RATIONAL APPROACH TO STANDARD THERAPY

D.R. Adizova  
*Bukhara State Medical Institute named after Abu Ali Ibn Sina 200101, Uzbekistan, Bukhara, 1 Navoi Avenue*, ndm2@mail.ru

N.G. Ashurova  
*Bukhara State Medical Institute named after Abu Ali Ibn Sina 200101, Uzbekistan, Bukhara, 1 Navoi Avenue*

F.A. Khalilova  
*Bukhara State Medical Institute named after Abu Ali Ibn Sina 200101, Uzbekistan, Bukhara, 1 Navoi Avenue*

N.O. Djuraeva  
*Bukhara State Medical Institute named after Abu Ali Ibn Sina 200101, Uzbekistan, Bukhara, 1 Navoi Avenue*

Follow this and additional works at: [https://uzjournals.edu.uz/pediatrics](https://uzjournals.edu.uz/pediatrics)

Recommended Citation

Available at: [https://uzjournals.edu.uz/pediatrics/vol2/iss2/16](https://uzjournals.edu.uz/pediatrics/vol2/iss2/16)

This Article is brought to you for free and open access by 2030 Uzbekistan Research Online. It has been accepted for inclusion in Central Asian Journal of Pediatrics by an authorized editor of 2030 Uzbekistan Research Online. For more information, please contact sh.erkinov@edu.uz.
RATIONAL APPROACH TO STANDARD THERAPY

Cover Page Footnote
Bukhara State Medical Institute named after Abu Ali Ibn Sina 200101, Uzbekistan, Bukhara, 1 Navoi Avenue.

This article is available in Central Asian Journal of Pediatrics: https://uzjournals.edu.uz/pediatrics/vol2/iss2/16
RATIONAL APPROACH TO STANDARD THERAPY

Adizova D.R., Ashurova N.G., Khalilova F.A., Djuraeva N.O.

Bukhara State Medical institute named after Abu Ali Ibn Sina
200101, Uzbekistan Bukhara 1 Navai Avenue

Resume,
133 women with chronic heart failure were analyzed for pharmacotherapy of chronic heart failure. The study showed that all patients who received standard CHF drug intake were unregulated in all patients, inadequate type and group of drugs and inadequate therapeutic doses, and complications were low.

Keywords: chronic heart failure, pharmacotherapy, compliance

The relevance of the topic
Modern treatment of chronic heart failure (CHF) is aimed not only at eliminating its symptoms but also preventing its emergence, preventing its developing, protecting the target parts, improving the quality of patient life, reducing hospitalization and the mortality rate [2,9]. However, despite the reduction in mortality from cardiovascular diseases in developed countries over the past three decades, there has been no decrease in mortality and hospitalization due to CHF [1,14].

The literature shows that there is a significant difference between the achievements in CHF pharmacotherapy and their use in clinical practice [4,7]. A study of EPOXA-XSN and EPOXA-O-XSN suggests that treatment of patients with CHF with adverse reactions from the inpatient to the outpatient phase is negative [9]. This does not mean that the outpatient procedure is not properly regulated, since patients do not have sufficient information about their disease, lack of constant contact with patients at both stages and associated psychosomatic conditions in patients, as well as age, gender, social and family status. It also affects the treatment of CHF, causing cases such as untimely implementation of these recommendations [6,12]. It is also important to acknowledge that the ineffectiveness of modern drugs and the high mortality from CHF are also important factors in the strict adherence to the recommendations of doctors, routine, dietary and lifestyle guidelines [10].

