IMPROVING THE QUALITY OF LIFE OF PATIENTS WITH CARDIOVASCULAR DISEASES

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Cardiovascular diseases are the most common cause of death in industrialized countries. These include coronary heart disease, cerebrovascular disease, and peripheral arterial disease. For many years, cardiovascular disease (CVD) has firmly held the leading position among all causes of death worldwide. Three risk factors for cardiovascular disease—hypertension, smoking, and dyslipidemia—are known to account for more than 75% of all cardiovascular mortality. The likelihood of developing coronary heart disease and other cardiovascular diseases increases with the number and severity of these risk factors [1]. The most significant forms of cardiovascular disease in terms of morbidity and mortality are coronary heart disease and stroke, as they account for more than 70% of all cardiovascular deaths. Therefore, the fight against cardiovascular diseases and their causes is a primary goal of cardiology [2]. Cardiovascular diseases affect a large number of the population. According to the WHO, the main risk factors for the development of heart disease and stroke are poor nutrition, physical inactivity, tobacco use, and harmful alcohol consumption. This pathology occurs at an earlier age than in previous years and is the leading cause of death worldwide. A third of all deaths are due to cardiovascular diseases. The most common cardiovascular diseases include coronary heart disease, hypertension, and cerebrovascular lesions. Men die significantly more often from myocardial infarction than women. One of the most dangerous diagnoses is acute coronary syndrome. In addition to damage to health and life, cardiovascular diseases cause significant annual economic losses to the state, amounting to 3.2%. [3]. Achieving this goal is possible with widespread citizen engagement in healthy lifestyle practices. This includes creating conditions for maintaining and promoting a healthy lifestyle, reducing the impact of the main risk factors (RF) for non-communicable diseases (NCDs), screening and early detection of diseases, and engaging workers in health promotion programs [4].

Objective: The objective of the study is to analyze the main risk factors, study their prevalence, assess the dynamics of cardiovascular disease risk factors, and implement preventive measures to reduce the risk of cardiovascular disease. This study also examines the incidence of cardiovascular diseases. According to V. I. Kharchenko, three risk factors for diseases, including CVD, should currently be distinguished:

classical traditional, socio-psychological, and socio-economic. Success in comprehensively eliminating or reducing the multiplicity and intensity of the impact of risk factors in all three areas will enable us to achieve success in reducing morbidity and mortality in the population, as confirmed by the successes in reducing morbidity and mortality from most diseases, including CVD, in economically developed countries. Insufficient effectiveness of efforts to reduce CVD morbidity and mortality is determined by the multiplicity of risk factors, their high severity, and the lack of success in combating unhealthy lifestyles and risk factors, including socioeconomic and sociopsychological ones. Classic risk factors for the development of coronary heart disease, the genesis of which has been well studied, include high levels of total cholesterol and low-density lipoprotein cholesterol in the blood serum, low levels of high-density lipoprotein cholesterol, arterial hypertension (AH), smoking, physical inactivity, overweight, etc. The leading role belongs to dyslipoproteinemia (DLP) [5]. A moderate risk of developing atherosclerosis and coronary heart disease is defined as the presence of one lipid risk factor in combination with any other factor. A high risk of developing coronary heart disease exists in the presence of two lipid risk factors (e.g., a TC level greater than 7.8 mmol/L is considered two risk factors) or one lipid risk factor and two other risk factors for coronary heart disease [6]. Age, male gender, and genetic predisposition are irreversible risk factors. Elimination of the remaining risk factors not only significantly reduces the likelihood of developing atherosclerosis but also delays the progression of its existing manifestations. The main reversible risk factors are smoking, physical inactivity, obesity, hypertension, and hyperlipidemia. Excess body weight is considered a risk factor for the development of coronary heart disease and atherosclerosis in a number of publications. It is often associated with other risk factors, such as a sedentary lifestyle, diabetes mellitus, and lipid metabolism disorders. It is now considered proven that excess body weight (BMI) is an independent risk factor for the development of coronary heart disease and its associated mortality. Furthermore, a clear link has been found between BMI and other risk factors (hypertension, dyslipidemia). In our country, obesity occurs in 20-30% of the adult population, and in 80% of cases, the primary causes are excessive food consumption, increased consumption of refined and high-calorie foods, and physical inactivity. Physical inactivity is currently considered an independent risk factor for coronary heart disease. Some sources indicate a higher risk of developing coronary heart disease in the presence of physical inactivity. Thus, it was found that among people with sedentary professions, the incidence of coronary heart disease and mortality from it is much higher than among people with working professions [6,7].

