Pain and inflammatory edema can mask manifestations of congestion in the large circulation circuit in case of chronic heart failure. Hypodynamia that is the result of pain facilitates development of obesity, which, in its turn, switches on a lot of additional molecular interactions worsening the course of underlying pathology.

Hence, AH and OA are comorbid pathology: they are related pathogenetically. Clinical manifestation of any of the couple worsens the second one.The search of criteria of early diagnostics and prediction of complications remains a topical task of medicine nowadays.

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METABOLIC SYNDROME IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Rheumatoid arthritis and metabolic syndrome are considered to be diseases with common traits that can increase the risk of cardiovascular disease incidence. The prevalence of metabolic syndrome (MS) among rheumatoid arthritis (RA) patients is 37%, which almost corresponds to the prevalence of metabolic syndrome among patients with coronary heart disease - 41% and occurs with greater frequency than in the population (10-30%). Patients with rheumatoid arthritis have an increased risk and a higher mortality from cardiovascular diseases, the rheumatologist should be aware of those MS risk factors and attempt to modify them.

The aim of our study was to investigate some criteria of MS (based on criteria recommended by the International Federation of Diabetes, 2005) in patients with RA.

The study involved 30 patients with RA who were hospitalized in the rheumatology department of Chernivtsy regional clinical hospital. The control group consisted of 20 healthy individuals. Clinical examination of each patient included general clinical and special studies. For the study of carbohydrate metabolism conducted laboratory studies of blood to the definition of indicators of blood glucose and insulin levels. The level of insulin resistance (IR) was calculated using the formula HOMA-IR. Waist circumference measured by tape at the navel.

Increased waist circumference (central obesity type) in women> 80 cm in men> 94 cm was observed in 40% of women and 36.7% of men in patients with RA. In the control group - 25 and 20%, respectively ($p < 0,05$). IP is observed in 20% of patients with RA, diabetes type 2 - 3.3% increase in fasting blood glucose> 5.6 mmol/l - in 23.3% of patients with RA in the control group IR 5% and improving fasting blood glucose by 10% ($p < 0,05$). Increased blood pressure (> 130/85 mm Hg) and / or the use of antihypertensive therapy was found in 46.7% of patients with RA and 10% in the control group ($p < 0,05$).

So, signs of metabolic syndrome in patients with rheumatoid arthritis are significantly more likely than in the control group. Combined course of disease requires attention from clinicians to develop a differentiated approach to the prevention of metabolic syndrome among patients with rheumatoid arthritis.

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QUALITY OF LIFE IN PATIENTS WITH CHRONIC HEART FAILURE AND DIABETES MELLITUS TYPE 2 AND POSSIBILITY OF ITS CORRECTION

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Diabetes mellitus (DM) is one of the leading medical-social problem of the modern society due to its high incidence, frequent comorbidity with concomitant pathology, increased mortality, high risk of chronic vessel complications. In Ukraine, same as in the world, the number of diabetic patients is continuously increasing mainly due to people with diabetes mellitus type 2, the number of which totally in the population of patients with this disease is around 90% (Pankiv V.I., 2010).

The aim of the research was to determine the impact of chronic heart failure and diabetes mellitus type 2 on the quality of life of elderly and senile patients.

A comprehensive survey of 108 patients with chronic heart failure (HF) of ischemic origin and DM type 2 was conducted. The average age of the patients was 76,04±1,84 years. All examined patients according to their comorbidities were randomized into the following subgroups: I – patients with HF without DM type 2 (n=32), II – patients with HF, complicated by concomitant DM type 2 (n=76). The control group for comparative studies comprised 24 people without HF and DM type 2, whose age was not significantly different from the average age of the patients of the experimental groups. All patients received basic therapy of the main and concomitant diseases. Moreover to achieve the objective of the investigation telmisartan was prescribed additionally. Therefore, patients with heart failure and diabetes mellitus type 2 were randomized into subgroups according to the prescribed treatment: IIA subgroup – patients who received only basic therapy (26 people); IIB subgroup (30 patients) – those for whom in the scheme of the standard treatment substitution of ACE inhibitor by angiotensin II receptor blocker telmisartan (MIKARDIS®, Boehringer Ingelheim) was conducted. Telmisartan was prescribed in the daily dose of 40 mg after meals. Duration of hospital treatment was 21-24 days, in addition, it was recommended to continue treatment with telmisartan up to 3 months. Quality of life was determined by Mezzich J. E., Cohen M., Ruiperez N. et al. questionnaire.

