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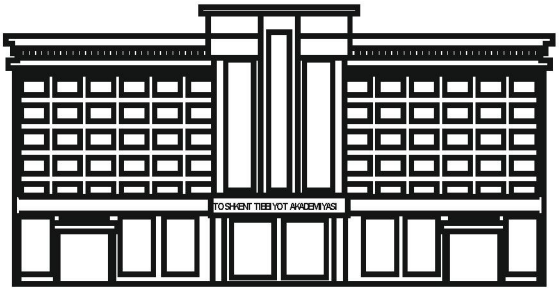

ВЕСТНИК ТАШКЕНТСКОЙ МЕДИЦИНСКОЙ АКАДЕМИИ

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СОДЕРЖАНИЕ CONTENT

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IMPORTANCE OF PULSE THERAPY IN PATIENTS WITH COMORBIDITIES IN SYSTEMIC SCLERODERMIA

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TIZIMLI SKLERODERMIYA VA YONDOSH KASALLIKLARI BOR BEMORLARDA PULS TERAPIYA O'TKAZISH

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ВАЖНОСТЬ ПУЛЬС-ТЕРАПИИ У ПАЦИЕНТОВ С СОПУТСТВУЮЩИМИ ЗАБОЛЕВАНИЯМИ ПРИ СИСТЕМНОЙ СКЛЕРОДЕРМИИ

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Annotation. *The investigation enrolled 25 patients with SSD and 15 sex and age-matched, apparently healthy individuals included in a control group. The Systematic Coronary Risk Evaluation (SCORE) scale was used to assess the risk of fatal in 10 patients with SSD and in 7 control individuals within 1 years. In SSD, BMI >25 kg/m2 was observed significantly more often and the frequency of hypercholesterolemia was lower than in the controls Hypertension and diabetes mellitus were slightly more frequently encountered in SSD patients than in the controls, but this difference was insignificant. Hypertension, overweight, and over 50 years of age were associated with more obvious structural heart disease, TRFs make a substantial contribution to the formation of a high Cardiovascular in patients with SSD, promoting the development of atherosclerosis and its complications.*

Keywords: *Systemic sclerosis; traditional cardiovascular risk factors, SCORE scale.*

Annotatsiya. *Tekshiruv uchun 25 TSD bilan bemorlar va 15 ta yondosh kasalliklari bor bemorlar nazorat guruhiga kiritilgan. Tizimli sklerodermiyada juda yuqori giperxolisterenimiya ancha keng tarqalgan va o'rtacha nazorat guruhida tez-tez kuzatilgan. TSD boshqaruv elementlariga nisbatan yuqori umumiy xavfining ko'payishi bilan tavsiflanadi. Gipertenziya, ortiqcha vazn va 50 yoshdan oshganlar aniqroq tizimli yurak kasalliklari bilan bog'liq edi,TSD bilan og'rigan bemorlarda yuqori xolisteren shakllanishiga katta hissa qo'shadi, ateroskleroz va uning asoratlarini rivojlanishiga yordam beradi. TSD bemorlarida baholash yurak-qon tomir o'limi xavfi yuqori bo'lgan bemorlarni aniqlashga va terapiyani o'z vaqtida buyurishga yordam beradi. Shunday yondosh kasalliklari bor bemorlarda puls terapiya utkazishni urganib chiqish ahamiyatlidir.*

Калит сўзлар: *системный склероз, традицион кардиоваскуляр омиллар, SCORE шкаласи.*

