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«Salutem»

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У збірнику представлені матеріали міжнародної науково-практичної конференції **«Досягнення медичної науки як чинник стабільності розвитку медичної практики»**. Розглядаються загальні проблеми клінічної та профілактичної медицини, питання фармацевтиної науки та інше.

Призначений для науковців, практиків, викладачів, аспірантів і студентів медичної, фармацевтичної та ветеринарної спеціальностей, а також для широкого кола читачів.

Усі матеріали подаються в авторській редакції.

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ЗМІСТ

10. Rana N.A., Haltiwanger R.S. Fringe benefits: functional and structural impacts of O-glycosylation on the extracellular domain of Notch receptors / N.A. Rana, R.S. Haltiwanger // Curr Opin Struct Biol. – 2011. – V. 21, № 5. – P. 583–589.
11. Ranganathan P., Weaver K.L., Capobianco A.J. Notch signalling in solid tumours : a little bit of everything but not all the time / P. Ranganathan, K.L. Weaver, A.J. Capobianco // Nat Rev Cancer. – 2011. – V. 11, № 5. – P. 338–351.
12. Takebe N., Harris P.J., Warren R.Q., Ivy S.P. Targeting cancer stem cells by inhibiting Wnt, Notch, and Hedgehog pathways / N. Takebe, P.J. Harris, R.Q. Warren, S.P. Ivy // Nat. Rev. Clin. Oncol. – 2011. – V. 8. – P. 97–106.
13. Weng A.P., Ferrando A.A., Lee W. et al. Activating mutations of NOTCH1 in human T cell acute lymphoblastic leukemia / A.P. Weng, A.A. Ferrando, W. Lee et al. // Science. – 2004. – V. 306, № 5694. – P. 269–271.

НАПРЯМ 2. КЛІНІЧНА МЕДИЦИНА: СТАН ТА ПЕРСПЕКТИВИ

COMPARATIVE ANALYSIS OF CARDIOVASCULAR DISEASE IN SOME AFRICAN COUNTRIES, INDIA AND UKRAINE

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Cardiovascular disease (CVD) currently accounts for nearly half of non-communicable diseases (NCDs). NCDs have overtaken communicable diseases as the world's major disease burden, with CVD remaining the leading global cause of death, accounting for 17.3 million deaths per year, a number that is expected to grow to >23.6 million by 2030 [6].

Increasingly, the populations affected are those in low- and middle-income countries (LIMC), where 80% of these deaths occur, usually at younger ages than in higher income countries, and where the human and financial resources to address them are most limited [8].

Cardiovascular diseases in Ghana. Cardiovascular diseases refer to diseases of the heart and/or blood vessels. The occurrence of cardiovascular diseases has risen exponentially in Ghana to become a leading cause of morbidity and mortality. Statistics at the National Cardiothoracic Center indicate that 60% of deaths among adults in the country results from cardiovascular diseases and stroke [7].

According to the latest data from WHO, Cardiovascular diseases cause 3000 deaths per every 100000 people which translates to 750250 deaths annually from cardiovascular diseases representing 3% of the population.

Among the cardiovascular diseases, the most prevalent in Ghana are as follows:

1. Rheumatic heart disease – 133 in every 100000.
2. Hypertensive heart disease – 154 in every 100000.
3. Ischemic heart disease – 910 in every 100000.
4. Cerebrovascular disease – 1016 in every 100000.
5. Inflammatory heart disease – 187 in every 100000.

The risk factors for these cardiovascular diseases are: obesity, hypertension, tobacco smoking, alcohol, diabetes mellitus and dyslipidemia.

Among the cardiovascular diseases, cardiovascular diseases are the most common in Ghana, accounting for about 35%–40% of heart-related cases in hospitals. The main risk factors for these cardiovascular diseases are hypertension, diabetes mellitus, smoking and obesity.

Hypertension is the major risk factor for this kind of cardiovascular diseases. Recent studies suggest that 13–25% of the country's adult population is hypertensive thus is prone to contracting cardiovascular diseases.

The eating of fatty and salty foods as well as lack of exercising puts many Ghanaians at risk of hypertension and thus cardiovascular diseases.

Also about 6–7% of the adult population are diabetics, and 6% have high cholesterol thus are prone to cardiovascular diseases.

Furthermore about 10% of the adult populations are tobacco smokers and 5–7% – obesity. All these data positively show why the occurrence of cardiovascular diseases in Ghana is a rampant and should be of concern to all stakeholders.

