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ORGANIZATION OF DIETARY TREATMENT OF PATIENTS WITH CHRONIC KIDNEY DISEASE

Resume: Diet therapy is an integral component of the treatment process and preventive measures for diseases of the kidneys and urinary system. It is in these diseases that timely correction of food rations by the main nutrients is very important. In this clinical and statistical group, nutritionists use two completely different tactics for prescribing therapeutic nutrition: diets with a low protein content (for kidney failure) and diets with a high protein content (during hemodialysis). Thanks to an individual approach to the choice of diet therapy and timely established chemical composition, energy value, the list of permitted and prohibited products, the volume of specialized products, it is possible to restore the impaired functions of excretion of toxins from the body, increase the reserve capacity of the urinary system.

Keywords: chronic kidney disease, therapeutic nutrition, low-protein diet, ketosteril, soy proteins.

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ОРГАНИЗАЦИЯ ДИЕТИЧЕСКОГО ЛЕЧЕНИЯ ПАЦИЕНТОВ С ХРОНИЧЕСКОЙ БОЛЕЗНЬЮ ПОЧЕК

Резюме: Неотъемлемым компонентом лечебного процесса и профилактических мероприятий при заболеваниях почек и мочевыделительной системы является диетотерапия. Именно при этих заболеваниях очень важна своевременная коррекция пищевых рационов основными нутриентами. В этой клинико-статистической группе

диетологами используются две совершенно различные тактики назначения лечебного питания: диеты с низким содержанием белка (при почечной недостаточности) и диеты с высоким содержанием белка (при проведении процедуры гемодиализа). Благодаря индивидуальному подходу к выбору диетотерапии и своевременно установленному химическому составу, энергетической ценности, перечню разрешенных и запрещенных продуктов, объему специализированных продуктов возможно восстановить нарушенные функции выведения шлаков из организма, повысить резервные возможности мочевыделительной системы.

Ключевые слова: хроническая болезнь почек, лечебное питание, малобелковая диета, кетостерил, соевые протеины.

Introduction. The kidneys play an important role in maintaining homeostasis in the body. The kidneys perform the functions of regulating the water-electrolyte and acid-base balance, and the kidneys are also involved in the endocrine regulation of the body and the metabolism of many nutrients. Kidney diseases can lead to a decrease in renal excretion, endocrine disorders, metabolic disorders. Against the background of the developed pathological phenomena, nutritional imbalances develop. Diet therapy is a method not only of symptomatic, but also pathogenetic treatment of kidney diseases.

Chronic kidney disease is a slow-moving disease and in the initial stages does not cause the patient particularly many complaints. The group of diseases with chronic kidney disease includes a number of kidney diseases in which renal function decreases for several years or decades. Nutritional status is an important factor that influences morbidity and mortality in patients with kidney diseases, especially in the terminal stage [1,5]. Among the many factors that have an adverse effect on outcomes in such patients, protein-energy deficiency (BEN) plays a leading role [2,3]. At the same time, despite the importance of therapeutic nutrition in the treatment of patients with renal diseases in the domestic literature, unlike foreign, we managed to find little information about

this type of treatment [1,4]. To fill this gap, an attempt has been made to highlight the state of this problem at the present stage.

In therapeutic nutrition in the complex therapy of kidney diseases, pronounced metabolic disorders and possible disorders of the digestive system are taken into account. Diet therapy is based on the main pathogenetic mechanisms of the disease and provides for the need to spare the kidneys, leveling metabolic disorders, potentiating the action of diuretics and other medications.

The main differences in dietary therapy relate to the amount of protein, salt and water, which is determined by the clinical form, the period of the disease and the functional feature of the kidneys. The presence or absence of edema, high blood pressure, azotemia, albuminuria, hypoproteinemia and their severity are important.

The purpose of the study. To evaluate the possibilities of early diagnosis of nutritional status disorders in patients with chronic renal insufficiency (CRF), to determine the most significant factors in the development of nutritional disorders, as well as the principles of their treatment in these patients.

