МІНІСТЕРСТВО ОХОРОНИ ЗДОРОВ'Я УКРАЇНИ
БУКОВИНСЬКИЙ ДЕРЖАВНИЙ МЕДИЧНИЙ УНІВЕРСИТЕТ»

М А Т Е Р І А Л И

105-ї підсумкової науково-практичної конференції
з міжнародною участю
професорсько-викладацького персоналу
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Матеріали підсумкової 105-ї науково-практичної конференції з міжнародною участю професорсько-викладацького персоналу Буковинського державного медичного університету, присвяченої 80-річчю БДМУ (м. Чернівці, 05, 07, 12 лютого 2024 р.) – Чернівці: Медуніверситет, 2024. – 477 с. іл.

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У збірнику представлені матеріали 105-ї підсумкової науково-практичної конференції з міжнародною участю професорсько-викладацького персоналу Буковинського державного медичного університету, присвяченої 80-річчю БДМУ (м. Чернівці, 05, 07, 12 лютого 2024 р.) із стилістикою та орфографією у авторській редакції. Публікації присвячені актуальним проблемам фундаментальної, теоретичної та клінічної медицини.

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the leading place among causes of mortality, and in recent years the clinical importance of comorbid conditions increases.

The leading factor contributing to the development of CHD in patients suffering from COPD is endothelial dysfunction, pathological vasoconstriction, platelets aggregation, proliferation and migration of smooth muscle cells, expression of adhesive molecules, and adhesion of monocytes. These conditions lead to development of defeat of target organs, progression of hypertension, atherosclerosis and tendency to hypercoagulation.

The aim of the study. To assess clinical and instrumental diagnostic markers of interdependent burden in patients with comorbidity of COPD and CHD.

Material and methods. We examined 40 patients with COPD II-III, group B (mean age of 65.2±5.3 years). All patients were hospitalized due to moderate to severe exacerbations of COPD (infectious type – 65%, non-infectious – 35%). CHD was diagnosed as concomitant pathology in 28 patients (1st group), COPD without combination with cardiac disease – in 12 patients (2nd group). Duration of COPD in patients of the 1st group lasted 10.3±2.2 years, in 2nd group - 8.8±1.6 years, duration of IHD – 8, 4±2.8 years.

Diagnostic markers were estimated twice before and after treatment by assessment of clinical symptoms and results of instrumental examinations: severity of dyspnea (mMRC scale), CAT questionnaire, cough (scores), bronchial patency (spirometry), state of the cardiovascular system (ECG).

Results. Spirometry data revealed the progression of irreversible bronchial obstruction in all patients (FEV_1 in patients of the 1st group was 54.3±5.2%, 2nd group - 62.3±4.3% predicted; the Hensler Index FEV_1\FVC (in patients of the 1st group was up to 29.9%, 2nd group - up to 25.3% less than normal range). Regarding to comorbidity of COPD and CHD, bronchial obstruction was prevalent in large caliber bronchi (MEF 25% - 41.2±5.3%), patients with COPD without CHD presented with more pronounced violation of the patency of small bronchi (MEF75% - 52.3±4.8%). The VC value was less than 80% predicted in 50% of patients from the 1st group and in 30% of patients from the 2nd group. Bronchial obstruction was irreversible in all patients from the 1st group and in 58% of patients from the 2nd groups.

Course of in-patient treatment resulted in the more prominent subjective improvement (mMRC scale, CAT) in the severity of dyspnea diagnosed in the patients from 2nd group. The prominence of bronchial obstruction was significantly decreased (rise of FEV_1 by 10.7% and Hensler index by 11.4% in patients of the 1st group; 12.4% and 14.2% relatively in patients of the 2nd group) without significant changes of VC. ECG data did not reveal the negative impact of the therapy with tiotropium bromide inhalation to the cardiovascular system.

