



New Day in Medicine
Новый День в Медицине

NDM



TIBBIYOTDA YANGI KUN

Ilmiy referativ, marifiy-ma'naviy jurnal



AVICENNA-MED.UZ



ISSN 2181-712X.
EiSSN 2181-2187

4 (54) 2023

Сопредседатели редакционной коллегии:

**Ш. Ж. ТЕШАЕВ,
А. Ш. РЕВИШВИЛИ**

Ред. коллегия:

М.И. АБДУЛЛАЕВ
А.А. АБДУМАЖИДОВ
А.Ш. АБДУМАЖИДОВ
Р.Б. АБДУЛЛАЕВ
М.М. АКБАРОВ
Х.А. АКИЛОВ
М.М. АЛИЕВ
С.Ж. АМИНОВ
Ш.Э. АМОНОВ
Ш.М. АХМЕДОВ
Ю.М. АХМЕДОВ
Т.А. АСКАРОВ
Ж.Б. БЕКНАЗАРОВ (главный редактор)
Е.А. БЕРДИЕВ
Б.Т. БУЗРУКОВ
Р.К. ДАДАБАЕВА
М.Н. ДАМИНОВА
К.А. ДЕХКОНОВ
Э.С. ДЖУМАБАЕВ
А.Ш. ИНОЯТОВ
С. ИНДАМИНОВ
А.И. ИСКАНДАРОВ
С.И. ИСМОИЛОВ
Э.Э. КОБИЛОВ
Д.М. МУСАЕВА
Т.С. МУСАЕВ
Ф.Г. НАЗИРОВ
Н.А. НУРАЛИЕВА
Б.Т. РАХИМОВ
Ш.И. РУЗИЕВ
С.А. РУЗИБОВЕВ
С.А.ГАФФОРОВ
С.Т. ШАТМАНОВ (Кыргызстан)
Ж.Б. САТТАРОВ
Б.Б. САФОВЕВ (отв. редактор)
И.А. САТИВАЛДИЕВА
Д.И. ТУКСАНОВА
М.М. ТАДЖИЕВ
А.Ж. ХАМРАЕВ
А.М. ШАМСИЕВ
А.К. ШАДМАНОВ
Н.Ж. ЭРМАТОВ
Б.Б. ЕРГАШЕВ
Н.Ш. ЕРГАШЕВ
И.Р. ЮЛДАШЕВ
Д.Х.ЮЛДАШЕВА
А.С. ЮСУПОВ
М.Ш. ХАКИМОВ
К.А. ЕГЕЗАРЯН (Россия)
DONG JINCHENG (Китай)
КУЗАКОВ В.Е. (Россия)
Я. МЕЙЕРНИК (Словакия)
В.А. МИТИШ (Россия)
В.И. ПРИМАКОВ (Беларусь)
О.В. ПЕШИКОВ (Россия)
А.А. ПОТАПОВ (Россия)
А.А. ТЕПЛОВ (Россия)
Т.Ш. ШАРМАНОВ (Казахстан)
А.А. ЩЕГОЛОВ (Россия)
Prof. Dr. KURBANHAN MUSLUMOV (Azerbaijan)
Prof. Dr. DENIZ UYAK (Germany)

www.bsmi.uz

<https://newdaymedicine.com>

E: ndmuz@mail.ru

Тел: +99890 8061882

**ТИББИЁТДА ЯНГИ КУН
НОВЫЙ ДЕНЬ В МЕДИЦИНЕ
NEW DAY IN MEDICINE**

Илмий-рефератив, маънавий-маърифий журнал

Научно-реферативный,

духовно-просветительский журнал

УЧРЕДИТЕЛИ:

**БУХАРСКИЙ ГОСУДАРСТВЕННЫЙ
МЕДИЦИНСКИЙ ИНСТИТУТ
ООО «ТИББИЁТДА ЯНГИ КУН»**

Национальный медицинский
исследовательский центр хирургии имени
А.В. Вишневского является генеральным
научно-практическим
консультантом редакции

Журнал был включен в список журнальных
изданий, рецензируемых Высшей
Аттестационной Комиссией
Республики Узбекистан
(Протокол № 201/03 от 30.12.2013 г.)

