

(<0,05), ascending aorta (<0,01), and arc (<0,001). Data calculated in ANOVA educed an increase sequence of changes of diameter values (from 3,3 toward 3,59) allowed to suggest a hypothesis about existence of linear dependence of changes of diameters of aorta root depending on progress diastolic dysfunction types. The method of "Up - and - down - runs test" (<0,01) proved the non-random character of sequence of diameters' changes of aorta root accordingly worsening of diastolic dysfunction. The result of one-sided test of Mann-Kendall (<0,01) specifies that the increase sequence of diameter of aorta roots has linear character due to diastolic dysfunction. A result is presented as a formula: value = a +[b x (a grade is in a sequence)], where a = 2,955, b = 0,115 (95 C = 0,085 - 0,250), =0,02. This regression equation gave an opportunity to expect the percent of relative increase of size of diameter dependently to the transition from one type of diastolic dysfunction to other, that equaled 4,67 % (95 CI = 2,20 - 7,21 %).

The study conclusion can be determined as following: arterial hypertension with concomitant diabetes mellitus type 2 is accompanying with structural changes of aorta with increasing of the diameters and decline of aortic compliance. This process could be described by specific linear regression model.

Shorikova D.V.

COVID-19 INFECTION AND AUTOIMMUNE VASCULITIS: CLINICAL CASE

*Department of Internal Medicine, Clinical Pharmacology and Occupational Diseases
Bukovinian State Medical University*

Since the emergence of SARS-CoV-2 worldwide, various manifestations and concurrent diseases have been reported, including COVID-19-associated Kawasaki-like multisystem inflammatory syndrome in young patients. In hospitalized patients with COVID-19, myocardial injury is observed in between 23% and 27.8% of cases.

A female patient T., 32 years old, appealed to the clinic in February 2021 with complaints about intensive constricting pain behind the sternum, spreading into the left hand, shortness of breath and acute weakness. 2 months previously, in the beginning of December the diagnosis of COVID-19 infection was confirmed by polymerase chain reaction (PCR) for SARS-CoV-2. She was treated with COVID-19 in infection department during 2 weeks by standard protocol. She has Guillain–Barré syndrome in anamnesis.

A week before the present hospitalization, she suffered from fever (up to 40 °C), which reiterated her into the hospital. Over the past 3 days, there began to show the constricting pain in rest, which become intensified by any physical activity, shortness of breath, acute general weakness. The patient's general condition demonstrated a moderate severity. Consciousness is clear, oriented in space and time. Peripheral lymphatic nodes are not palpable. Bone-articular system was without visible changes. No peripheral edema was present. There were changes in acute phase inflammatory indicators: ESR was 55 mm/hour, a CRP - 48 mg/l, Fibrinogen plasma content - 7.6 g/l, D-dimer - 345 ng/ml. On the ECG the ST-segment elevation in leads II, III, AVF is recorded. Troponin I was demonstrated a weak reaction (+ \ -). The echocardiography data showed moderate enlargement of the dimensions of the both ventricles, hypertrophy of the LV walls, aorta is not expanded, and the structure of valves is seen without visible changes. The myocardial contractility is reduced, the EF is 50%. The hypokinesia of all walls of LV, with more reliable changes of interventricular septum (IVS) were observed.

On the 3rd day, despite the treatment, the patient's condition did not improve, the complaints were preserved, hyperthermia appeared, there was not dynamical changes of the signs of acute myocardial infarction appeared on ECG. The next diagnosis was established: Kawasaki disease of adult, with recurrent course and severe activity. Coronaritis (inflammatory coronary damage) with the development of multiple aneurysms of left main coronary artery, anterior descending coronary artery, diagonal branches, Left circumflex coronary artery, right main coronary artery, Posterior descending artery. Basal non-Q myocardium infarction, HF II FC. The combination of anticoagulants (enoxaparin), -blockers (metoprolol), antithrombocyte agents (clopidogrel and aspirin) used in the treatment represented standard patient scheme management with acute coronary

syndrome, but the special non-atherosclerotic inflammatory etiology of myocardial infarction required also the use of prednisone with dose 150 mg/day in parenteral administration along 7 days, then methylprednisolone 28 mg/day, as well as azathioprine 100 mg bid.

Thus, patients with COVID-19 may present with ST-segment elevation suggestive of myocardial infarction in the absence of atherothrombosis. This situation requires a specific diagnostic approach and management.

Shuper V.O.

INQUIRY OF THE NON-ADHERENCE TO THE PATIENTS THERAPY WITH CORONARY HEART DISEASE

*Department of Internal Medicine, Clinical Pharmacology and Occupational Diseases
Bukovinian State Medical University*

Most causes of deaths all over the world can be attributed to chronic diseases. Approximately half of patients with chronic diseases do not take their medication as prescribed. Many researches have shown that non-adherence leads to increased morbidity, mortality and the cost of healthcare. Coronary heart disease (CHD) has become a global health problem and a primary cause of morbidity and premature death worldwide. The levels of non-adherence among patients with CHD is typically in the range of 33%–50%. Non-adherence to secondary prevention medications has been associated with a 10%-40% increase in the risk of cardiac hospitalization and a 50%–80% increase in mortality.

The aim of the work was to investigate the adherence to secondary prevention medications among patients with Coronary Heart disease and identify factors associated with it. 40 patients diagnosed with CHD with age more than 50, which has been prescribed with optimal medication for 1 year during hospitalization were examined. Patients' adherence was defined according to MMS-8 Morisky values for secondary prevention medications prescribed by doctors. Also, questionnaires about individual reasons of non-compliance and for individual patient's opinion about importance and usefulness of knowledge according risk factors of the increase cardiovascular mortality was designed and proposed to the patients. Simple descriptive statistics were used to elucidate the characteristics of the patient population and results from individual adherence tools. Final score was analyzed and correlation between patients' data and level of adherence to prescribed treatment were identified. A correlation matrix (using Spearman's coefficient) was reviewed for any evidence of collinearity.

Our study demonstrated higher level of non-adherence with secondary prevention medications in patients with CHD (60.0%). This fact can be explained by the socioeconomic reasons, less informative strategies from the medical staff to the patients. Severe regress of adherence was demonstrated after discharge from the hospital due to subjective improvement of the patients' condition with absence of supervision by out-patient specialists.

Demographic characteristics of the patients suggested that some non-modified factors can affect compliance with the prescribed treatment. Better adherence was demonstrated by female married patients with higher educational level, with family history about cardiovascular death. Also, too much prescribed medications with difficult regime of usage with non-adequate out-patient supervision may significantly decrease adherence causing development of complications which may lead to re-hospitalizations and cardiovascular death.

Our investigation demonstrated also non-complete information of the patients about lifestyle and medical risk factors of the cardiovascular mortality increase.

So, results of our study can provide useful practical information on the prevalence and severity of non-adherence among patients with CHD. Analysis of the factors influencing the adherence demonstrated the main reasons from patients and healthcare professionals affecting the level of compliance with the prescribed treatment. The step towards improving adherence can be initiated by the healthcare professional to overcome the patient's concerns about the prescribed medication. It is important to continue personal monitoring of patients by healthcare professionals in the form of