Systemic scleroderma (SSD) is a connective tissue disease characterized by systemic inflammation, widespread microcirculatory vasculopathy, and progressive skin fibrosis and internal organs [1]. SJS varies in severity and progression most patients develop visceral complications, which are usually the cause of death [2] Primary heart disease that develops as a direct consequence of SSD may be manifested by changes myocardium, pericardium and valvular apparatus. In patients, SJS pathology of the heart can also be secondary to acute scleroderma kidney and pulmonary arterial hypertension. Vasculopathy in SJS is characterized by a progressive restructuring of the microvasculature, which can contribute to the development of a variety of cardiovascular changes. Endothelial dysfunction and hemorheological disorders characteristic of SSD are also considered as risk factors for the early development of atherosclerosis (ASC). The common pathogenetic mechanisms of SSD and ASC suggest a high likelihood of atherosclerotic vascular disease in patients with SSD [3, 4]. G.S. [5] expressed the assumption that ASC in patients with SSD makes a certain contribution to macro- and microvascular damage to the myocardium. Patients with SSC have a fourfold an increase in mortality compared with the general population, with a third of the causes of mortality accounted for by cardiovascular diseases (CVD) [6]. In SSC, the leading cause of death unrelated to the underlying disease is CVD [7], which causes from 20 to 30% of deaths [8]. ASC is a complex pathological process Part of which is infection, which is important for the entire evolution of atherosclerotic plaque (ATP) [9]. With autoimmune inflammatory rheumatic diseases such as rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), primary antiphospholipid syndrome, systemic vasculitis, one of the main causes of disability and are cases of CVD associated with an increased risk of developing ASA. Compared to the general population, development of ASA in RA and SLE age and is often asymptomatically variable [10]. Apart from traditional risk factors (TFR), in systemic connective tissue diseases, additional risk factors are important: chronic inflammation, duration and activity of an autoimmune disease, immunosuppressive therapy. The role of chronic inflammation is indicated by the fact that inflammatory mediators such as C-reactive protein, heat shock proteins, are also involved in the pathogenesis of ASC [3, 7]. With rheumatic diseases, chronic inflammation can accelerate the formation of ATP, both through a direct effect on the wall sarteries and indirectly, by influencing lipid profile. Along with inflammation, antibodies produced in autoimmune diseases can also lead to changes in the blood lipid spectrum [9]. Other specific factors may also contribute to the development of premature ASA (decrease

in the number and function of endothelial progenitor cells, accelerated apoptosis of endothelial cells, epigenetic changes). It has not yet been established whether ASC develops in patients SJS earlier than in the population. A number of studies indicate an increase in the frequency of detection of ASA in SSD. It is known that both pronounced and subclinical manifestations of ASC are found in SJS with a high frequency. So, the defeat of the carotid arteries is noted in 40%, endothelial dysfunction - in 76.4% of patients. In SSC, the incidence of CVD and macrovascular disease is increased compared with the general population, and the combination SJS with ASA worsens the prognosis. On examination 5860 of patients with SJS, it was shown that cardiovascular disorders were the cause of death in 26% of them, and among the causes of death not related to SJS itself, almost 1/3 (29%) of cases were due to CVD. SJS is characterized by a high risk of mortality from vascular accidents [9]. In addition, patients with SSC have higher in hospital mortality from cardiovascular complications (CVS) associated with ASA compared with patients with SLE and RA [10] The pathogenesis of ASC in SS remains unclear. It is believed that TFRs contribute to its accelerated development [8]. However, the results of studies in which TFR were evaluated in patients with SSc are contradictory and do not yet confirm significant differences in the TGF profile compared to with control. Preliminary data show an increase in the frequency of arterial hypertension (AH), dyslipidemia and an increase in body mass index (BMI) in patients with SJS, which may contribute to the formation functional and structural changes in the heart, worsening the prognosis of the disease in general. At present, a comprehensive analysis is considered one of the promising approaches to improve prognosis in SSD.

The aim of this study was to assess the frequency of CVD TFR in patients with SSD and to analyze their relationship with the clinical manifestations of SSD, as well as with structural changes in echocardiography data.

Material and methods. The study included 125 patients with SSD (13 women and 12 men) aged 22 to 17(average 50.68±11.9 years) and with a duration of illness from 1 year to 36 years (average 8.9±8.0 years). The diagnosis of SSD was reliable and met the criteria of the College of Rheumatology (ACR) 1980; and ACR/European League Against Rheumatism (EULAR) 2013. In 73% of cases, there was a limited form of SSD. Patients had a typical picture of SSD, including sclerodactyly (92%), gastrointestinal involvement (GIT; 92%), interstitial lung disease (ILD; 50%), signs of digital ischemia (43%), telangiectasia (43%), osteolysis (27%), soft tissue calcification (20%). The median skin score was 4 [2;8]. The following were assessed: increase in BMI >25 kg/m2, hypercholesterolemia [total cholesterol (CH)>5.2 mmol/l], AH [level of systolic arterial pressure (BP)>140 mm Hg. Art. and diastolic blood pressure >90 mm rt. Art.], smoking, diabetes mellitus (DM). All patients received standard vascular therapy, according to indications - glucocorticoids, immunosuppressants. All patients with SSD underwent a standard electrocardiography (ECG) and 121 - echocardiography control the group consisted of 30 people (5 men and 15 women) aged 25 to 60 years (mean age 47.08±8.01 years) from among the employees of the them. The control and main groups were comparable in terms of gender and age. Assessing the risk of fatal CVD during10 years on the SCORE scale was carried out in 30 patients with SSD and 27 people from the control group. The rest (25 patients with SSD and 3 people from the control group) immediately were identified as being at very high cardiovascular risk (CVR) because they had diabetes and/or coronary heart disease (CHD), suffered a heart attack myocardial infarction (MI) or stroke. Data analysis was carried out using the statistical program

