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COURSE OF ISCHEMIC HEART DISEASE IN WOMEN OF CLIMACTERIC AGE

Summary. The results of a study of clinical features and risk factors for the development of coronary heart disease in young and middle-aged women are presented. The following risk factors were observed: smoking and arterial hypertension. The relationship between the prevalence of ischemic heart disease and aggravated gynecological history has been established. In the first place among gynecological diseases that can be risk factors for coronary artery disease was uterine fibroids, then the use of hormonal contraceptives and ovarian failure.

Key words: coronary heart disease, women, risk factors.

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ТЕЧЕНИЕ ИБС У ЖЕНЩИН КЛИМАКТЕРИЧЕСКОГО ВОЗРАСТА

Резюме. Представлены результаты изучения клинических особенностей и факторов риска развития ишемической болезни сердца у

женщин молодого и среднего возраста. Наблюдались следующие факторы риска: курение и артериальная гипертензия. Констатирована связь между распространенностью ИБС и отягощенным гинекологическим анамнезом. На первом месте среди гинекологических заболеваний, которые могут быть факторами риска ИБС, была миома матки, затем применение гормональных контрацептивов и яичниковая недостаточность.

Ключевые слова: ишемическая болезнь сердца, женщины, факторы риска.

Relevance. Cardiovascular disease (CVD) is the leading cause of death in women in most developed countries of the world [1]. In the United States, more than half a million women die each year from CVD, and CHD accounts for the bulk of the causes of death. Mortality in myocardial infarction in women is 3 times higher than in men [2]. IHD in women develops 10 years later than in men. This is due to the protective role of estrogen. However, in the presence of risk factors and their combined action, the development of manifestations of coronary artery disease in young and middle age is possible [3].Diagnosis of ischemic heart disease in young and middle-aged women presents significant difficulties [4]. The existing belief that coronary heart disease is a disease of men, and in women it develops in old age, leads to errors in diagnosis, lack of treatment and worsening prognosis [5]. Purpose of the study. Assessment of clinical features and risk factors for the development of coronary artery disease in young and middle-aged women.

Material and research methods. The examined women were divided into 2 groups: 1st group - 105 patients with coronary artery disease and with preserved menstrual cycle, whose average age was 46 ± 3.28 years; 2nd - 36 patients with coronary artery disease and those in the period of menopause, whose average age was 48.7 ± 2.25 years. In group I, the duration of ischemic heart disease averaged 2.1 ± 2.75 years. Exertional angina pectoris was in 47.6% of cases. One history of myocardial infarction was in 58% of cases, two or more MIs suffered - 13.3%. In group II, the duration of ischemic heart disease averaged 2.4 ± 3.0 years.

Exertional angina pectoris was noted in 50% of cases. One MI in the anamnesis was in 61.1% of patients, two or more MIs suffered in 11.1%.

Drug therapy in two groups included the main groups of antianginal drugs, symptomatic therapy. The clinical course of coronary artery disease in response to treatment was assessed by the frequency and severity of angina attacks, the appearance of new "coronary episodes", the nature of cardiac arrhythmias, as well as the death of the patient from ischemic heart disease. During the observation period, a comprehensive examination was carried out: anamnesis of the disease and life; electrocardiography; biochemical study (indicators of the blood lipid spectrum: total cholesterol (CS), triglycerides (TG), high density lipoprotein cholesterol (HDL cholesterol).

Statistical data processing was performed using statistical software SPSS version 10.0. Signs with normal distribution were calculated using the Student's coefficient. All data are presented as M ± m (M is the arithmetic mean of the sample population, m is the standard error of the mean). Differences were considered significant at $p < 0.05$.

Research results and discussion. The analysis of risk factors (RFs) for CHD in women of group I showed that the most common RFs were smoking (70.5%) and arterial hypertension (AH) (62%). Atherogenic dyslipidemias (DLP) were observed in 54.3% of cases. The incidence of diabetes mellitus (DM) was 14.9%.

In women of group II, AH (83.3%) and atherogenic DLP (66.7%), smoking (27.8%), diabetes mellitus accounted for 19.4% of cases most often. Most women with CHD had a combination of 2 or 3 risk factors. Moreover, patients of climacteric age were characterized by the presence of a greater number of IHD RF than for women with a preserved menstrual cycle: they were significantly more likely to have 4 or more RFs (33.3% and 16.2%, respectively, $p < 0.05$).

