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THE STRUCTURE OF COMORBIDITY IN PATIENTS WITH CORONARY ARTERY DISEASE AND STENTING OF CORONARY ARTERIES AFTER MYOCARDIAL INFARCTION

Summary. In recent years, it has become possible to obtain a holistic view of the mechanics of contraction and relaxation of various zones of the myocardium using methods for assessing myocardial deformation. Echocardiographic (EchoCG) examination of patients with coronary heart disease (CHD) is an important diagnostic method that allows monitoring the patient before and after revascularization. IHD can manifest itself in the form of angina attacks, differingin duration and severity. It should be noted that in case of exertional angina during standard echocardiography, changes in the contractile function of the left ventricle (LV) may not be observed, while in unstable angina, it is possible to identify zonesof hypo- or a kinesis.

Key words: patients, coronary heart disease, echocardiography, comorbid pathology, angina attacks, myocardial infarction.

Introduction. In the domestic literature, this technology is defined by the term “visualization of the myocardial velocity vector” [5]. LV contractile function is the result of the interaction of longitudinal, radial and circular fibers.

One of the most important scientific tasks of modern cardiology is creation of algorithms for the management of patients with coronary artery disease who have undergone myocardial infarction and have comorbid pathology, taking into account the ratio of potential risks and benefits of revascularization using coronary bypass grafting or percutaneous angioplasty of the coronary arteries against the background of adequate drug therapy.

Purpose of the study: To assess the effect of coronary artery disease and surgical revascularization on the deformity and strain rate of longitudinal, circular and radial fibers of the LV myocardium.

The obtained results contribute to understanding the role of comorbidity in the clinical course of MI. Assessment of the severity of comorbidity will allow predicting the development of complications and the risk of death after reperfusion therapy and enables practitioners to identify a high-risk group that requires special attention, both in a hospital setting and in an outpatient setting.

Material and Methods: The structure of comorbid pathology in patients with coronary artery disease according to Sumin A.N., Korok E.V. and others in men is represented by diseases of the urinary tract - 43.5%, gastric ulcer in 20.7%, chronic pyelonephritis occurred in 16.8% of cases [6].

Among the most common comorbid pathologies, type 2 diabetes mellitus and Metabolic syndrome (MS) should be singled out [92,159]. IHD is the cause of death in 40-50% of patients with type 2 diabetes, and in people without type 2 diabetes, mortality is 2-4 times lower [4].

There is also a high prevalence of diseases of the stomach and duodenum in patients with coronary artery disease. According to some authors, chronic hepatitis is diagnosed in developed countries in 80-90% of patients. Of particular importance is the etiological role of Helicobacter pylori (HP), since

more than 90% of CG is associated with this infection [5]. Patients with coronary artery disease often develop acute erosions and ulcers of the gastrointestinal tract in the early days of myocardial infarction. They differ from chronic ulcers in a weak inflammatory process and rapid scarring. The causes of ulcers are associated with the activation of the pituitary-adrenal system and increased secretion of gastric juice, as well as the intake of drugs such as acetylsalicylic acid [4].

In patients with coronary artery disease, a number of authors point to the widespread prevalence of chronic obstructive pulmonary disease (COPD). According to foreign researchers, COPD ranks fourth among the causes of death on the planet [1]. In patients with COPD, the most common comorbid pathology is coronary artery disease [4]. According tolarge population-based studies in patients with coronary artery disease and COPD, the risk of mortality increases two to three times higher than in the general population [1]. In patients with COPD, the risk of developing myocardial infarction increases five times with exacerbations of more than 5 during the year. The severity of COPD has a direct correlation with the incidence of myocardial infarction, for example, in mild COPD, painless forms of myocardial ischemia were observed 50% more often than pain forms. In patients with severe COPD, painful and painless forms of myocardial ischemia were observed with the same number of cases. [2].

It should be noted that in a number of studies there is a high prevalence and severity of anxiety and depressive disorders, in comparison with patients with acute MI. Severe comorbid pathology was often associated with distress personality type, bipolar affective and anxiety disorders [1]. In a study by I. Kawachi involving 34,000 surveyed, it was shown that the higher the initial level of anxiety, the more severe IHD occurs later. According to Bot M. et al., 2012, in patients with myocardial infarction and comorbid pathology in the form of type 2 diabetes, the probability of developing a fatal outcome 5 years

after myocardial infarction increases by 38%, with the addition of depression, the risk also increases by 40%. And in the case of a combination of depression and type 2 diabetes, the probability of developing a fatal outcome increases by 3 times [4].

Thus, in the modern literature there are numerous studies with conflicting data on the prevalence of comorbid pathology in patients with coronary artery disease.

Conclusions: Comorbidity is a risk factor for the development of recurrent myocardial infarction and a high risk of mortality in the next 6 months. Direct positive correlations were established between the Charlson comorbidity index and the risk of death in the next 6 months according to the GRACE scale for patients with AMI and PMI

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