion of the think about, the severity of the clinical course of NSTEMI-ACS was compared with the level of haemoglobin and the percentage of myocardial dead tissue.

In general, the percentage of myocardial dead tissue within the bunch of patients with NSTEMI-ACS and IDA was 89.3%, and within the bunch of patients with NSTEMI-ACS and typical Hb levels, it was 78.4%. As takes after from the table. 4, In patients with direct and severe IDA, the chance of developing MI is essentially greater than that in patients with a slight decrease in Hb or its moderate level (93.7 and 97.3% versus 84.2 and 78.4%, respectively) (p < 0.05). Hence, the hazard of creating myocardial localized necrosis in patients with NSTEMI-ACS specifically corresponds to the degree to which Hb levels are decreased.

Of the 112 patients with IDA, 69 (61%) experienced signs of death—intense in 51 (63.3%) patients and constant blood loss—in 18 (16.1%) patients. Among the causes of gastrointestinal death in 77.6% of patients, the source was erosive and ulcerative injuries of the mucous layer of the upper gastrointestinal tract; in 17.1%, a persistent ulcer of the stomach or duodenum; and in 5.3%, erosive injuries of the mucous layer of the bladder with the improvement of hematuria. Covered up constant blood misfortune with the advancement of IDA was upheld by the discovery of erosive and ulcerative injuries of the mucous layer of the upper gastrointestinal tract or other localizations without signs of dying. The rate of complications in patients with NSTEMI-ACS differed according to the nearness and seriousness of IDA (Table 4).

As shown in the displayed table, in patients with NSTEMI-ACS and a lack of frailty, the frequency of cardiogenic stuns was essentially greater than that in patients with direct and gentle iron deficiency, as was the frequency of typical Hb levels (93.4% versus 59.2, 51.1 and 53.6%, respectively) (p < 0.05). Thromboembolism of the aspiratory supply route (PE) and its branches occurs more regularly in patients with intense stroke and press insufficiency iron deficiency than in patients with ordinary hemoglobin levels (36.2, 64.8 and 68.8% versus 17.5%, respectively) (p < 0.05) and did not depend on the severity of IDA (p > 0.05).

Table 4

Complications of acute non-ESRD according to Hb level

Complications	ACS + mild anemia (n = 58)	ACS + moderate anemia (n = 37)	ACS + severe anemia (n = 17)
Cardiogenic shock (n = 21)	0	2 (9.5%)	19 (90.4%)*
External cardiac rupture (n = 7)	0	1 (14.2%)	6 (85.8%)
PE (n = 5)	1 (20%)*	1 (20%)*	3 (60%)*

Within the cohort of patients with IDA (n = 112), antithrombotic drugs were endorsed in 45.1% of patients, and within the cohort of patients with typical Hb levels (n = 97), antithrombotic drugs were endorsed in 95.2% of patients. The frequency of complications shifted depending on the proximity of antithrombotic drugs as a portion of complex pharmacotherapy. Among patients with NSTEMI-ACS and IDA

who did not receive antithrombotic treatment within the healing center, 83.7% versus 61.4% of the patients accepted anticoagulants (p < 0.05). PE in patients with NSTEMI-ACS and IDA within the nonappearance of antithrombotic treatment was 50.2% more common than when anticoagulants were endorsed (p < 0.05). Moreover, among patients with IDA who were diagnosed with NSTEMI-ACS or IDA and who did

