МІНІСТЕРСТВО ОХОРОНИ ЗДОРОВ'Я УКРАЇНИ
БУКОВИНСЬКИЙ ДЕРЖАВНИЙ МЕДИЧНИЙ УНІВЕРСИТЕТ

М А Т Е Р І А Л И

106-ї підсумкової науково-практичної конференції
з міжнародною участю
професорсько-викладацького колективу
БУКОВИНСЬКОГО ДЕРЖАВНОГО МЕДИЧНОГО УНІВЕРСИТЕТУ
03, 05, 10 лютого 2025 року

Конференція внесена до Реєстру заходів безперервного професійного розвитку, які проводитимуться у 2025 році №1005249

Чернівці – 2025

УДК 61(063)
М 34

Матеріали підсумкової 106-ї науково-практичної конференції з міжнародною участю професорсько-викладацького колективу Буковинського державного медичного університету (м. Чернівці, 03, 05, 10 лютого 2025 р.) – Чернівці: Медуніверситет, 2025. – 450 с. іл.

У збірнику представлені матеріали 106-ї науково-практичної конференції з міжнародною участю професорсько-викладацького колективу Буковинського державного медичного університету (м. Чернівці, 03, 05, 10 лютого 2025 р.) зі стилістикою та орфографією у авторській редакції. Публікації присвячені актуальним проблемам фундаментальної, теоретичної та клінічної медицини.

ISBN 978-617-519-135-4

Bukach O.P.

DIAGNOSTIC AND THERAPEUTIC SIGNIFICANCE OF BLOOD LIPID SPECTRUM IN RHEUMATOID ARTHRITIS DEPENDING ON COMORBIDITY

Department of Internal Medicine
Bukovinian State Medical University

Introduction. The modern approach to the treatment of rheumatoid arthritis (RA) remains relevant, in particular, due to inadequate control of systemic inflammation, simultaneous administration of a large number of potentially dangerous drugs, which provokes the emergence of comorbid pathology, which complicates the course and treatment of this disease.

The aim of the study. To establish the role of disorders of the blood lipid spectrum in the development and progression of RA against the background of abdominal obesity (AO), type 2 diabetes mellitus (T2DM), and arterial hypertension (AH).

Material and methods. To achieve the goal, the following research methods were used: general clinical, anthropometric, laboratory (blood lipid spectrum). 60 patients with rheumatoid arthritis and 20 practically healthy persons were examined. The diagnosis of RA was made according to the 2019 criteria of the American College of Rheumatology and the European Antirheumatic League. Statistical processing was performed using the BM SPSS Statistics® 23.0 and MS® Excel® 2013 application programs. Rheumatoid arthritis patients received basic therapy telmisartan, rosuvastatin, and L-arginine aspartate for 30 days (taking into account concomitant pathology).

Results. In 45% of patients with RA, regardless of the presence of comorbid pathology, type IIb dyslipidemia was detected, in 35% - type IV dyslipidemia according to D. Fredrickson. The content of TG in RA in combination with hypertension, AO and diabetes mellitus 2 exceeded that in RA without comorbid pathology by 33.81% ($p<0.05$). The concentration of HDL cholesterol decreased in patients with RA - by 22.3% ($p<0.05$), with RA and hypertension - by 29.27% ($p<0.05$), with RA, hypertension and AO - by 33, 61% ($p<0.05$) and in patients with RA, hypertension, AO and diabetes 2 - by 44.55% ($p<0.05$). A decrease in the level of TG in the dynamics of treatment was also established: by 16.54% - in RA with hypertension, by 16.54% - in RA with hypertension and AO, by 26.53% - in RA with hypertension, AO and diabetes 2, according to simultaneous increase in the level of HDL cholesterol by 11.38%, 11.76% and 16.36%, respectively ($p<0.05$).

Conclusions. The use of telmisartan, rosuvastatin, and L-arginine aspartate against the background of disease-modifying antirheumatic therapy in rheumatoid arthritis in combination with comorbid pathology contributed to the correction of changes in the blood lipid spectrum.

Buzdugan I.O.

