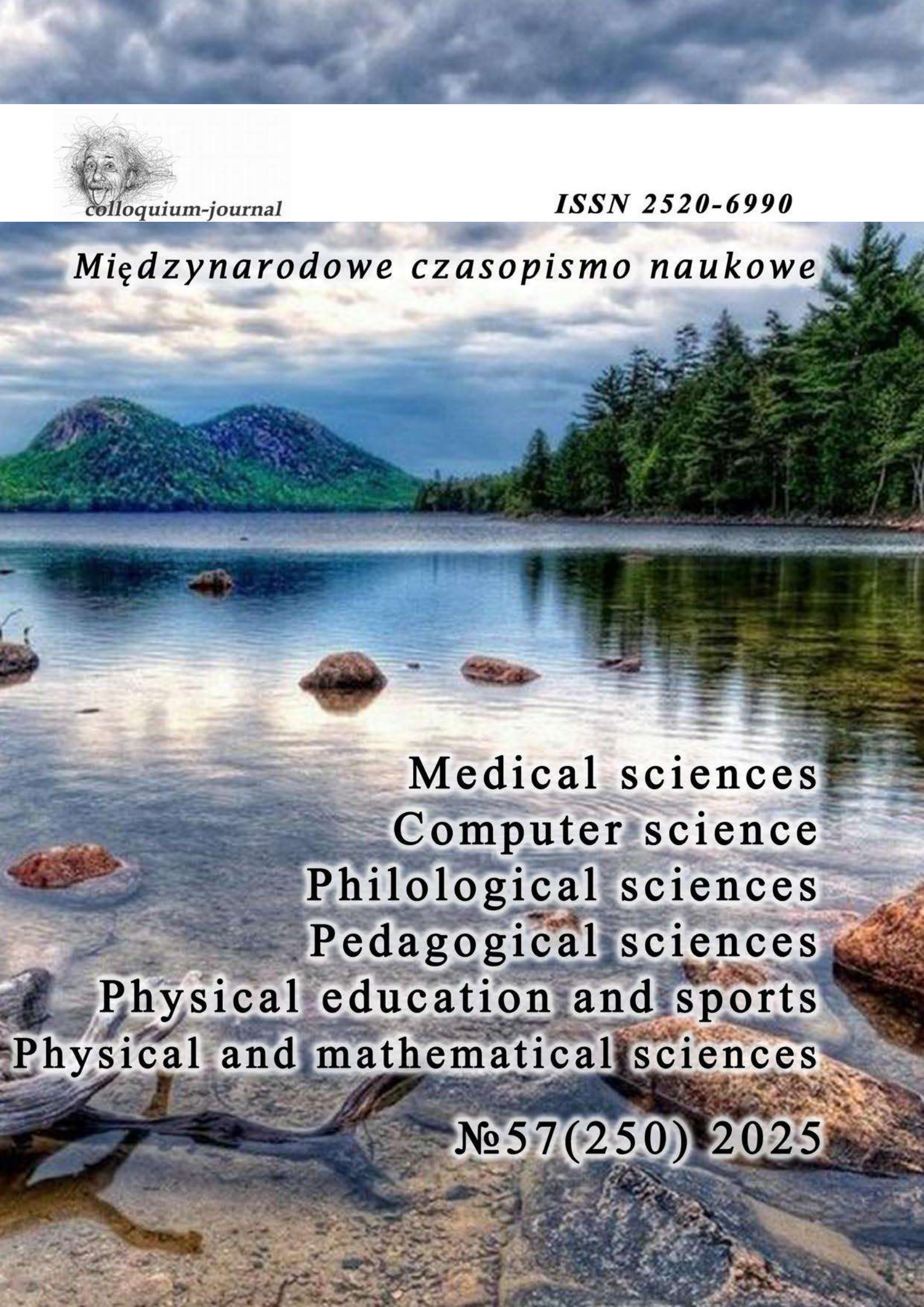
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BASIC PRINCIPLES OF SECONDARY PREVENTION OF ARTERIAL HYPERTENSION IN THE RURAL POPULATION

Abstract

The rural population needs special attention in the application of preventive technologies. It is extremely important to correct the behavior of patients with arterial hypertension living in the village. Every rural resident with detected arterial hypertension should be taken into account for dynamic observation. The doctor's tactics should be multifaceted, it should not be limited only to the treatment itself, but should correspond more to the concept of "medical management of patients", that is, be oriented towards involving patients in active cooperation in the implementation of preventive technologies.

Key words: *arterial hypertension, rural population, secondary prevention, healthy lifestyle, risk factors.*

We emphasize once again that the treatment of arterial hypertension (AH) is a classic form of secondary prevention, that is, the prevention of its complications and a way to achieve the most positive course of the disease.