Cardiovascular diseases in Somalia. Although the mortality rate from cardiovascular diseases has been greatly reduced from the 70'th they continue to cause nearly half of the working-age deaths in Somalia. In fact they form the largest group of death causes. In 2012 heart infarct attacks and coronary artery disease in all age groups had a total of 21 769. The number of men suffering from this group of diseases slightly outreaches the half of the cases [2].

Working-age Somalis infarction and coronary artery disease attacks in one year period was 4052, men numbered four-fifths of this amount. Regional differences in cardiovascular spreading and mortality are high in Somalia.

Coronary heart disease is found about one and a half times more often in the south-western Somalia in comparison with the eastern and north-eastern part of the country. Also, the socio-economic differences are noticeable. Groups of smaller incomes have higher risk of developing cardiovascular disease and dying from it.

Somalia was the world's top ranked middle-aged men with coronary heart disease mortality in the 1960s. In the beginning of 2000 years the middle-aged men mortality level was reduced by approximately one fifth of its highest level. Currently from coronary artery disease die more than 12 000 Somalis each year.

In 2012, coronary heart disease caused the death of 11 591 people and more than a half of them were men; died 1252 people of working age and about 83 per cent of them were men.

A reduction in coronary heart disease over the past decades has contributed improved prevention and treatment along with improved lifestyles. in recent decades bypass surgery and angioplasty are developing in Somalia.

Although the incidence has declined there appeared some fears that the aging population is increasing number of cases. As with other cardiovascular disease heart failure occurs more commonly in eastern and northern Somalia than in the south and southwest Somalia. The number of sufferers is probably declining. In 2010 the special rights to compensation of heart failure medication about 43 000 Somalis were given.

Cardiovascular diseases in India. Heart diseases have emerged as the number one killer among Indians. According to the World Health Organization, heart related disorders will kill almost 20 million people by 2015, and they are exceptionally prevalent in the Indian sub-continent [4].

According to a recent study by the Registrar General of India (RGI) and the Indian Council of Medical Research (ICMR) about 25 percent of deaths in the age group of 25–69 years occur because of heart diseases. If all age groups are included, heart diseases account for about 19 percent of all deaths.

It is the leading cause of death among males as well as females and in all regions of India, the study found. India, with more than 1.2 billion people, is estimated to account for 60 percent of heart disease patients worldwide.

Half of all heart attacks in this population occur under the age of 50 years and 25 percent under the age of 40. It is estimated that India will have over 1.6 million strokes per year by 2015, resulting in disabilities on one third of them.

The threat of heart disease isn't a new one. It's been glaring at us for years, making us question every detail of our complicated lifestyle choices, diet and level of physical activity. It's been a leading killer in the West and has now aggressively made its way to India. According to government data, the prevalence of heart failure in India due to coronary heart disease, hypertension, obesity, diabetes and rheumatic heart disease ranges from anywhere between 1.3 to 4.6 million, with an annual incidence of 491,600 to 1.8 million [5].

According to a report by published by The Associated Chambers of Commerce and Industry of India (ASSOCHAM), one of the apex trade associations on the cardiovascular disease scenario in India, the country has seen a considerable increase in the number of heart disease cases over the past couple of decades. The report suggests that the leading cause of this is India's economic growth and urbanization. A large section of the population has adopted an unhealthy lifestyle combined with decreasing physical activity, increasing stress levels and a higher intake of saturated fats and tobacco.

To address this rising heart disease epidemic, the government had initiated an integrated National Program for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Strokes.

Cardiovascular diseases in Ukraine. Every year cardiovascular diseases kill more than 500 thousand Ukrainians (an average of 1370 people die every day). According to the State Statistics Service, in 2013 about half of the deaths are due to cardiovascular diseases. In comparison with 2012 the mortality rates have not changed in Ukraine. The main reasons: low culture of prevention, diagnostic and treatment of cardiovascular diseases among the Ukrainians [1].

Over the last years, diseases of the cardiovascular system make up 66% of the total number of Ukrainians mortality. While in most European countries, this index does not exceed 50%. For example, the mortality rate from stroke in Ukraine is higher than in Switzerland (men – 18 times, women – 14 times).

Ukraine is a member of the international community of countries that have set a goal to reduce CVD mortality by 25 percents to 2025. First of all this progress will depend on educational work of scientists, doctors etc.