STATE OF HEMOCOAGULATION OF BLOOD IN PATIENTS WITH PEPTIC ULCER OF THE STOMACH AND DUODENUM COMBINED WITH ARTERIAL HYPERTENSION AND TYPE 2 DIABETES

Department of Internal Medicine
Bukovinian State Medical University

Introduction. During the exacerbation of the main disease, microcirculation disorders are generalized and may be caused by changes in the rheological and coagulation properties of blood. Taking into account the interdependence and coordination of physiological processes in the human body, the study of the relationship between changes in the metabolic and hemocoagulation links of homeostasis in PVS and PDK is relevant and allows a new approach to the development of issues of the pathogenesis of PVS and PDK with arterial hypertension (AH) and diabetes (T2DM).

The aim of the study. To evaluate the hemostasis systems in combined CKD and CKD and hypertension and T2DM.

Material and methods. 65 people were examined, of which: 20 people with PVS and PDK, 30 people with PVS and PDK combined with hypertension and T2DM and 15 practically healthy people. Blood for biochemical studies was taken from the patients' elbow veins in the morning on

an empty stomach, after 12-15 hours of fasting. The following studies were conducted: time of recalcification of blood plasma - CRP; prothrombin time - PF; thrombin time - TC; antithrombin III; indicators of fibrinolysis (total fibrinolytic activity of blood - SFA, non-enzymatic - NFA and enzymatic - FFA); rheological properties of erythrocytes (index of deformability of erythrocytes - IDE, relative viscosity of erythrocyte suspension - VVES). According to the studies, the following groups were made: 20 people with peptic ulcer disease (PEG) and DPC (group N1), 30 people with PPC and DPC combined with hypertension and T2DM (group N2) and 15 practically healthy people (group N3).

Results. In Table 1. a decrease in coagulation potential in all groups of patients is presented. In particular, the plasma recalcification time decreased by 7.96%, the prothrombin time by 16.22%, and the thrombin time by 22.62% in the group of patients with PVS and CKD with hypertension and T2DM, compared to the group of patients with CKD and CKD , and respectively by 17.02%, 38.78%, and 28.99% in comparison with practically healthy individuals (table).

Table

The total coagulation potential of blood in patients with peptic ulcer disease combined with arterial hypertension and type 2 diabetes

Groups of examinees Indicators	Practically healthy persons (group 1) (n=15)	Patients with PU and PUD (group 2) (n=20)	Patients with PU and DPK with hypertension and T2DM (group 3) (n=30)
Plasma recalcification time	98,65± 7,09	90,40±6,06*	85,03±2,98*
Prothrombin time	25,09±3,89	21,09±1,30*	18,21±0,21
Thrombin time	20,42±1,89	18,90±1,12*	15,67±0,65

Note. * - reliability of differences ($p<0.05$) between indicators in the 1st and 2nd, 1st and 3rd groups;

** - reliability of differences ($p<0.05$) between indicators in the 2nd and 3rd groups

Conclusions. Reduction of blood plasma recalcification time (by 6.96% ($p<0.05$)), prothrombin time (by 15.22% ($p<0.05$)), thrombin time (by 20.62% ($p<0.05$)) indicates a violation of the body's compensatory capabilities and is an important factor for diagnosing the progression of this disease.

Chernetska N.V.

ASSESSMENT OF THE QUALITY OF LIFE OF PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Department of Internal Medicine
Bukovinian State Medical University

Introduction. Chronic obstructive pulmonary disease (COPD) is one of the most important problems in modern medicine due to its high prevalence and mortality worldwide. Treatment is aimed at reducing symptoms, the frequency and severity of exacerbations, and improving health and endurance.

The aim of the study. To investigate the clinical features of the course of the disease during physical exertion and to evaluate the quality of life of patients with COPD.

Material and methods. 20 patients participated in the examination. The patients were divided into two groups: the main group - 10 patients with COPD and the control group - practically healthy individuals. We assessed tolerance to physical exertion using a 6-minute walk test. The 8-item COPD assessment test (CAT-test) was used to determine the deterioration of health status in COPD. The total number of points ranged from 0 to 40. The interpretation of the results was based on the following scale: from 0 to 10 points – mild impact of COPD on patients' lives; from 11 to 20 points - the average impact of COPD on the lives of patients; from 21 to 30 points – severe impact of COPD on patients' lives; from 31 to 40 points - a very severe impact of COPD on the lives of patients.