The results of the study showed that under conditions of spontaneous diuresis, significant changes in the function of the kidneys in patients were absent. At the same time, during the water loading, the diuresis was reduced, both absolute and standardized; glomerular filtration (GF) was reduced by 3 times ($p<0.05$) in relation to a group of healthy individuals. There was also a significant impairment of the ion-regulating function of the kidneys: if in healthy individuals, sodium excretion increased by 50% in relation to spontaneous diuresis, then it was to decrease in patients with CH ($p<0.05$). Similar changes were observed regarding the excretion of ammonia and titrated acids ($p<0.05$)

Correlation analysis showed the relationship between the MA indicator in the blood and the specific gravity of urine ($r= 0.81$, $p<0.05$), as well as GF ($r=-0.56$, $p<0.05$); and the level of MMP 280 correlated with the level of sodium in the blood and its excretion ($r=-0.54-0.58$, $p<0.05$)

Thus, in patients with chronic hepatitis in the early stages of the disease during the water load, there is a disturbance of the adaptive properties of the kidneys by reducing GF. At the same time, both FRP and the SEI may have a certain role in the development of these disorders, which requires further study.

Liakhovych O.D.

FEATURES OF THE CLINICAL COURSE OF NON-ALCOHOLIC STEATOHEPATITIS DEPENDING ON THE PRESENCE OF COMORBID DISEASES: OBESITY AND OSTEOARTHRITIS

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Today non-alcoholic fatty liver disease (NAFLD) is one of the most common diseases in hepatology, which leads to poor quality of life, reducing its duration. With regard to the etiology of NAFLD, it is quite diverse, although its close relationship with insulin resistance (IR) is noted. The liver is a major target of lesions in conditions characterized by IP, which is a factor in the risk of progression of liver steatosis in NASH, with an inherent risk of progression to cirrhosis.

Objective – to find out the features of the clinical course of non-alcoholic steatohepatitis (NASH) depending on the presence of comorbid diseases: obesity (Ob) and osteoarthritis (OA), the degree of obesity. 140 patients with NASH, OA, obesity or with their combination, were examined including 30 patients with OA and normal weight (BMI = 21-25 kg /m^2), 80 patients with OA, NASH and obesity (BMI higher than 30 kg/m^2), 30 patients with NASH and obesity without OA (BMI>30 kg/m^2). The average age (63.1±5.3) years. The duration of NASH disease ranged from 2 to 11 years. The control group consisted of 30 healthy individuals with normal body weight, including 12 men and 18 women.

Clinical manifestation of non-alcoholic steatohepatitis during comorbid obesity and osteoarthritis (compared with the course without OA) includes prevailing astheno-vegetative syndrome and hepatomegaly (96,3% and 100,0% of cases versus 50,0% and 93,3% in patients without osteoarthrosis), dyspeptic (OR=2,61, 95% CI [1,13-6,03]) and cholestatic (OR=3,40, 95% CI [1,21-9,58]) syndromes (with frequency of 78,8% and 56,3% of cases vs. 30,0% and 16,7% for NASH without OA), splenomegaly (OR=4,75, 95% CI [1,04-21,75]) (31,7% vs. 6,7%) frequency and intensity of biochemical syndromes: cholestasis (65,0% vs. 23,3%), mesenchymal inflammation (100,0% vs. 40,0%), hepatic cell failure (41,3% vs. 10,0%), which significantly exceeded their intensity in NASH patients without OA ($p<0,05$).

With increase of obesity from I to II degree in patients suffering from NASH with OA the frequency of asthenia, cholestasis, splenomegaly increased among biochemical clinical signs: degree of liver steatosis (Steato-test), mesenchymal inflammation and cholestasis ($p<0,05$). With increase of obesity from the II to III degree the frequency of dyspepsia, cholestasis, abdominal discomfort, splenomegaly increased among clinical signs. The frequency of cholestasis and hepatic cell failure (HCF) increased among biochemical syndromes ($p<0,05$). The chance of occurrence of biochemical syndromes: mesenchymal inflammation (OR = 2,50, 95% CI [1,17-5,34]), cholestasis (OR=2,79, 95% CI [1,11-6,96]), HCF (OR = 4,50, 95% CI [1,27-16,04]) and the formation of

glucose tolerance disorders (OR = 2,42, 95% CI [1,13-5,17]) with NASH and comorbid obesity and osteoarthritis was significantly higher than for NASH without OA (p<0,05).

Olinyk O.Ju.

METABOLIC SYNDROME IN RHEUMATOID ARTHRITIS PATIENTS

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The prevalence of metabolic syndrome (MS) among rheumatoid arthritis 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%). Insulin resistance is an essential feature of the metabolic syndrome that has been linked to rheumatoid arthritis (RA). Understanding how inflammation arising in one tissue affects the physiology and pathology of other organs remains an unanswered question with therapeutic implications for chronic conditions including obesity, diabetes mellitus, atherosclerosis, and RA.

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). Elevated serum triglycerides level to≥1.7 mmoles/L were present in 52 % of the patients (p<0,05). IR 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).

The above studies represent small, but significant advances in the effort to understand the complex interplay between MS and RA. The prevalence of MS has been reported to be significantly higher in patients with RA as compared to the general population. 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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GASTROINTESTINAL MOTILITY DISORDERS IN PATIENTS WITH METABOLIC SYNDROME: A WAY OF CORRECTION

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Metabolic syndrome (MS) has attracted increasing attention of the medical community as a burgeoning global problem, with an increasing prevalence in urban populations. Approximately one fourth of the adult European population is estimated to have this disorder. The main components of the cascade of metabolic disorders or metabolic syndrome-abdominal obesity, hyperlipidemia, tissue insulin resistance, hypertension are closely related to the functional state of the digestive system. Gastrointestinal motility disorders occur in 70-80% of patients with MS that significantly affects their quality of life.

The aim is to study the efficacy and tolerability of itopride hydrochloride in patients with MS and gastrointestinal motility disorders compared to domperidone.

The study involved 30 patients with metabolic syndrome and digestive tract motility disorders. Patients were randomly and equally divided into two groups: Group 1 received Itopride