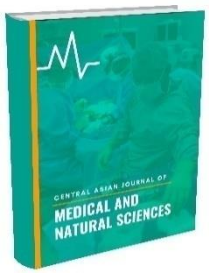
CENTRAL ASIAN JOURNAL OF MEDICAL AND NATURAL SCIENCES



Volume: 04 Issue: 06 | Nov-Dec 2023 ISSN: 2660-4159

http://cajmns.centralasianstudies.org

Diagnosis Arterial Hypertension and Assessing the Effectiveness of Antihypertensive Therapy

1. **Dilbar Baxriddinovna Rakhmatova**

Received 2nd Oct 2023,
Accepted 19th Nov 2023,
Online 6th Dec 2023

[1] Bukhara state medical institute, Bukhara, Uzbekistan

Abstract: Two-year clinical and epidemiological monitoring was carried out in 650 women with acute coronary syndrome (ACS). ACS in 56.1% of cases manifests itself or proceeds with a predominance of symptoms of an unstable course of angina pectoris, and in 43.9% with symptoms of myocardial infarction (P <0.05). ACS is more common among women with AT (55.9%), among people without hypertension, the incidence of ACS was 31.8% (P <0.05).

Key words: epidemiology, prevention, clinical sings, monitoring, acute coronary syndrome, prevention.

Relevance. Acute coronary syndrome is a working, preliminary diagnosis, which is established when it is suspected that the patient is developing or may soon develop acute myocardial infarction. [5] Subsequently, during in-patient observation and examination, the final diagnosis is made. If the corresponding signs of cardiomyocyte necrosis are identified, acute myocardial infarction is checked, in the absence of such signs, unstable angina is diagnosed.[1-3] In some cases, after the examination, a diagnosis of another disease is established, and the diagnosis of ACS is excluded. Diagnosing ACS is not an easy task. Even the typical symptoms of ACS have low indicators of sensitivity and specificity. [7-10] So, among patients admitted to the hospital with chest pain characteristic of ACS, only 50% subsequently confirm the diagnosis of AMI or unstable angina; while 30-50% of patients with AMI do not have typical chest pain [4]. In the early diagnosis and assessment of the clinical course of acute coronary syndromes, the timely identification of the “main” symptoms and / or leading clinical variants of the course of this disease is important and priority. [8,9] Such a scientific strategy is necessary to identify risk groups and timely / adequate diagnosis and treatment of acute coronary syndromes (ACS) [1,2,3].

Objective: to study the regional characteristics of the clinical pathomorphism of ACS in the climatic conditions of the Ferghana Valley of Uzbekistan.

Material methods. Two-year clinical and epidemiological monitoring was conducted in 650 women with ACS. ACS criteria:

1. An increase and / or subsequent decrease in the level of biochemical markers of myocardial necrosis in the blood and their combination with at least one of the following evidence of myocardial ischemia:

A. the clinical picture of myocardial ischemia;

B. ECG changes indicating the appearance of myocardial ischemia;

C. the appearance of a pathological Q wave on the ECG;

D. the appearance of signs of loss of a viable myocardium or impaired local contractility when using techniques to visualize the heart.

2. Unexpected sudden cardiac death, often against the background of symptoms that make it possible to suspect myocardial ischemia.

3. Signs of acute myocardial infarction (AMI), identified by pathological examination.

4. Criteria of previously transferred MI:

A. the appearance of new pathological Q waves on the ECG,

B. evidence of the loss of a viable myocardium, local thinning of the wall and violation of local contractility obtained by visualizing methods in the absence of indications of their non-ischemic nature,

C. signs of a healed or healing MI identified during pathological examination.

Statistical testing of the results of the study was carried out using a special program package and the Mann-Whitney method. The significance of differences was evaluated using Student (t).

Results. It was found that unstable angina pectoris (NS) is manifested in the form of angiospastic unstable angina pectoris - 10.8%, first-appeared NS - 4.4%, progressive NS - 47.5% and post-infarction angina pectoris - 1.2%. (Fig. 1 and Table 1).

A progressive form of NS occurs with high frequency, and postinfarction NS ($P < 0.001$) is observed at the lowest prevalence. Peculiarities during myocardial infarction (MI) of the examined female population are observed:

- MI with Q wave (67.1%) prevails over MI without Q wave (32 9%) ($P < 0.01$);
- with a high frequency there is an anginal variant of MI (65.2%);
- the asthmatic variant of MI occurs only in 6.7% of cases;
- the abdominal variant is noted with a frequency of 5.5%;
- in 4.3% of cases there is an atypical clinical manifestation of MI; cerebrovascular symptoms prevail in the clinical picture of MI in 2.4% of women;
- in 4.9% of cases there is a collaptoid variant of the clinical course of MI;
- Right ventricular MI occurs with frequency of 1.8%; in 6.7% of various cases. Table1

Features of the clinical manifestations of ACS and the frequency of their detection in women

Unstable stenocardia (n=657)										Myocardial infarction (n=164)							
Angiospastic US		First emerge US		Progressive US		US After operations		Post-infarction US		MI with Q wave		MI without Q wave		MI anginal variation		MI asthmatic variation	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	N	%
71	10.8	29	4.4	312	47.5	0	0.0	7	1.2	110	67.1	54	32.9	107	65.2	11	6.7

Myocardial infarction (n=164)

MI gastralgic form		MI atipic variaton		MI cerebrovascular form		MI collapse form		Right ventricular MI		MI arrhythmic form		MI with cardiogenic shock and cardiac tamponade		ACS with a predominance of stenocardias		ACS with a predominance of confirmed diagnosis symptoms	
n	%	n	%	n	%	N	%	n	%	n	%	n	%	n	%	N	%
9	5,5	7	4,3	4	2,4	8	4,9	3	1,8	11	6,7	4	2,4	419	56,1*	326	43,9

cardioarhythmias prevail over other symptoms of MI; ● in 2.4% of cases, a complicated course of MI was observed with cardiogenic shock and cardiac tamponade.

Conclusion. Patients with NS in the group of people with normal blood pressure and high blood pressure are found in 32.1% and 67.9% (P <0.001), and with AMI - in 31.1% and 68.9%, respectively (P <0.05). These data can be widely used in practical medicine to improve methods for the diagnosis, treatment and prevention of ACS in women.

LITERATURE

1. Kamali AL, Soderholm M, Ekelund U. What decides the suspicion of acute coronary syndrome in acute chest pain patients. BMC Emerg Med. 2014; 14: 9. doi: 10.1186 / 1471-227X-14-9.
2. Sullivan AL, Beshansky JR, Ruthazer R, et al. Factors associated with longer time to treatment for patients with suspected acute coronary syndromes: a cohort study. Circ Cardiovasc Qual Outcomes. 2014; 7 (1): 86-94. doi: 10.1161/ CIRC0UTC0MES.113.000396. Epub 2014 Jan 14.
3. O'Connor RE, Al Ali AS, Brady WJ, et al. Part 9: Acute Coronary Syndromes: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation.2015; 132(18Suppl2):S483-500. doi:10.1161/ CIR.0000000000000263.
4. Haasenritter J, Biroga T, Keunecke C, et al. Causes of chest pain in primary care - a systematic review and meta-analysis. Croat Med J. 2015; 56 (5): 422-430. doi: 10.3325 / cmj.2015.56.422.
5. Veauthier B, Sievers K, Hornecker J. Acute Coronary Syndrome: Out-of-Hospital Evaluation and Management. FP Essent. 2015; 437: 11-6.