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Measures to Improve the Quality of Life of Patients with Comorbid Heart Pathology and Increase the Effectiveness of Their Treatment

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ABSTRACT

The data of most scientific and practical studies indicate that since the beginning of the 21st century, chronic heart failure remains the main medical and social problem in the developed countries of the world due to the high morbidity, disability and mortality in this pathology.

The dominant method for assessing the quality of life is questionnaires (questionnaires), both general and specific. The study of the patient's QOL before and during treatment allows one to obtain extremely valuable multidimensional information about the individual response of a person to the disease and ongoing therapy.

Relevance. Currently, in the conditions of demographic aging of the population, there is an increase in the number of diseases in one patient. At the same time, WHO experts predict an increase in the number of people over the age of 80 by 2050 from the current 125 million to 434 million people [6,7,9]. The aging of the population entails huge medical and social consequences, generates many problems and poses new challenges to healthcare [1,2,8].

In recent years, practitioners have increasingly had to face the problems of comorbidity development, to solve the issues of choosing rational tactics for managing patients with combined pathology [3,4,5]. At the same time, algorithms for the management of such patients have not yet been worked out, and the creation of such algorithms is becoming more and more urgent.

Our experience of working with patients with combined pathology makes it possible to offer tactical approaches to the management of comorbid patients at the outpatient stage, allowing to prevent the development of complicated forms of diseases, minimize the phenomena of undesirable drug interactions, optimize resource costs both at the outpatient and inpatient stages of patient observation.

The purpose of the study: To study ways to improve the quality of life of patients with comorbid pathology of the heart and increase the effectiveness of their treatment.

Material and methods of research: Material and methods. 203 patients (130 men and 73 women, average age 61.8=9.6 years) with CHF were examined. Comorbidity, psychological status, degree of adherence to non-drug and drug therapy of patients with CHF were

investigated.

Results and discussion. The study of the psychological characteristics of the satisfaction of patients with CVD with their physical and mental health, reflecting the main parameters of the quality of life associated with health, was conducted using the SF-12 quality of life assessment questionnaire. Scores were calculated on eight scales of the questionnaire.

Indicators of self-assessment of their physical and mental health of patients with CVD and the normative group are reliably close in almost all parameters: physical activity; the influence of physical condition on the performance of everyday activities; the intensity of pain and its impact on daily activities; general health; vitality; social activity; mental health. The only indicator that distinguishes CVD patients from healthy ones is the influence of the emotional state on the patients' performance of their daily activities.

Therefore, we can say that in general, the overall assessment of one's physical (36.3 ±18.1 and 33.3±20.0, respectively; $p > 0.05$) and mental health (60.7±19.4 and 60.8± 14.7, respectively; $p > 0.05$) in cardiovascular pathology changes slightly. Patients tend to consider themselves practically healthy and do not find in the disease those reasons that would significantly limit their physical (50.0±30.9 and 49.7±34.6, respectively; $p > 0.05$) or social functioning (58.5±28.3 and 62.1±30.4, respectively; $p > 0.05$). It is noteworthy that patients with CVD note a less connection of their emotional state with the performance of work or any other daily activity than the healthy group ($p < 0.01$).

To get a more complete picture of the features of the physical and mental functioning of patients, taking into account their belonging to a certain clinical group, it is possible with an intergroup comparison of SF-12 indicators (Figure). Thus, with the help of a single-factor analysis of variance, significant differences in the level of physical activity (PF scale) between patients of the studied clinical groups were determined (46,8±29,3; 58,9±26,5; 47,2±35,2; $p < 0.05$). This indicates that patients with GB attribute to themselves the highest activity (58.9±26.5; $p < 0.05$), noting that they are slightly limited in performing moderate physical activity. The lowest indicators of self-assessment of physical activity are in patients with coronary heart disease (46.81±29.3; $p < 0.05$), which reflects their real assessment of their significantly reduced capabilities associated with the presence of somatic disease. A group of patients with PS according to self-assessment of their physical activity is in an intermediate position between patients with GB and CHD.

Conclusion. Thus, the development and implementation of technology for the selection of diagnostic and therapeutic and preventive tactics in patients with comorbid pathology and moderate, high and very high risk of cardiovascular complications, the creation of programs for assessing the risk of cardiovascular disasters at the stage of chronic course of comorbid conditions and their exacerbations is an urgent medical and social problem of practical healthcare, the solution of which will allow effective individualized preventive therapy.

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