



Studies of bronchial cholinergic tone regulation and that of the gallbladder in patients with combined course of chronic acalculous cholecystitis (CAC) and chronic obstructive pulmonary disease (COPD) are especially topical.

92 patients were involved in the study: 30 patients with COPD (1st group), 30 patients with COPD and comorbid CAC in the acute phase (2nd group), 32 patients with CAC in the acute phase (3rd group) and a control group – 30 practically healthy individuals (PHI) of the respective age.

All the patients with COPD and COPD combined with CAC had a marked predominance of the parasympathetic nervous system, as evidenced by the established reliable decrease of the activity of the blood acetylcholinesterase in patients with isolated COPD by 1.4 times ($p < 0,05$), in patients with COPD combined with CAC – there was more intense inhibition of enzyme activity – by 1,8 times ($p < 0,05$) and in patients with CAC of the 3-rd group there were identical changes – a decreased activity of the blood acetylcholinesterase by 1,6 times ($p < 0,05$) with reliable intergroup difference between the groups ($p < 0,05$).

The indicator that contributes to the development and progression of chronic obstructive pulmonary disease with concomitant chronic acalculous cholecystitis is the presence of a pronounced cholinergic imbalance, one of the manifestations of which is a significant reduction in the activity of the blood acetylcholinesterase.

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MONOTHERAPY WITH ANGIOTENSIN-CONVERTING ENZYME INHIBITORS AND COMBINED ANTIHYPERTENSIVE THERAPY IN PATIENTS WITH DIABETIC NEPHROPATHY: RETROSPECTIVE STUDY

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Diabetes and hypertension affect heart, kidneys, brain and blood vessels of the retina. End-stage renal disease with a combination of these pathologies is the commonest cause of disability and mortality.

The aim was to compare the efficiency of monotherapy with ACE inhibitors at high doses and combination therapy (ACE inhibitor and moxonidine or ACE inhibitor and indapamide) in patients with hypertension on the background of diabetic nephropathy.

We analyzed 68 clinical records and 34 blood pressure diaries. The first group of patients is represented by 16 patients who received only ACE inhibitor (enalapril or lisinopril) at a dose of 20-60 mg/day, the second group includes 27 patients treated with the combination of enalapril or lisinopril (10-20 mg/day) with moxonidine (3-4 mg/day), the third group is represented by 25 patients treated with the combination of ACE inhibitors (as in the second group) and indapamide at a dose of 1.5 mg/day.

The more significant effect was proved in the second group (blood pressure after treatment was 130 ± 4 (systolic) and 85 ± 3 mm Hg (diastolic) vs. 136 ± 4 and 88 ± 2 in the first group and 133 ± 3 and 80 ± 2 in the third group ($P < 0,05$), respectively, and we found out a positive effect in the second group on the heart rate (70 ± 3 beats/min in the second group vs 80 ± 6 in the first group and 83 ± 4 beats/minute in the third group ($P < 0,05$)), which positively changed quality of patients' life. The use of combined therapy with ACE inhibitors and moxonidine in patients with diabetic nephropathy demonstrates higher clinical efficiency and a favorable safety profile.

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ANCYLOSING SPONDYLOARTHRITIS AND ASSOCIATED COMORBIDITY

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Ankylosing spondyloarthritis (AS) is a chronic inflammatory rheumatic disease affecting primarily the axial skeleton and the sacroiliac joints. AS can be associated with peripheral joint involvement and may also be accompanied by the presence of extra-articular manifestations. AS is associated with comorbidities, accompanying pathologic process, and adds the complexity to the management and strategies of treatment. Understanding of these comorbidity profiles will help to evaluate the impact of comorbid conditions on AS clinical course.

We have evaluated comorbidity and its association with clinical parameters in 22 patients with AS (17 men and 5 women). Diagnosis of AS was based on *Modified New York Criteria*. Disease activity was estimated by Ankylosing Spondylitis Disease Activity Score (ASDAS), functional status by Bath Ankylosing Spondylitis Functional Index (BASFI) and spinal mobility by Bath Ankylosing Spondylitis Metrology Index (BASMI).

The survey of the results demonstrated that comorbidities were detected in 19 (86.4%) patients. Cardiovascular disorders (ischemic heart diseases, hypertonic diseases, heart insufficiency), gastrointestinal diseases (chronic gastroduodenitis, peptic ulcer, bowel irritations disorders), hepatobiliary diseases (chronic persistent hepatitis, noncalculous cholecystitis, chronic pancreatitis), lung problems (chronic bronchitis) prevailed in comorbidity profile. Diabetes mellitus (2 patients), osteoporosis (3 patients), anemia of chronic diseases (3 patients), kidney disorders (nephrolithiasis) – 1 patient were diagnosed in patients. The number of comorbid diseases in the age group up to 40 years was within 2-4, 40-50 years - 5-6 diseases.

Patients with comorbidities had significantly higher scores in ASDAS, BASMI, BASFI. The frequency of comorbidities was higher in the patients with peripheral joints involvement and associated with more active disease and functional impairments, depending from age, duration of disease. The growth of comorbidity caused a more severe and