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CLINICAL AND PATHOGENETIC FEATURES OF RECURRENT STROKE

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✓ ***Resume***

When we consider the distribution of patients by age and gender, one (1.4%) was detected in men between the ages of 18-44, 30 (52.5%) between the ages of 45-59, 28 (41.7%) between the ages of 60-74, and 3 (4.4 %) between the ages of 75-90. A significant level was found in patients between the ages of 45-59 suffered more than ischemic stroke.

Keywords: re-strokes, risk, rehabilitation.

QAYTA INSULTLARINING KLINIK VA PATOGENETIK XUSUSIYATLARI

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Buxoro davlat tibbiyot instituti

✓ ***Rezyume***

Bemorlarning yoshga va jinsga nisbatan taqsimlanishini ko‘rib chiqganimizda 18-44 yosh oralig‘idagi erkaklarda 1 nafar (1,4 %), 45-59 yosh oralig‘ida 30 nafar (52.5%), 60-74 yosh oralig‘ida 28 nafar (41,7 %), 75-90 yosh oralig‘ida esa 3 nafar (4.4 %) bemor aniqlangan. Ahamiyatli darajada 45-59 yosh oralig‘idagi bemorlarda ishemik insult nisbatan ko‘p uchrashi aniqlandi.

Kalit so'zlar: qayta insultlar, xavf, reabilitatsiya.

КЛИНИКО-ПАТОГЕНЕТИЧЕСКИЕ ОСОБЕННОСТИ ПОВТОРНЫХ ИНСУЛЬТОВ

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✓ ***Резюме***

Когда мы рассматривали распределение пациентов по возрасту и полу, у мужчин в возрасте 18-44 лет было выявлено 1 (1,4%), у мужчин в возрасте 45-59 лет-30 (52,5%), у женщин в возрасте 60-74 лет-28 (41,7%), у мужчин в возрасте 75-90 лет-3 (4,4%). В значительной степени установлено, что ишемический инсульт встречается относительно часто у пациентов в возрасте от 45 до 59 лет.

Ключевые слова: повторные инсульты, риск, реабилитация.

Relevance

The risk of recurrent strokes is about 30%. At the same time, 2-3% is observed in the first month after the primary stroke and 4-14% in the first 2 years [Gafurov B.G., 2019; SHtulman D.R., Levin O.S., 2008]. In many cases, re-circulatory disorders in the brain lead to a significant decrease in the ability to self-serve, a profound damage to the social adaptation of patients.

In recent years, a system of neurorehabilitation of patients has been created in the country, early rehabilitation technologies have been developed [Gafurov BG, Majidova YO.N., 2012]. Recovery may be partially spontaneous, but rehabilitation accelerates the process, as well as helping the patient to improve their new living conditions and overcome existing neurological defects.

Despite the rapid development of medicine, recovery and early rehabilitation, measures in patients with recurrent stroke remain untimely.

When we consider the distribution of patients by age and sex, 1 in men aged 18-44 years (1.4%), 30 people in the age group of 45-59 years (52.5%), 28 people in the age group 60-74 years (41.7%),

and 3 patients (4.4%) were identified between the ages of 75-90 years. Significantly, ischemic stroke was found to be relatively common in patients aged 45-59 years.

There were no cases of secondary ischemic stroke in women aged 18-44 years. 23 patients (56.3%) in the 45-59 age group, 17 patients (41.3%) in the 60-74 age group, and 1 patient (2.4%) in the 75-90 age group. significantly more cases of recurrent ischemic stroke were observed in sick women aged 45–59 years.

Male patients with secondary hemorrhagic stroke were 3 (10.3%) aged 18-44 years, patients aged 45-55 years were 7 (24.1%), and 56-65 years old were 5 (17.2%), and among patients over 66 years of age, 4 patients (13.7%). Significant recurrent hemorrhagic strokes have been reported in men aged 45-55 years.

No secondary hemorrhagic stroke was detected in female patients aged 18-44 years with recurrent hemorrhagic stroke. In the age group of 45-55 years, 2 patients (6.9%), in the age group of 56-65 years, the figure was 5 patients (17.2%), and in the age group of 66 years and older - 3 patients (10.3%).). Significantly, this figure is higher in the age group of 56-65 years

In both strokes, secondary strokes were found to be more prevalent in men than in women. Men are more prone to recurrent strokes than women. In women, this difference is weakened by age, as older women lose the protective effect of estrogens after menopause.

In women over the age of 45, the rate decreases. In this case, the difference is due to the specific characteristics of the hormonal background. In men, meanwhile, recurrent strokes are more common in older men due to vascular insufficiency, lack of physical activity, and the presence of risk factors.

To determine the clinical and pathogenetic features of recurrent strokes, patients in the primary and control groups were compared on a number of parameters. Group 1 (primary) included 137 patients with recurrent ischemic (108) and hemorrhagic stroke (29). The ratio of ischemic and hemorrhagic strokes in this group is 4: 1. In 2 groups (control), 20 patients with primary ischemic (20) and hemorrhagic stroke were selected. The proportion of ischemic and hemorrhagic strokes in the control group was equal.

According to statistics, ischemic stroke accounts for 70% to 85% of primary and recurrent cerebral circulatory disorders. In patients, ischemic mechanisms in the cerebrovascular system predominate, which is explained by an increase in the number of risk factors with age. The proportion of patients with hemorrhagic and ischemic stroke in different age groups. The table shows that the specific gravity of patients with recurrent ischemic stroke in the main group gradually increased with age.

