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EFFECTIVENESS OF CORRECTION OF DYSLIPIDEMIA IN ELDERLY PATIENTS WITH TYPE 2 DIABETES MELLITUS

Muallif	[1] **Mardiyev Giyosjon,** [2] **Kurbanova N.S.**
O'qish yoki ish joyi	[1] **Students of medical course 417 group, Samarkand State Medical University ,** [2] **Assistant of the Department of Endocrinology, Samarkand State Medical University**
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Abstract

For a long time, diabetes was considered only as a disorder of carbohydrate metabolism, and the sole purpose of insulin was considered to maintain normal blood glucose concentrations [1,2]. However, it is now obvious that this disease is accompanied by a complex metabolic disorder not only of carbohydrates, but also of lipids and proteins. The main clinical manifestations of diabetes - polyuria, polydipsia, polyphagia - are associated with hyperglycemia and glycosuria, but the 2 main complications of diabetes mellitus: atherosclerotic damage to large vessels and ketoacidosis are consequences of lipid metabolism disorders and it is difficult to expect that control of hyperglycemia alone can reduce the increased risk of heart disease.

Vascular complications in patients with diabetes mellitus. [3,4,5] Diabetes as a risk factor for coronary heart disease Both types of diabetes are associated with a markedly increased risk of coronary heart disease, cerebrovascular disease, and peripheral vascular disease. According to large epidemiological studies, diabetes is an important risk factor for coronary heart disease (CHD), especially in women [6,7,8]. In the Framingham study, at 20-year follow-up, the absolute risk of coronary death in diabetes was 2 times higher in men and 4.7 times higher in women than in persons of the same sex without diabetes [9,10,12]. It is known that in large populations, the prevalence of CHD among women before menopause is lower than among men of the same age. Diabetes significantly reduces this relative protective effect of being female [11,13]. Diseases, caused by atherosclerosis in patients with diabetes Mortality from cardiovascular diseases in patients with type 2 diabetes is 3 times higher than in the general population [14,15]. The contribution of cardiovascular diseases to the overall mortality of adults with diabetes is 75-80%, with 3/4 of these deaths due to ischemic heart disease, and the rest due to cerebrovascular diseases and peripheral vascular diseases [16,17,18]. In general, more people with diabetes die from diseases caused by atherosclerosis than from all other causes combined. The incidence of acute infarction among diabetic patients is higher than among nondiabetic individuals [19]. The size of infarctions in patients with diabetes is usually larger and they are more likely to develop complications - congestive heart failure and cardiogenic shock, and a worse long-term prognosis after surgical coronary revascularization [10]. Mortality after a heart attack is significantly higher in people with diabetes than in people without diabetes. It has been shown that after suffering a myocardial infarction, 40-50% of patients with diabetes mellitus die within the next 5 years [11]. In the TRACE (Trandolapril Cardiac Evalution Study), mortality over 7 years after acute myocardial infarction among diabetic patients was 79, 73, and 62%, respectively, in the groups treated with insulin, taking oral

hypoglycemic drugs, and using only a hypoglycemic diet, compared with 46% in patients with diabetes. without diabetes [11]. In a study from Finland, survival over 8 years of follow-up in diabetic patients without myocardial infarction was the same as in patients with myocardial infarction and without diabetes [8]. In this regard, modern guidelines recommend combating risk factors in diabetic patients without coronary artery disease as aggressively as in patients with coronary artery disease who have suffered a myocardial infarction [4,5]. Features of risk factors for diabetes types 1 and 2 In patients with type 1 diabetes, with good control of glucose levels, lipid levels and blood pressure remain normal for a long time. However, poor glucose control and the development of nephropathy are accompanied by dyslipidemia and arterial hypertension. In this case, the incidence of cardiovascular diseases in patients with type 1 diabetes over 30 years of age is significantly higher than in people without diabetes of the same age [1,2]. Unlike type 1 diabetes, type 2 diabetes is associated with more pronounced and profound disturbances in risk factors, which are already present at the stage of impaired carbohydrate tolerance.

Purpose of the study

To evaluate the effectiveness of medication in correcting atherogenic dyslipidemia in elderly patients with type 2 diabetes mellitus and high cardiovascular risk.

Materials and methods

A study of 160 case histories of patients with type 2 diabetes mellitus, observed for 2 years in the Samarkand branch of the Russian Scientific Research Center for Emergency Medicine, was carried out. The average age of the patients was 71.5 ± 8.9 years, the average duration of the disease was 16 ± 7.8 years. The selection of patients was carried out using random sampling. The inclusion criterion was the presence of cardiovascular pathology. Exclusion criteria were the presence of cancer, senile dementia, severe liver and kidney damage. All patients were examined for the level of total cholesterol (TC), low-density lipoprotein cholesterol (LDL-C), triglycerides (TG), glycated hemoglobin (HB), serum creatinine (with calculation of glomerular filtration rate), liver tests, general urine analysis and analysis urine for microalbuminuria, ECG, blood pressure level, body mass index. The degree of cardiovascular risk was assessed for each patient. The effectiveness and safety of prescribing statins in elderly patients was studied. Lipid-lowering therapy was considered effective if the patient's target lipid levels were detected during the study in accordance with the recommendations (LDL < 2.5 mmol/l).

Research results

In the study group, 99.7% of patients had a high vascular risk, but only 20.4% of them took recommended lipid-lowering drug therapy. Of these, 24.4% took statins for less than 1 year, 75.6% for more than a year, and only 13.4% took statins for 2 years. In 88.9% of cases, statin therapy was discontinued on its own, in 12.5% due to an increase in liver enzymes. Achievement of the target level of all 3 indicators of the lipid spectrum was stated only in 1.7% (in 2 patients). In general, in the group of patients, TC exceeded the target level in 104 patients (57.7%), TG in 129 (71.6%), and LDL cholesterol in 149 patients (91.6%). Achievement of target LDL levels was noted in 25 patients (22.1%).

Conclusion

There is an underestimation of the importance of correcting dyslipidemia in patients with type 2 diabetes mellitus in the older age group. Low effectiveness of lipid-lowering therapy was revealed in the examined patients, which was probably due to insufficient doses of prescribed statins.

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