The level of physical welfare was the highest in the patients of the control group (6,2±0,56 points) dominating over the corresponding figure in the group of patients with chronic HF up to 1,37 times (4,5±0,48 points, p<0,05), and up to 2,82 times (2,2=0,11 points, p<0,05) in patients with chronic HF and DM type 2. Value of the index of psychological and emotional welfare in the patients of the control group was 57% more than in the patients with heart failure, its lowest value was determined in the patients of II group – 2,1±0,25 points, which differed significantly from the patients of the control group (p<0,05) and the patients of the I group (p<0,05). The lowest level of self-service and independence of activity was detected in the patients with chronic HF and diabetes mellitus type 2 (4,1±0,14 points), being significantly different from the corresponding value in the group of patients with heart failure of ischemic origin (6,3±1,11 points, p<0,05), and the control group (9,4±0,62 points, p<0,05). Workability index was higher in patients of both experimental groups than in the patients of the control group. Thus, both in the patients with isolated HF and in the patients with combined course of chronic HF and diabetes mellitus type 2 the difference between the corresponding values was statistically significant, same as comparing to the patients with the control group (2,5±0,60 points and 3,8±0,09 points to 5,4±1,08 points, correspondingly, p<0,05). The level of interpersonal interaction and socio-emotional support was statistically significantly lower in comparison with the control group only in the patients of II experimental group. The lower value of this figure in the patients with chronic heart failure was statistically improbable comparing with patients of the control group. The level of public support in the patients of I experimental group was statistically improbable lower than in the control group (6,4+1,03 against 8,6+0,65 points, p>0,05). In the patients with chronic heart failure and diabetes mellitus type 2 the following figure was 4,6±0,32 points, being statistically significantly different from the patients of the control group (p<0,05). Figure of the personal implementation was the highest in the patients of the control group (7,4±0,64 points). Due to chronic heart failure of ischemic origin its decreasing to 5,67+0,52 points was determined, though we found no statistically significant difference comparing to the control group (p>0,05). The lowest level of personal implementation was detected in the experimental II group of patients with HF and DM type 2 (2,8±0,40 points, p<0,05 comparing with both control and I group). The index of religious implementation was almost equal in all investigated groups. Comparing with the control group overall perception of quality of life in patients with chronic heart failure was lower by 23%, and in patients with heart failure and diabetes mellitus type 2 – by 42% respectively (p<0,05 in both cases).

In the IIA experimental group during treatment we managed to achieve significant increasing of the figure of physical welfare by 59% comparing with one before treatment (p<0,001), psychological and emotional welfare – by 130% (p<0,001), workability – by 27% (p<0,02), overall perception of quality of life – by 13% respectively (p<0,02). At the same time, the inclusion of telmisartan to the scheme of a comprehensive treatment resulted in statistically significant improvement of the overall perception of the quality of life by 1,74 times (p<0,001), particularly accompanied by improvement of physical welfare by 2,78 times against corresponding value before treatment (p <0,001), psychological and emotional welfare – by 3,09 times (p<0,001) and workability – by 1.56 times (p<0,001), interpersonal interaction – by 1,33 times respectively (p<0,02). In addition, in the patients of IIB group we noted the improvement of the values of socio-emotional support by 67% (p<0,001), public support – by 24% (p<0,02) and personal realization – by 103% (p<0,001).

Thus, inclusion of telmisartan to the scheme of a comprehensive treatment of the patients with chronic heart failure and diabetes mellitus type 2 results in the improvement of the patients' quality of life as well as its main components.

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ACCENTS OF MEDICINE: DISEASE OR HEALTH?

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Assuming the fact that improving health of the nation by means of money investment into the treatment of diseases is a right way, then why it results in constant increase of sickness rate?

A man cured from the disease does not mean a healthy person. In several months he/she appears again with another disease – and again examination and treatment require some expenses. Why not to try another way?

Effective methods are teaching operative ways of improving and keeping health of the population, as well as consciousness to take care of one's body and soul, to think about one's future and confidently achieve positive results.

There are several examples to follow. For example, cycle ways and pedestrian paths run through the whole Poland – you are welcome to move! Finland, for example, has surprised Europe altogether. The country has consistently popularized a healthy and active way of life, rational diet and achieved excellent results – for 25 years mortality rate due to ischemic heart disease became 73% lower! Their popularization was maintained by real actions on the state level. One of them was handing round salads in public catering places free of charge. Therefore, they trained people to eat green vegetables.

There is a kind of paradox in our medicine: targeting health as an aim it deals with diseases. The experience is indicative of the fact that medicine is able to treat and save the human life in acute situations, but often it fails to restore health in case of chronic diseases which are the main causes of death in modern life (cardio-vascular, malignancies, endocrine diseases etc.). Therefore, the priorities and accents in medicine should be changed. To achieve good health one should take care of health but not a disease.