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PECULIARITIES OF PATHOGENETIC CHANGES IN STABLE ANGINA IN THE
ANALYSIS OF HEART ATTACK

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The aim of the research is to study the peculiarities of the course of stable angina pectoris (STA) of different functional classes (FC) with postinfarction and diffuse atherosclerosis. 120 patients with an objectified diagnosis of STA of II and III FC, who were divided into two groups, were examined during our research: the 1st group included the patients with verified STA of II FC and the 2nd group included the patients with heart contractions (HC) of III FC (25.83 and 74.17% of cases, respectively).

According to the presence or absence in the history of myocardial infarction (MI), the distribution led to the division into three groups: patients with postinfarction atherosclerosis after Q-MI (44, 17% cases), with postinfarction atherosclerosis after non-Q-MI (17.50% of cases) and with diffuse atherosclerosis (38.33% of cases).

At the beginning of inpatient treatment and after 6 months at the outpatient stage, all patients underwent clinical and laboratory examination, which included biochemical blood tests (lipid profile, creatinine, uric acid (UA), enzyme-linked immunosorbent assay of serum to determine the levels of amino-terminal propeptide natriuretic peptide (NT-proBNP) and C-reactive protein (CRP).

It was found that in the group with a history of Q-MI, the proportion of patients with FC III STA probably predominates (51.69 ± 5.30 and 22.58 ± 7.51)% of cases, respectively ($p < 0.01$), with probably less detection of severe angina among people without IM (32.58 ± 4.97 and 54.84 ± 8.94)% of cases, respectively ($p < 0.05$).

The level of total cholesterol (LTC) in the blood is significantly higher in patients with STA III FC - (5.86 ± 0.14), against (5.33 ± 0.21) mmol / l, respectively ($p < 0.05$), regardless of the presence in patients with a history of Q- and non-Q-MI - (5.81 ± 0.20), against (5.67 ± 0.16), against (5.81 ± 0.20) mmol / l, respectively (in all cases $p > 0.5$). The level of HC is significantly higher in patients with STA III FC - (500.58 ± 17.52), against (374.14 ± 20.89) $\mu\text{mol} / \text{l}$, respectively ($p < 0.001$). However, this indicator increases only in the combination of STA with transferred Q-MI (against patients without MI - (517.32 ± 23.34), against (425.73 ± 21.99) $\mu\text{mol} / \text{l}$, respectively, $p < 0, 01$), without significant differences in the value of this indicator in combination with STA with transferred non Q-MI (against patients without MI - (435.63 ± 32.336), against (425.73 ± 21.99) $\mu\text{mol} / \text{l}$, respectively, $p > 0.5$).

Blood creatinine values were determined to be significantly higher in patients with severe STA - (111.19 ± 3.88), against (96.48 ± 4.36) $\mu\text{mol} / \text{l}$, respectively ($p < 0.05$), and in combination

with STA with Q-MI - against patients without MI (115.60 ± 5.28), against (94.37 ± 2.98) $\mu\text{mol} / \text{l}$, respectively ($p < 0.001$) and not Q-MI - against patients without MI (115.19 ± 8.78), against (94.37 ± 2.98) $\mu\text{mol} / \text{l}$, respectively ($p < 0.05$). There was a probable increase in the levels of NT-pro BNP - (365.28 ± 52.03), against (191.16 ± 29.23) pg / ml , respectively ($p < 0.01$) and CRP - ($13, 60 \pm 1.18$), against (6.77 ± 0.40) mg / l , respectively ($p < 0.001$). There was no difference in these biomarkers depending on the presence in the history of transferred Q- and non-Q-MI. The concentration of CRP in patients without MI, after Q- and non-Q-MI (10.34 ± 1.19), against (11.34 ± 0.86), against (12.76 ± 5.50) mg / l , respectively (in all cases $p > 0.5$) did not have a reliable position.

In contrast, the level of triglycerides (TG) does not significantly depend on the severity of STA - (2.33 ± 0.07), against (2.16 ± 0.12) mmol / l , respectively ($p > 0.5$), nor from the transferred Q- and not Q-MI. The level of TG in patients without MI, after Q- and non-Q-MI is (2.28 ± 0.13), against (2.31 ± 0.07), against (2.09 ± 0.08) mmol / l , respectively (in all cases $p > 0.5$).

Analyzing the results, it should be noted that the higher functional class of stable angina involves an increase in total cholesterol, levels of amino-terminal propeptide natriuretic peptide and C-reactive protein, regardless of the presence of a history of Q- and non-Q-myocardial infarction.

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ADJUVANT THERAPY OF METEOROLOGICAL PATIENTS WITH ISCHEMIC HEART DISEASE

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The existing standards for the treatment of age-related vascular pathologies of the heart and brain do not provide the correction in weather-dependent patients, so there is a problem of finding drugs with multiorgan action, among which herbal medicines have undeniable advantages.

The aim of the investigation is to study the clinical efficacy of Krateprovin (Bovios Pharm, Ukraine) and its effect on left ventricular ischemia in the complex treatment of patients with coronary heart disease (CHD) in the inpatient and outpatient stages. Krateprovin consist of ginkgo biloba leaf extract (EGB) 50 mg, hawthorn fruit extract 150 mg, periwinkle extract 60 mg, pueraria root extract 50 mg. 98 patients with coronary heart disease, stable angina pectoris II-III functional class, aged 47-75 years were examined. Patients in the comparison group (23 people 23.47%) received standard treatment (angiotensin-converting enzyme inhibitor, beta-blocker, nitrate, if necessary - diuretic), patients in the control group - (75 people, 76.53%) - additional drug Krateprovin (2 capsules per day regardless of meals for 2-4 months). Daily ECG monitoring was performed using a portable complex "Solvaig" (Hungary). Examinations were performed in the first two days on a drug-free background and 14-16 days after the course of treatment. It was found that all patients had different degrees of meteorological dependence, 76 people (77.55%) had increased cardiac manifestations, which were accompanied by headache, sleep disturbance, irritability, arthralgia, which neurologists assessed as manifestations of dyscirculatory encephalopathy I-II degree. The seasonal manifestations of meteorological dependence in the late autumn and early spring periods were clinically more significant and longer than in the winter and summer periods.

The use of Krateprovin in the complex treatment of patients with coronary heart disease significantly contributed to accelerate the regression of clinical manifestations of coronary heart disease by 2 –5 days. The results of Holter ECG monitoring show that the reduction of ischemia manifestations in patients with coronary heart disease was achieved by taking Krateprovin- the number of ischemic episodes decreased from 7.2 ± 0.58 to 3.1 ± 0.21 ($p < 0.05$), the duration of ischemic episodes decreased from 46.7 ± 4.08 to 21.2 ± 2.01 min ($p < 0.05$), respectively, with a significant difference compared to similar parameters of the comparison group.

This effect Krateprovin demonstrates, probably, due to the content of flavonoids (quercetin, isoquercetin, rutin, triterpene compounds, ginkgolides A, B, C, J and bilobalides) - the main active substances of EGB and pueraria. They determine the antispasmodic, capillary-strengthening, anti-inflammatory and membrane-stabilizing properties of the drug. The vasoprotective properties of