DLP in women aged 40-44 years was in 26.3% of cases, at the age of 45-49 years - 57.9% and at the age of 50 and more - 15.8%, normolipoproteinemia (normoLP) - 9%, 12, 7% and 14.5%, respectively. Among women of the 1st group

who underwent MI, hypercholesterolemia (HC) was detected 2.1 times more often than in the corresponding group. Atherogenic DLPs were significantly more common in group 1 than in group 2 (54.3% and 25.8%, respectively, $p < 0.05$).

The most common among all women was type IIa DLP. DLP type IV was observed 2 times more often in women in group 1 than in group 2 (11.4% and 5.6%, respectively). DLP IIb was observed with the same frequency in both groups (22.9% and 22.2%, respectively, $p = 0.5$). In 45.7% of young women with coronary artery disease, the lipid spectrum of blood was normal.

Normolipidemia in women of this group was observed more often than in patients of group II, however, no significant differences were obtained (45.7% and 33.3%, respectively, $p = 0.1$). The average values of the main lipid parameters of blood in women of the 1st group slightly exceeded the norm, and in women of the 2nd group - pronounced atherogenic changes in the lipid spectrum of the blood: a high level of total cholesterol and triglycerides and lower cholesterol levels of HDL, compared with 1- group (total Xc 7.4 ± 1.6, TG 2.8 ± 1.1, HDL cholesterol 0.9 ± 0.7, versus 6.8 ± 1.3 and 2.3 ± 1.0, 1 , 2 ± 1.0, respectively).

In women with coronary artery disease, a burdened gynecological history was significantly more often observed (group 1 - 42.8%; second - 66.7%): irregular menstrual cycle, infertility, early menopause and other signs of ovarian insufficiency. In women of the 1st group, uterine fibroids were observed (23.8%), the use of hormonal contraceptives (22.8%), ovarian failure (resection or removal of one ovary) - 8.6% were noted.

In group I, in 36.0% of cases, there was an improvement in the condition with standard antianginal therapy, in 58.0% - without much change, and in 6.0% - worsening of the condition. In 57.1% of patients, the course of ischemic heart disease was stable, the frequency of angina attacks did not increase, and there were no coronary episodes. An improvement in the clinical course of the disease was observed in 36.2% of patients. In 69.4% of women, the condition remained stable. Improvement was noted in 19.4% of patients: anginal attacks disappeared, exercise tolerance increased, and the dosage of antianginal drugs decreased. The severity of

the course of the disease in patients of group II was influenced by the presence of two or more MIs in the anamnesis and the duration of the course of ischemic heart disease. As well as in patients of group I, the severity of the course of coronary artery disease did not depend on age. In patients of group I, the prognosis of the disease was more favorable than in group II: an improvement in the condition was observed 1.4 times more often, deterioration occurred 2.4 times less often, which is associated with a shorter duration of the course of the disease. In women of group I, deterioration in the clinical condition was associated with the presence of repeated MI in the anamnesis and practically did not depend on the age and duration of IHD.

The severity of the course of the disease in women of group II was influenced by the presence of two or more MI in the anamnesis, the duration of the course of IHD. During drug therapy for coronary artery disease in both groups, antiplatelet agents were most often prescribed, followed by ß-blockers and nitrates. Moreover, nitrates and ß-blockers were more often prescribed to patients in group II than in group I (77.7% and 94.4%, compared with 61.9% and 80%, respectively), which is associated with a severe course of coronary artery disease. ACE inhibitors and calcium antagonists were more often prescribed to patients in group I than in group II (66.7%, 59% versus 52.8%, 47.2%).

Thus, RFs such as smoking (70.5%) and hypertension (62%) were observed with a greater frequency. The relationship between the prevalence of ischemic heart disease and aggravated gynecological history has been established. The first place among gynecological diseases that can be risk factors for coronary heart disease was uterine fibroids (23.8%), followed by the use of hormonal contraceptives (22.8%) and ovarian failure (resection or removal of one ovary) - 8.6%.

Output. The course of ischemic heart disease in women with a preserved menstrual cycle was more favorable than in patients who are in the menopause.

The course of the disease in these patients worsened in the presence of repeated MI and did not depend on the age and duration of IHD.

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