In women, the basic treatment of CHF doesn’t differ from men’s. However, in some cases, with CHF pharmacotherapy, it may be necessary to consider some of the features of CHF in women. A study in Tyumen as part of the EPOXA-XSN program shows that male patients on outpatient care have a rational approach to treating CHF than women. According to the results, men with CHF had higher rates of cardiac glycoside and drug consumption (1.9 men and 1.4 women) [7]. F.T. Ageyev’s data also show that men with SHF symptoms are more likely to be in the clinic than women [1]. The results of a study conducted in the framework of “Prevention and treatment of hypertension in the Russian Federation” show that men achieve 3 times more treatment and 2 times more effective than women. Given that the main etiological factor in the occurrence of CHF is arterial hypertension, we consider this information important for our analysis [7]. Failure to treat women often raises doubts as to whether CHF is a consequence of concomitant psychoemotional disorders. Since some studies conducted on an outpatient basis have shown that treatment of psychoemotional disorders in combination with the underlying disease in patients with CHF can increase patient adherence to recommendations [5,11]. Some studies reported that patients reached CHF individual and specialized schools, improving their quality of life, contributing to positive psycho-emotional disorders in patients [6, 7]. Systematic monitoring of cardiovascular disease in each region will significantly improve inpatient and outpatient care [13]. Taking into account the foregoing, the identification of CHF medication therapy in women and the impact on them are of particular concern.

The objective
Analysis of chronic heart failure in women in clinical practice of pharmacotherapy

Materials and methods

The study involved 133 women with CHF who are undergoing treatment at the Department of Cardiology and Gerontology of the Tashkent Institute of Advanced Studies of Doctors. The research excluded patients with hypertrophic,
restrictive, obstructive, dilated cardiomyopathy, mainly cardiomyopathy with damage to the right ventricle, constructive pericarditis, primary pulmonary hypertension or pulmonary heart, myocarditis, acute myocardial infarction (within 30 days), unstable angina, valvular heart disease, acute cerebrovascular accident (6 months), renal and hepatic failure, autoimmune and endocrine disorders, patients with systemic collagenases. Patient functional status in chronic heart failure was evaluated according to the New York Association of Cardiologists Association (NYHA, 1964) criteria recommended for clinical practice by the International and European Association of Cardiologists.

The examinations were prospective, and clinical evaluation of patients was carried out in a generally accepted manner, which included questioning, screening, and physical examination. Physical examination was performed on measurements of body mass, indicators of major vital functions (UU, AB, NS), palpation, percussion, auscultation. Complaints and anamnestic data were collected in standardized manner and additional questions were asked by the patient as needed.

The adherence to the standard CHF treatment, the types and dosage of the drug, the patient's attitude and information about the SYUE disease and its treatment were determined using the Moriski-Green test according to the patient's questionnaire [15].

**Research results**

The principles of drug therapy and treatment of any disease and heart failure, in particular in the second decade of the 21st century, are based on evidence-based medicine. In other words, only drugs that have proven effective with long-term effects (including effects on the disease) and safety can be recommended for widespread practice. All recommendations regarding the dosage and the quantity of doses used during the day are also based on controlled studies that have proven the effectiveness of a particular therapy method.

Analysis of questionnaires displayed that 56 (42.1%) women received drugs included in the CHF standard of therapy, 51 (38.3%) women received symptomatic treatment, and 11 (8.3%) women received drugs only during inpatient treatment. Overall, 88.7% of patients received some treatment, and 15 (11.3%) studies did not receive any drugs that were included in standard CHF treatment (Fig. 1).
intake of the drug were more likely to have arterial hypertension II, III and MI.

While evaluating the effectiveness of treatment according to The Moriski-Green test showed that patients were being treated with high compliance of therapy in only 27 (20.3%) patients. In this group of patients who receive regular medication, there is an impression that there is a shortage of dosage and regular administration of drugs.