Study materials and methods: The prevalence of traditional cardiovascular risk factors was assessed in a representative sample of 76 individuals aged 30 to 59 years. A full analysis of the data was conducted, taking into account age, gender, and

social status. A medical history was collected, a physical examination, blood pressure measurements, anthropometric parameters, body mass index (BMI), heart rate, and respiratory rate were assessed, along with the identification of pathological symptoms and diagnosis.

Results. It was established that the average age of CVD detection in the study was 46.3 years, the prevalence of overweight was 35.0%, and obesity was 30.3%. Abdominal obesity was detected in 53.8%, family history of early CVD (59.0%) of the examined subjects. Smoking was confirmed by 21.2%, quit smoking (not smoking for more than a year) by another 20.0%. Alcohol consumption more than 2 times a month was noted among the respondents (10.5%). It should be noted that the prevalence of arterial hypertension (HTN) was 27.9% of the examined subjects, and in 4.8% of the examined subjects, increased blood pressure was detected for the first time in this study. The prevalence of type 2 diabetes mellitus (DM) was 4.7%. It was found that the majority of works were devoted to the study of diseases of the heart and blood vessels, hypertension and coronary heart disease (CHD).

Results of the study and their discussion: It is known that individuals who regularly experience high psychoemotional stress, which serves as a trigger for cardiovascular events due to local and systemic activation of oxidative processes [2,7], are highly susceptible to CVD. Smoking is an independent predictor of CVD mortality, as shown in studies conducted in Western and Eastern European countries, and is a widespread behavioral factor that is undoubtedly modifiable by risk factors. With regard to smoking, it should be noted that cigarette smoke is characterized by a very high content of free radicals and unsaturated aldehydes [7]. The mineral composition of the diet is of great importance for the prevention of CVD. Excessive consumption of table salt (more than 6 g/day) contributes to the development of gout, atherosclerosis, hypertension, and stroke. It has been proven that limiting the intake of sodium, which it contains, can help lower blood pressure in patients with hypertension. Even a moderate reduction in sodium intake by 1 g/day reduces SBP by 3.1 mmHg. In patients with hypertension, the average daily salt intake was 1.6 mmHg. This may be clinically significant, as a 10 mmHg reduction in blood pressure can significantly reduce the risk of major cardiovascular diseases, coronary heart disease, stroke, heart failure, and all-cause mortality. In most Western countries, salt intake is 9–10 g/day, while the recommended maximum intake is 5 g/day. The optimal level of consumption may be up to 3 g/day, this amount corresponds to the current recommendations of the European Society of Cardiology for the prevention of CVD [6,7].

Conclusions: Regardless of the changes occurring in society, the main indicator of the well-being of any country is the health of its inhabitants. Achievements of medical science and successes in practical healthcare have not obscured the alarming trend of increasing morbidity and mortality among the planet's population. According

to WHO experts, negative dynamics of population health indicators have been recorded even in countries with a high standard of living: an increase in oncological and endocrine pathologies, an increase in the prevalence of cardiovascular diseases is noted. An even higher increase in pathologies of these systems is observed in the population living in ecologically unfavorable regions. Of particular importance is the cardiovascular system, which, along with the delivery and transfer of various substances, is one of the first to respond to changing conditions. [8]. Currently, the concept of prevention of non-communicable diseases is based on the principles of risk factor prevention [1,8]. Widespread implementation of preventive measures based on the elimination of RF in order to form a healthy lifestyle reduces the risk of developing CVD. its prognosis is improved, and the quality of life of patients is increased [7,9].

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