not receive antithrombotic treatment within the healing center, the frequency of cardiogenic stunting was 83.7% versus 61%, respectively. 4% of patients agreed to anticoagulants ($p < 0.05$). PE in patients with NSTEMI-ACS and IDA within the nonappearance of antithrombotic treatment was 50.2% more common than when anticoagulants were endorsed ($p < 0.05$). Moreover, in patients with IDA who were treated with antithrombotics for NSTEMI-ACS, the rate of hemorrhagic complications was 12.4% greater than that in patients with NSTEMI-ACS who were not treated with anticoagulants within the clinic ($p < 0.05$). Therefore, avoiding thrombotic complications of intense coronary syndrome outweighs the hazard of dying. Hence, in patients with NSTEMI-ACS and severe IDA, the risk of thrombotic and hemorrhagic complications is high, which affirms the importance of therapeutic strategies. PE in patients with NSTEMI-ACS and IDA who did not receive antithrombotic treatment occurred 50.2% more frequently than did PE in patients who received anticoagulant therapy ($p < 0.05$). Moreover, among patients with IDA who were treated with antithrombotics for NSTEMI-ACS, the frequency of hemorrhagic complications was 12.4% greater than that among patients with NSTEMI-ACS who were not treated with anticoagulants within the hospital ($p < 0.05$). In any case, anticipating thrombotic complications of intense coronary disorder exceeds the hazard of dying. Hence, in patients with NSTEMI-ACS and extreme IDA, the hazard of thrombotic and hemorrhagic complications is high, which affirms the nearness of troubles during treatment. PE in patients with NSTEMI-ACS and IDA within the nonappearance of antithrombotic treatment was 50.2% more common than when anticoagulants were endorsed ($p < 0.05$). Moreover, in patients with IDA who were treated with antithrombotics for NSTEMI-ACS, the frequency of hemorrhagic complications was 12.4% greater than that in patients with NSTEMI-ACS who were not treated with anticoagulants within the healing center ($p < 0.05$). In any case, avoiding thrombotic complications of intense coronary disorder exceeds the chance of dying. Hence, in patients with NSTEMI-ACS and severe IDA, the risk of thrombotic and hemorrhagic complications is high, which affirms the nearness of troubles during treatment. who were treated with antithrombotics for NSTEMI-ACS, the frequency of hemorrhagic complications was 12.4% greater than that in inpatients with NSTEMI-ACS who did not receive anticoagulant treatment within the healing center ($p < 0.05$). Prevention of thrombotic complications resulting from intense coronary disorders exceeds the chance of death. Hence, in patients with NSTEMI-ACS and severe IDA, the chance of thrombotic and hemorrhagic complications is high, which affirms the presence of challenges during treatment. who were treated with antithrombotics for NSTEMI-ACS, the frequency of hemorrhagic complications was 12.4% greater than that in patients with NSTEMI-ACS who did not receive anticoagulant treatment within the clinic ($p < 0.05$). In any case,

anticipating thrombotic complications of intense coronary disorder exceeds the hazard of dying. In this way, in patients with NSTEMI-ACS and extreme IDA, the chance of thrombotic and hemorrhagic complications is high, which affirms the presence of complications during treatment.

Another objective was to consider the viability and safety of heparin in 83 patients with NSTEMI-ACS, IDA, a tall hazard of dying and a tall chance of unfavorable outcomes (passing, MI). Redress of press insufficiency, notwithstanding the degree to which Hb was diminished and the seriousness of the press lack of frailty, as a portion of complex pharmacotherapy for NSTEMI-ACS was carried out in 100% of the patients. Positive results were obtained for the endpoints of dying, myocardial dead tissue, and passing from any cause. Within the fundamental bunch, 2 patients with MI with a neurotic Q wave were registered, which was consistent with the abrogation of heparin in these patients.

The remaining 35 patients were instantly wrapped in heparin on the 5th day of treatment at the healing center. Within the control group, 9 patients had MI with an obsessive Q wave. Myocardial localized necrosis without a pathological Q wave was created in 19 patients within the fundamental gather, whereas within the control gather, STEMI improved the amount of myocardial dead tissue without an obsessive Q wave in 32 patients. In patients with NSTEMI-ACS and IDA who received LMWH treatment, the frequency of MI with a neurotic Q wave was 14.2% lower ($p < 0.05$), and the rate of MI without an obsessive Q wave was 18.2% lower ($p < 0.05$) than that in patients who did not receive HMH treatment. No cases of bleeding occurred during heparin treatment. The plasma anti-Xa activity was within the range of 0.2–0.4 IU/ml. Within 10 days following sedate cessation,

Within the control bunch, two cases of nosebleeds (recurrence 4.3%) were recorded via gentle review according to the Zeal scale ($p > 0.05$). Amid the time spent within the cardiac serious care unit, no passes were recorded within the main bunch, whereas 3 patients passed on within the control gather. Within the following 10 days of healing center treatment, 2 patients passed on within the primary bunch, and 3 patients passed on within the control gather. Hence, the overall mortality rate within the primary gather was 8.1%, and that within the control bunch was 13.1% ($p < 0.05$). Against the foundation of the redress of IDA with a ferrous press arrangement, in both bunches, the concentrations of Hb ($p < 0.05$), serum pressure ($p < 0.05$), and ferritin ($p < 0.05$) increased, while the level of transferrin decreased ($p < 0.05$) and UIBC ($p < 0.05$).

Conclusion. In this way, the results of this study support the broad use of heparin in the treatment of patients with intense coronary disorders without increasing ST section height, lacking iron deficiency and a tall chance of gastrointestinal death.

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