Preventive and therapeutic care for AH is a complex process, the components of which are primary and secondary prevention. The occurrence and course of AH are closely related to uncontrollable and controllable risk factors.

The share of controllable risk factors for AH in AH regulation is more than 50%. This is what our preventive medical technologies for AH and the strategy for its prevention are aimed at, which are based on three levels, of which levels I and II are primary prevention, level III is secondary prevention.

Level I is mass promotion of a healthy lifestyle, identification and correction of risk factors.

Level II is early detection of patients with AH: providing the population with devices for measuring AH and other conditions for implementing this technology.

Level III is drug and non-drug normalization of arterial pressure (AP) to the desired level under the supervision of a physician in order to alleviate the course of the disease, avoid complications and extend life expectancy. [1; 2; 3].

Secondary prevention of AH at the present stage involves the so-called «treatment». It has been proven that timely treatment of AH can reduce the likelihood of developing and more severe course of the disease; reducing even slight increases in AP reduces morbidity and mortality from diseases of the circulatory system. The lower the AP level, the lower the risk of stroke and ischemic heart disease.

The goal of antihypertensive treatment is to reduce AP as much as possible. It is desirable to achieve the following levels:

• not higher than 120 – 130 / 80 mm Hg. in young people with moderately elevated AP;

• below 140 / 90 mm Hg. in elderly patients with elevated AP;

• not higher than 140 mm Hg. CAT in patients with isolated systolic AN, if this can be achieved without undesirable effects. [4; 5].

Treatment of AH is divided into non-drug and drug. Non-drug treatment includes primary prevention measures aimed at changing lifestyle and correcting other risk factors.

There is no direct evidence that non-drug treatments can reduce morbidity and mortality. However, the use of the above measures can normalize moderately elevated AP levels.

The effectiveness of drug measures has been repeatedly proven by various randomized trials. The following classes of drugs are recommended as first-line antihypertensive drugs: diuretics; angiotensin-converting enzyme inhibitors; long-acting calcium antagonists, angiotensin II receptor antagonists; beta-blockers. This problem is also of clinical importance and is the domain of clinicians, so we will talk about it very briefly.

However, it is worth noting that a patient with AH should have individual therapy, which is prescribed after a thorough examination of the patient, taking into account the price and effectiveness of the drugs. Self-prescription of drugs to reduce AP is unacceptable. [5; 6; 7].

We recommend the following model-scheme of the basic principles of AN treatment (as a component of the general prevention model):

1. Treatment (medicated and non-medicated) should be started as early as possible and carried out continuously, mostly throughout life. The concept of “course treatment” for antihypertensive therapy is unacceptable.

2. The treatment regimen should be simple, if possible – according to the principle of «one tablet per day». This increases the number of patients who are actually treated and, accordingly, reduces the number of those who stop treatment.

3. Preference should be given to long-acting antihypertensive drugs, including retard forms, since this prevents significant fluctuations in AP during the day, and also reduces the number of prescribed tablets.

4. All persons with elevated AP are subject to non-drug treatment or lifestyle modification.

5. Elderly patients with isolated systolic hypertension are subject to treatment in the same way as with systolic-diastolic hypertension.

6. In patients with secondary hypertension, the primary task is to treat its cause. Such AH is also subject to mandatory correction.

As the World Health Organization expert committee notes, to improve the prognosis of a patient with AH, it is more important to reduce AP per se than the nature of the drugs used for this. In difficult economic circumstances, it is advisable to prescribe cheap and «unfashionable» drugs to the patient than not to prescribe antihypertensive treatment at all, which is very important in rural areas, because the availability of modern and expensive drugs for the rural population, taking into account the difficult socio-economic situation in the countryside, is much lower than for the urban population, which is proven by our research. We borrowed and improved the algorithm of the doctor's action in the event that a patient is diagnosed with arterial hypertension. [1; 3; 5].

We emphasize once again that the technologies of treatment of AH are a classic form of secondary prevention of the disease.

It is worth noting that the considered preventive measures or technologies of primary, secondary and tertiary prevention are difficult to distinguish, because they are all interconnected and are components of the performance of other functions by medical workers: medical, organizational, managerial activities.

We add that tertiary prevention of AH is determined by the condition of the sick person, so its technologies are not given here. Based on the above, we can distinguish four main components of medical prevention of AH and other diseases of the circulatory system: the first is a healthy lifestyle; the second is medical examination; the third is sanitary education; the fourth is treatment.

Thus, the complex nature of the use of preventive technologies in rural areas allows maintaining their health at a high level, leading a full life, characterized by physical, spiritual and social well-being.

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