Materials and methods of research. 150 patients with CRF in the predialysis period were under observation, divided into three equal groups depending on the protein content in the daily diet. The first group consisted of patients receiving a combined low-protein diet (MBD) with soy isolate (0.6 g of protein per kg of recommended body weight (RMT) per day: 0.4 g / kg with a normal diet plus 0.2 g / kg in the form of soy isolate SUPRO 760); the second - standard MBD without additives (0.6 g/kgkg of RMT protein per day); the third is a free diet (about 0.9 g / kg of RMT protein per day). After the introductory period (three months), the number of patients in the groups decreased. The main reasons are non-compliance with the doctor's recommendations and the rapid progression of CRF, which required the initiation of substitution therapy (mainly in the control group).

The results of the study. The results of our studies with oral protein loads for healthy people and patients with CKD also allowed us to make the assumption that high protein intake is not limited to the effect on the state of renal hemodynamics.

Indicators of nutritional status in patients with various variants of MBD were evaluated on the basis of clinical, laboratory, anthropometric, calculated and functional indicators. At the beginning of the study, both groups were comparable on the basis of food diary entries on the level of fats, carbohydrates, protein consumed, as well as calculated data on protein and energy consumption.

Observation of patients in all groups was carried out in dynamics for 26 ± 3 months. The rate of progression of CRF was estimated by the magnitude of the increase in creatininemia (P(").

In the first group, the increase in serum creatinine was practically absent for 24 months, after which there was even a slight negative trend. In the second group, creatininemia remained relatively stable for 14 months, after which an increase in Rgc was noted. On average, the increase in serum creatinine levels during follow-up in the second sample was significantly less than in the first. In the third group, from the second month of observation, there was an increase in Rsa, which persisted throughout the entire period. On average, statistically significant differences were noted between the indicators of this and the first two samples.

Comparison of the first two groups of patients by the rate of change in creatinine clearance also showed that the rate of progression of CRF in the second group was significantly higher. The results obtained undoubtedly indicate a distinct slowdown in the progression of CRF in patients on MBD compared with patients receiving a diet without protein restriction, at the same time MBD with soy isolate is clearly more effective in this regard than standard.

The increase in total serum protein in patients with CRF was significantly higher on average with MBD with soy isolate, compared with the group receiving standard MBD ($p < 0.05$). The increase in total protein in the first sample during the observation period as a whole was more than 2.5 g/l, whereas with a normal low-protein diet, this indicator remained almost stable.

Dietary restrictions in CRF have their own characteristics. Firstly, the diet for chronic renal failure should be followed throughout life. Prolonged deviations from the recommended menu can lead to serious complications. Secondly, the degree of severity of chronic renal failure is taken as the basis for calculating the required amount of protein. With an insignificant clinic, human nutrition in relation to proteins changes little — up to 70-80 g of proteins remain on the table. The diet is supplemented with a sufficient amount of carbohydrates, salt is limited to 4 g per day. The volume of water should not exceed the daily discharge of urine. This includes the liquid that is present in soups, dairy dishes, vegetables and fruits. Fasting days — watermelon, pumpkin, apple - will help to get rid of edema and facilitate the work of the kidneys. They do them once a week. With an increase in the manifestations of renal insufficiency, the low—protein diet is tightened - the amount of protein is reduced to 20-30 g per day, while simultaneously increasing the volume of carbohydrate-containing food to 350-380 g. These recommendations are valid for patients undergoing medical treatment.

Conclusion. Thus, the nutritional status in terms of outcomes in patients with chronic renal insufficiency (CRF) is of strategic importance. Its importance becomes even more significant, taking into account the new concept that has appeared in the everyday life of nephrologists - the concept of chronic kidney disease (CKD), which makes it possible to further enhance the role of therapeutic nutrition by moving its beginning to earlier stages.

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