Conclusions. Thus, the combination of COPD and CHD is the frequent comorbid disorder, with the development of the syndrome of interdependent burden. This combination is characterized by a more pronounced progression of COPD, is manifested by development of lung restriction and decreased reversibility of airway obstruction, reduced response to therapy with bronchodilators and worsening of quality of patients' life.

Sluhenska R.V.

REHABILITATION AS A KEY FACTOR IN THE RECOVERY OF CIVILIANS AND THE MILITARY

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Introduction. The term rehabilitation originates from Latin words *habilis* "ability", and *rehabilis* "restoration of "ability". Rehabilitation is a branch of modern medicine that relies primarily on the patient's personality in its various methods, actively trying to restore human functions impaired by the disease, as well as a person's social ties. Thus, rehabilitation is restoring health, functional status, and performance impaired by illness, injury, or physical, chemical, and social factors.

The aim of the study. Rehabilitation is a process aimed at providing comprehensive assistance to sick and disabled people to help them achieve the maximum possible physical, mental, professional, social, and economic fullness in terms of their disease. Thus, rehabilitation should be considered a complex, socio-medical issue divided into several types or aspects: medical, physical, psychological, professional (occupational), and socioeconomic.

Material and Methods. Rehabilitation is a pivotal aspect of health that aims at enhancing function and independence, evolving through different stages. The first and foremost stage of rehabilitation (medical and physical) is to restore the patient's health through the integrated use of various means to maximize the recovery of impaired physiological functions of the body.

The second stage is the psychological aspect of rehabilitation, which aims to correct the patient's mental status and form a person's attitude to treatment, medical recommendations, and rehabilitation activities.

The third one is the stage of vocational rehabilitation, which deals with issues of employment, vocational training, and retraining, determination of the work capacity of patients, association of persons with similar history of the disease in specific organizations for some common interest, etc.

The last stage in the rehabilitation process is socio-economic rehabilitation, which aims to restore the victim's economic independence and social fullness.

Results. All stages of rehabilitation are ultimately a multifaceted process of restoring a person’s health and reintegrating them into occupational and social life. It is essential to clarify that the three types of rehabilitation (medical, occupational, and social) correspond to three types of disease consequences: 1) medical and biological consequences of diseases, which consist of deviations from the normal functional status; 2) decrease in working capacity; 3) social maladjustment, i.e., disruption of ties with family and society.

A fundamental principle of rehabilitation is continuity in the transition from one stage to another, from one medical institution to another. For this purpose, at each stage, the rehabilitation record must provide information about methods and means of treatment and used rehabilitation that disclose the functional status of the rehabilitated individual.

Conclusions. The main goal of rehabilitation is the practical and early return of sick and disabled people to everyday life, work, society, and family and to restore personal characteristics as full community members. The optimal final result of medical rehabilitation can be full health recovery and a return to everyday professional work.

Teleki Ya.M.

CLINICAL FEATURES OF OSTEOARTHRITIS COMBINED WITH OBESITY, ARTERIAL HYPERTENSION AND TYPE 2 DIABETES

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Introduction. Osteoarthritis (OA) is a leading cause of pain and disability among adults worldwide and inflicts a significant burden on the individuals affected, including activity limitations and reduced quality of life. OA is associated with substantial direct health care costs due to health care visits, diagnostic procedures, medications and surgery, and indirect costs related to lost workplace productivity.

The aim of the study. It is the clinical indicators of joint syndrome in patients with osteoarthritis combined with type 2 diabetes, obesity and arterial hypertension.

Material and methods. 116 patients were examined and the following clinical groups of dynamic observation were selected: group I – 37 patients with osteoarthritis; II group – 21 patients with OA in combination with arterial hypertension; III group – 41 patients with OA with concomitant arterial hypertension and abdominal obesity; IV group – 17 patients with OA in combination with arterial hypertension, abdominal obesity and type 2 diabetes; group V - 25 practically healthy people.

Results. It was established that patients with a moderate course of osteoarthritis