The number of patients with recurrent hemorrhagic stroke is small. Hemorrhagic strokes are rarely reported in 66-year-olds and older. Only 4 patients in the control group had hemorrhagic stroke, which does not allow to draw statistically reliable conclusions. The Manny-Whitney criterion compared the observations of the main and control groups at different ages.

According to the NIHSH scale for all three age groups, the differences between the main and control, groups were found to be statistically unreliable (r> 0.05). Patients with recurrent stroke are expected to have more pronounced neurological deficits. However, in the elderly, patients with gross recurrent neurological deficits are less likely to survive a recurrent stroke.

In addition, recurrent strokes are more likely to be fatal. According to the literature, the mortality rate from recurrent ischemic stroke in patients aged 75-90 years is 1.5 times higher. Up to 30% of patients are hospitalized, where half of the patients die within the first 2 days (V.V Flud, 2008). Comparing observations from different age groups with recurrent stroke revealed statistically significant differences. Neurological deficits were lower in the 74–90-year-olds ($U = 409.5$, $r < 0.01$) and less in the 45–59-year-olds ($U = 541$, $r < 0.05$). There are no significant differences in the control group. Thus, the need to use neuroplastic reserves in recurrent strokes affected the severity of the neurological defect formed in patients aged 74–90 years (Fig. 1).

As shown in Table 1, the most common symptoms in the primary and control groups were statico-locomotor ataxia, and coordination disorders were significantly more common in patients with recurrent stroke in the 45-59 age group (r <0, 05) and in large groups this difference was less. Akinetic-rigid syndrome was observed in the main group of patients, and its frequency increased with age, reaching 17% in the 75-90 age group.

Table 1

The most common neurological symptoms in the primary and control groups

NS	Age groups							
	18-44 years old		45-59 years old		60-74 years old		75-90 years old	
	The main group	Control group	The main group	Control group	The main group	Control group	The main group	Control group
A	8 (25,0%)	0 (0%)	8 (25,0%)	0 (0%)	12(29,3%)	3 (25,0%)	8 (17,0%)	1 (6,7%)
AAS	3 (9,4%)	0 (0%)	3 (9,4%)	0 (0%)	11(26,8%)	0 (0%)	9 (19,1%)	0 (0%)
MS	4 (12,5%)	1 (14,3%)	4 (12,5%)	1 (14,3%)	3 (7,3%)	0 (0%)	4 (8,5%)	0 (0%)
GG	7 (21,9%)	2 (28,6%)	7 (21,9%)	2 (28,6%)	13(31,7%)	9 (75,0%)	24(51,1%)	1 (6,7%)
G	15(46,9%)	2 (28,6%)	15(46,9%)	2 (28,6%)	24(58,5%)	8 (66,7%)	31(66,0%)	5 (33,3%)
PM	23(71,9%)	3 (42,9%)	23(71,9%)	3 (42,9%)	26(63,4%)	10(83,3%)	34(72,3%)	10(66,7%)
GD	5 (15,6%)	0 (0%)	5 (15,6%)	0 (0%)	3 (7,3%)	0 (0%)	7 (14,9%)	0 (0%)
ARS	2 (6,3%)	0 (0%)	2 (6,3%)	0 (0%)	5 (12,2%)	0 (0%)	8 (17,0%)	0 (0%)
SLA	28(87,5%)	5 (71,4%)	28(87,5%)	5 (71,4%)	39(95,1%)	11(91,7%)	44(93,6%)	14(93,3%)

Note: NS - neurological syndrome, A - aphasia, AAS - apracho-agnostic syndrome, MS - meningeal symptoms, GG - hemihypesthesia, G - hemiparesis, MP - mimic muscle paresis, COPD - eye movement disorders, ARS - akinetic rigid syndrome, SLA - static-locomotor ataxia.

Disorders of coordination, which occur in degenerative diseases of the central nervous system, such as dyscirculatory encephalopathy or parkinsonism, are characteristic of patients with recurrent stroke and exacerbate the course of stroke. With recurrent cerebral circulatory disorders, these manifestations become more pronounced as the brain's compensatory reserves decrease.

Oculomotor disorders were also observed in the main group of patients of all ages, which was not reported in the control group. Facial muscle paresis was reported in the majority of patients of any age in single-stroke strokes without statistically significant differences. Statistical differences were observed in one-third of patients in the primary and control groups - hemihypesthesia, hemiparesis of varying severity, and hemihypesthesia in about half.

A comparative analysis of upper cortical function between baseline and control group observations redefined statistically significant differences: apracho-agnostic syndrome predominated in patients aged 75–90 years. Gnosis and praxis disorders were not reported in the control group. Speech disorders predominated in both groups between the ages of 75 and 90 years, but were reliably more common in patients with recurrent cerebral circulatory disorders ($r < 0.05$).

Table 3.3

Outcomes of MMSE impairment of cognitive function during hospitalization

Check day of arrival	Ischemic stroke		Hemorrhagic stroke	
	Primary (control group)	Secondary	Primary (control group)	Secondary
5-8	13,4±0,7	11,5±1,1	16,6±0,2	13,1±0,8
9-12	26,8±0,4	25,6±0,9	27,9±0,9	26,7±0,3
After 12 days	28,7±0,3	27,3±0,8	29,3±0,7	28,8±0,6

Conclusion

When the MMSE scale of patients of different ages in the main (n = 137) and control (n = 40) groups was divided, only moderate dementia was observed in the main group. Among the patients in the main group, the depth of cognitive impairment increased with age: ($U = 584$, $r < 0.05$) cognitive impairment was detected. No such pattern was identified in the control group. The generalization of these factors leads to the development of cognitive impairment in patients with recurrent stroke.

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