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*Primkulova Gulbakhor Nazirzhonovna*

*Department of Propaedeutics of Internal Diseases*

*Andijan State Medical Institute*

**MANAGEMENT OF PATIENTS WITH CHRONIC HEART  
FAILURE AT THE PRESENT STAGE**

**Resume:** Chronic heart failure (CHF) is a clinical syndrome with typical complaints (shortness of breath, fatigue, leg edema) and manifestations (high pressure in the jugular veins, leg edema, wheezing in the lungs) caused by structural and/or functional changes in the heart that led to a reduced cardiac output and/or increased intracardiac pressure at rest or during exercise.

**Key words:** heart failure, diagnosis, edema, treatment.

*Примкулова Гулбахор Назиржановна*

*Кафедра пропедевтики внутренних болезней*

*Андижанский государственный медицинский институт*

**ВЕДЕНИЕ ПАЦИЕНТОВ С ХРОНИЧЕСКОЙ СЕРДЕЧНОЙ  
НЕДОСТАТОЧНОСТЬЮ НА СОВРЕМЕННОМ ЭТАПЕ**

**Резюме:** Хроническая сердечная недостаточность (ХСН) – клинический синдром с типичными жалобами (одышка, утомляемость, отеки ног) и проявлениями (высокое давление в яремных венах, отеки ног, хрипы в легких), вызванный структурными и/или функциональными изменениями сердца, которые привели к сниженному сердечному выбросу и/или повышенному внутрисердечному давлению в покое или при нагрузке.

**Ключевые слова:** сердечная недостаточность, диагностика, отек, лечения.

**Introduction.** Heart failure is characterized by a change in the structure or function of the heart, leading to its inability to deliver oxygen in accordance with the need of tissues, despite the normal filling pressure [3,6].

In accordance with modern international recommendations, chronic heart failure (CHF) is defined as a syndrome in which a patient has typical complaints (shortness of breath, swelling of the legs, fatigue) and symptoms (increased venous jugular pressure, wheezing in the lungs, displaced apical thrust) as a result of changes in the structure or function of the heart [1,4].

Heart failure can manifest itself with both reduced and normal left ventricular ejection fraction (LVEF). Here and further, CHF is considered only with reduced LVEF as the most common variant in patients after myocardial infarction[2,5].

There are many patients with CHF of various genesis in the primary health care, while the tactics of managing these patients at the polyclinic stage at the initial stages of heart failure have not been sufficiently studied, which indicates the absence of clear criteria for the diagnosis of CHF at the earliest period of its development at the outpatient stage. At the same time, practitioners in outpatient practice do not sufficiently use the diagnostic capabilities of echocardiography (ECHO CG), although in many respects the choice of CHF therapy depends on the predominance of systolic or diastolic LV dysfunction [1,3].

With a high percentage of the occurrence of CHF diagnosis in patients with cardiovascular diseases, there is a small number of studies confirming this diagnosis, which prepares a good ground for verifying the existing diagnosis of CHF. The authors of various studies have repeatedly studied the prognosis of survival from all causes, prescribing medications in patients diagnosed with CHF, however, the data obtained in the early two thousand years are outdated, which underlines the importance of assessing the compliance of non-drug and drug therapy prescribed to patients diagnosed with CHF at the outpatient level with international recommendations[2,6]

**The purpose of the study.** To study the possibilities of differential diagnosis and optimal treatment of chronic heart failure in a city polyclinic.

**Material and methods of the study.** A prospective observational study of patients who turned to a therapist in the polyclinics of AOMPБ during the year was conducted. Andijan.

**The results of the study.** "Soft" criteria for the diagnosis of chronic heart failure (CHF) had 29.8% of patients from the entire one-year appointment of a cardiologist at the polyclinic. As a result of the examination, the diagnosis of CHF was confirmed in 50.3% of cases. In the remaining patients, including 33.3% of men and 59.5% of women, alternative causes of complaints were identified: COPD (10.8%), hypothyroidism (9.2%), transient myocardial ischemia (9.2%), obesity (10.3%), psychogenic causes (4.3%), anemia (3.2%), arrhythmias (2.2%).

In 90.8% of cases, the differential diagnosis of CHF was completed in a polyclinic and a district diagnostic clinical center, and only 9.2% of patients required additional examination in a specialized cardiological institution. The lack of the possibility of studying the brain natriuretic peptide for screening, territorial remoteness and waiting for studies at the district clinical center contributed to an increase in the time (up to  $101.8 \pm 88$  days on average) and the cost of examination ( $8.03 \pm 2.1$  diagnostic services per person), as well as the withdrawal from the study of 36.1% of patients with suspected CHF.

Patients with verified CHF corresponded by gender (equal number of men and women), etiology, the average functional class of NYHA ( $2.1 \pm 0.7$ ) and the proportion of persons with a low left ventricular ejection fraction (44.1%) to the contingent of the European register EuroHeart Failure survey, but differed in younger age ( $64.8 \pm 10.6$  years) and higher prevalence of arterial hypertension (74.2%), similar to patients of the Russian register EPOCH-O-CHF.

ACE inhibitors or angiotensin II receptor antagonists were prescribed by 95%, recommended p-blockers - 91%, spironolactone - 71%, diuretics - 90%,

digoxin - 27%, statins - 61% of patients with CHF. In CHF with low LVEF, target doses of ACE inhibitors/ARAP and P-blockers were

achieved in 51% and 44%, respectively, at least 50% of the target doses - in 68%, target heart rate - in 83% of cases, which required the addition of ivabradine in 23% of patients with sinus rhythm. The use of oral anticoagulants remained insufficient, which only 43.2% of patients who had appropriate indications were able to prescribe.

**Conclusion.** The present study contributes to the development of ideas about a typical patient with a diagnosis of CHF, observed in real outpatient practice. The results of this work significantly supplement and clarify the data on the implementation of diagnostic measures and the formulation of the diagnosis of CHF. In addition, the obtained data will allow analyzing the features of therapy of patients diagnosed with CHF in real outpatient practice.

The data obtained reflect the features of the course and prognosis of CHF, taking into account comorbidity, which can contribute to predicting the risk of death and show potential ways to reduce it

Arterial hypotension (39%), bradyarrhythmias (17%), bronchial obstruction (12%), hyperkalemia (5%), obliterating atherosclerosis of the arteries of the lower extremities (5%) and decreased glomerular filtration rate (2%) prevented the achievement of the target doses of the main recommended drugs. On average, blood pressure, potassium and plasma creatinine remained within normal limits.

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