Recent studies have shown that the main method leading to the full implementation of doctors' recommendations is individual interviews with patients and the subsequent creation of special schools or extensive information about CHF patients in these schools. The quality of patient care at CHF depends not only on the knowledge and skills of inpatient and outpatient doctors, but also on patients' compliance with their recommendations. To further increase the effectiveness of treatment, it is important to find out the reasons for non-compliance with the recommendations of the patient and turn to treatment for each patient [6, 12]. Of the examined patients, 51.1% had information about their disease, but not all followed to the recommendations of the doctor, 21.8% of the patients said that the advice and recommendations of their doctor were unreliable, and 29.3% said that they did not need to follow them, 63.2% of respondents indicated that they would like to receive more and more accurate information from their doctors about their disease and the effects of drugs (Picture -2).

As part of our study, we analyzed the use of evidence-based medicine principles, including the use of the first series of drugs that must be proven in the absence of evidence-based effective therapeutic doses and multiple daily doses. It should be remembered that the first set of CHF drug groups, including older women, was and remains an Aβ (or ARA) inhibitor, a β-blocker. When analyzing the use of drugs included in standard CHF treatment, the most commonly used drugs were angiotensin-modifying enzyme (AOPF) inhibitors, which accounted for 68.6% (n = 81) of 118 patients, and only 41 (34, 7%) of the patient. Regulatory administration of AOFF inhibitors. Although the use of this drug is relatively high, it should have been 100% in SYUE International Recommendations, taking into account the indications and side effects of the group of drugs.

Evidence of its effectiveness and importance in reducing the number of deaths and hospitalizations in enalaprilCHF was 91.3% of the total group of Aβ inhibitors used, with the rest ramipril and lisinopril.

The intake of angiotensin II receptor antagonists (ARA) was 21 (17.8%), 9 (7.6%) AOF inhibitors had no side effects, or the drug was replaced due to inefficiency, 12 (10.2).% ARA is recommended from the first day of treatment. In the ARA group, the drug was regulated in 8 (6.8%) cases.

The second place in drug use in the main group was β-blockers, of which 38 (32.2%) were used by patients, and in 18.6% they received the regimen. Out of the b-blockers used, 76.3% were bisoprolol, while the remaining 23.7% were atenolol, carvedilol, nebilet and metoprolol, but atenolol made a significant contribution.

Patients administered diuretics, listed in the main group of drugs as 22.9%, cardiac glycosides
7.6%, and aldosterone antagonists 3.3%. Regarding the analysis of regularity, diuretics were regularly obtained in 15.3%, cardiac glycosides 5.1% and aldosterone antagonists 1.7% (Pic. 3). However, despite the widespread use ofaldosterone antagonists in accordance with medical recommendations for inpatients, the use of this drug is low.

**Pic-3 The use of drugs of the main group with standard treatment of SSC (%)**

Consumption of calcium antagonists from side effects of CHF treatment was found in 19.4% of patients and 26.2% of nitrates. 62.7% of the antagonists were used in the subgroup.

The use of 3 or more drugs in the main group of standard CHF treatment showed 13.5% (7.6% of the drugs were regulated), the use of 2 drugs was 21.1% (7.6% constant).

The average therapeutic dose of the CHF standard treatment was 7.5 mg for AOF inhibitors and 5.5 mg for β-blockers, but did not reach the median dose in international guidelines.

**Conclusion**
1. Based on the results, 42.1% of the examined patients received regular CHF drugs, and only 20.3% of them had a high compliant rate.
2. In the CHF study, the main group of drugs was Aβ inhibitors, followed by β-blockers, diuretics in are 3rd place, and cardiac glycosides are in 4th place.
3. Drugs that are part of the standard CHF treatment are used in doses lower than the recommended therapeutic.

**REFERENCES:**
5. Vologdina I.V. Anxiety-depressive disorders and quality of life in patients of old age with coronary heart disease complicated by chronic heart failure, correction possibilities: /Abstract of thesis. ... Dr. med. - St. Petersburg, 2009; 36-40.
11. Syromyatnikova L.I. Gender characteristics of the clinical, metabolic and psycho-emotional status in patients with myocardial infarction and their prognostic value // Abstract. dis ... Dr. med. - Perm, 2010; 48.

Entered 05.03. 2019