Results The frequency of TFR in patients with SSD did not differ significantly from that in the control group, with the exception of incidence of hypercholesterolemia and elevated BMI In SSD, an increase in BMI >25 kg/m2 was observed significantly more often, and the frequency of hypercholesterolemia was lower than in controls p.0.18. in SSD were slightly more common than in control, but this difference is not significant. There were no smokers among patients with SSD and in the control group. When studying the relationship between and clinical manifestations of SSD was noted that in the limited form of the disease, AH occurred significantly more often than with diffuse 34.1 and 5.99%, respectively; p=0.015). In patients with SSD older than 50 years, significantly more often than in younger patients, (36 and 12%, respectively; p=0.0029) and hypercholesterolemia (62.7 and 44%, respectively; p=0.0398) were detected. There are no significant differences in the frequency of low and high risk observed. As can be seen from Table. 2, in SSD, the total risk of CVD was high or very high on the SCORE scale in almost 1/3 of patients. At the time of the examination, 20% of patients already had proven signs of developed ASC and its complications, which significantly exceeded the corresponding indicator in the control group. In 14 (11%) patients there were signs of circulatory failure. It is known that in a number of diseases there is a certain relationship between CVR and changes in the structure and function heart, e.g. with left ventricular remodeling (LV). In SSD, structural changes in the heart compared to healthy individuals have not been studied enough. In this study, 83% of patients with SSD had some or other changes in echocardiography It concerned the first sequence of changes in the aortic and mitral valves in the form of their compaction and calcification of the valves. LV diastolic dysfunction was observed in almost half sick. In 7% of patients, there was a significant decrease in the ejection fraction (EF) of the LV (25 kg/m2) and hypertension (r=0.23; p<0.05)

Conclusion TFRs make a significant contribution to the formation high CVR in patients with SSD, contributing to the development of ASC and its complications. Evaluation of TGF in patients with SSD will allow identify patients with a high risk of cardiovascular mortality and timely conduct therapy aimed at reducing it. AG is an important TFR that in SSD is associated with signifi-

cant structural changes in the heart, therefore, to improve the prognosis SSD is important for adequate control of hypertension, especially in people over 50 years of age.

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ВАЖНОСТЬ ПУЛЬС-ТЕРАПИИ У ПАЦИЕНТОВ С СОПУТСТВУЮЩИМИ ЗАБОЛЕВАНИЯМИ ПРИ СИСТЕМНОЙ СКЛЕРОДЕРМИИ

Бекенова Г.Т., Набиева А.Х., Ганиева Н.А., Зияева Ф.А., Камалова Д.К.

Аннотация. *В исследовании приняли участие 25 пациентов с ССД и 15 сопоставимых по полу и возрасту, внешне здоровых лиц, включенных в контрольную группу. Шкала систематической оценки коронарного риска (SCORE) была использована для оценки риска развития ССД с летальным исходом у 10 пациентов с ССД и у 7 лиц контрольной группы в течение 1 года. При ССД ИМТ >25 кг/м2 наблюдался значительно чаще, а частота гиперВ холестеринемия была ниже, чем в контрольной группе. Гипертоническая болезнь и сахарный диабет несколько чаще встречались у пациентов с ССД, чем в контрольной группе, но эта разница была незначительной. Артериальная гипертензия, избыточный вес и возраст старше 50 лет были связаны с более выраженными структурными заболеваниями сердца вносят существенный вклад в формирование высокого гиперхолестеринемия у пациентов с ССД, способствуя развитию атеросклероза и его осложнений.*

Ключевые слова: *системный склероз, традиционные кардиоваскулярные факторы риска, шкала SCORE.*