Next is a serious problem – the difficult economic situation in the country and the low level of material security of citizens. High rates of CHD are especially troublesome in Ukraine and other formerly Soviet Republics in transition, where health systems are not sufficiently financed to respond to a high demand for chronic disease treatment, and out-of-pocket health care expenditures incurred by patient households are often catastrophic [3].

The different regions of the world face different stages of the epidemic. Currently, the Eastern European countries and members of the former Soviet Republic are facing enormous burdens with over half of all deaths attributed to cardiovascular disease. Meanwhile, countries in Sub Saharan Africa are just beginning to see increases in these chronic illnesses while still grappling with HIV/AIDS. The trends in risk factors suggest the problem is only going to continue to grow in the near term. Nonetheless, viable solutions to curbing if not reversing the epidemic exist. The reduction in the disease burden will require changes at the policy level as well as at the personal level. From societal perspective efforts to improve lifestyle choices such as tobacco control strategies will be paramount. At the personal level strategies to assess risk will need to be simplified as well as the treatment modalities employed. Further, alternative uses of allied health workers such as community health workers will need to be evaluated given the reduce human resources in most developing countries [3]. Indicators of cardiovascular morbidity in India are lower than in other countries, including Ukraine. However, taking into account the population, heart disease in India is a serious worldwide problem.

References:

1. Щорічна доповідь про стан здоров'я населення, санітарно-епідемічну ситуацію та результати діяльності системи охорони здоров'я України. 2013 рік / За ред. О.С. Мусія. – К., 2014. – 438 с.
2. Crimmins E.M. Gender differences in health : results from SHARE, ELSA and HRS / E.M. Crimmins, J.K. Kim, A. Sole-Auro / Eur J Pub Health. – 2011. – 21. – P. 81–91.
3. Gaziano Thomas A. Growing Epidemic of Coronary Heart Disease in Low- and Middle-Income Countries / Thomas A. Gaziano, Asaf Bitton, Shuchi Anand, Shafika Abrahams-Gessel, Adrianna Murphy // Curr. Probl. Cardiol. – 2010. – 35(2) – P. 72–115.

4. Gupta R. Burden of coronary heart disease in India / R. Gupta // Indian Heart J. – 2005. – Vol. 57, Suupl 6. – P. 632–638.
5. Joshi R. Fatal and Nonfatal Cardiovascular Disease and the Use of Therapies for Secondary Prevention in a Rural Region of India / R. Joshi // Circulation. – 2009 – Vol. 119, Suppl. 14. – P. 1950–1955.
6. Laslett Lawrence J. The Worldwide Environment of Cardiovascular Disease : Prevalence, Diagnosis, Therapy, and Policy Issues A Report From the American College of Cardiology / Lawrence J. Laslett, Peter Alagona, Bernard A. Clark, Joseph P. Drozda, Frances Saldivar, Sean R. Wilson, Menolly Hart // J Am Coll Cardiol. – 2012. – Vol. 60, Suppl. 25. – P. S1–S49.
7. Mensah G.A. Ischaemic heart disease in Africa / G.A. Mensah // Heart. – 2008. – Vol. 94, Suppl. 7. – P. 836–843.
8. Smith S.C. Our time : a call to save preventable death from cardiovascular disease (heart disease and stroke) / S.C. Smith, A. Collins, R. Ferrari // J. Am. Coll. Cardiol. – 2012. – Vol. 60. – P. 2343–2348.

ЕФЕКТИВНІСТЬ КОМПЛЕКСНОГО ЛІКУВАННЯ ГЕНЕРАЛІЗОВАНОГО ПАРОДОНТИТУ В ХВОРИХ НА ШИЗОФРЕНІЮ

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Дослідженнями багатьох вчених показаний тісний взаємозв'язок уражень тканин пародонта із загальними захворюваннями організму, виявлена значна розповсюдженість та певні особливості перебігу захворювань пародонта при різних системних патологіях [1; 2; 4; 6]. Серед них значне місце займають ураження пародонта в осіб із захворюваннями нервової системи та психічними розладами [3; 5; 7]. Вивчення особливостей механізмів розвитку та перебігу захворювань пародонта у хворих з порушеннями психіки та розробка методів комплексного лікування та профілактики цих захворювань має важливе значення і є актуальними для практики терапевтичної стоматології.

Комплексне лікування генералізованого пародонтиту (ГП) проведено 104 хворим на шизофренію, розподілених, залежно від методу лікування, на дві порівняльні за віком і станом пародонта групи. В основній групі (72 особи) комплексне лікування проводили із застосуванням розроблено-