РЕДАКЦИОННЫЙ СОВЕТ:

М.М. АБДУРАХМАНОВ (Бухара)
Г.Ж. ЖАРЫЛКАСЫНОВА (Бухара)
А.Ш. ИНОЯТОВ (Ташкент)
Г.А. ИХТИЁРОВА (Бухара)
Ш.И. КАРИМОВ (Ташкент)
У.К. КАЮМОВ (Тошкент)
Ш.И. НАВРУЗОВА (Бухара)
А.А. НОСИРОВ (Ташкент)
А.Р. ОБЛОКУЛОВ (Бухара)
Б.Т. ОДИЛОВА (Ташкент)
Ш.Т. УРАКОВ (Бухара)

4 (54)

2023

апрель

Received: 20.03.2023, Accepted: 25.03.2023, Published: 20.04.2023.

UDC 616.8-009.7

STRUCTURE OF TEMPORARY DISABILITY OF PATIENTS WITH BACK PAIN ACCORDING TO POLYCLINIC SERVICE

Mirdzhuraev E.M., Akilov D.Kh., Zukhritdinov U.Yu. Miralimov M.M.

Center for the development of professional qualifications of medical workers under the Ministry of Health of the Republic of Uzbekistan

✓ *Resume*

The article analyzes temporary disability from back pain among the population of the city of Andijan. It was revealed that according to the localization of pain, the largest number of patients was with pain in the lumbar region - 64.2%, in the cervical region - 27.4%, and the smallest number of patients was in the thoracic region - 8.4%. However, according to the average days of disability, cervical localization was the leader (10.6±0.8 days), slightly less - lumbar localization (9.8±0.5 days) and the least - thoracic localization (8.4±1.1 days). The average age of patients depending on the localization of back pain revealed an increase in it from the lumbar to the thoracic and cervical (41.1±0.6 years, 43.3±1.9 and 46.0±1.0, respectively). With increasing age, both the severity of diseases leading to back pain and the average days of disability will increase (8.7 ± 0.8 days in 20-30 years old - up to 12.2 ± 1.0 days in 50 years and older).

Keywords: back pain, temporary disability, polyclinic service.

СТРУКТУРА ВРЕМЕННОЙ НЕТРУДОСПОСОБНОСТИ БОЛЬНЫХ С БОЛЯМИ В СПИНЕ ПО ДАННЫМ ПОЛИКЛИНИЧЕСКОЙ СЛУЖБЫ

Мирджураев Э.М., Акилов Д.Х., Зухритдинов У.Ю. Миралимов М.М.

Центр развития профессиональной квалификации медицинских работников при МЗ РУз

✓ *Резюме*

В статье проведен анализ временной нетрудоспособности от болей в спине у населения г.Андижан. Выявлено, что по локализации болей наибольшее количество больных было с болями в поясничном отделе 64,2%, в шейном отделе – 27,4% и самое меньшее количество больных было в грудном отделе – 8,4%. Однако, по средним дням нетрудоспособности лидировало шейная локализация (10,6±0,8 дней), немного меньше – поясничной локализации (9,8±0,5 дней) и наименьшее – грудная локализация (8,4±1,1 дня). Средние возраста больных в зависимости от локализации болей в спине выявлено увеличение его от поясничного отдела к грудному и шейному (41,1±0,6 лет, 43,3±1,9 и 46,0±1,0 соответственно). С увеличением возраста увеличивается как тяжесть болезней приводящие к болям в спине, так и среднии дни нетрудоспособности (8,7±0,8 дней в 20-30 лет – до 12,2±1,0 дней в 50 лет и старше).

Ключевые слова: боль в спине, временная нетрудоспособность, поликлиническая служба.

ПОЛИКЛИНИКА ХИЗМАТИ МАЪЛУМОТЛАРИГА КЎРА, БЕЛ ОФРИГИ БИЛАН ОФРИГАН БЕМОРЛАРНИНГ ВАҚТИНЧАЛИК МЕХНАТГА ЛАЁҚАТСИЗЛИГИНИНГ ТУЗИЛИШИ

Мирджураев Э.М., Оқилов Д.Х., Зухритдинов Ў.Ю. Миралимов М.М.

Ўзбекистон Республикаси Соғлиқни сақлаш вазирлиги хузуридаги Тиббиёт ходимларини касбий малакасини ривожлантириш маркази

✓ Резюме

Мақолада Андижон шаҳри аҳолисининг бел оғригидан вақтинчалик меҳнатга лаёқатсизлик ҳолати таҳлил қилинган. Маълум бўлишича, оғриқнинг локализациясига кўра, беморларнинг энг кўп қисми бел соҳасидаги оғриқларга эга - 64,2%, бўйин соҳасида 27,4%, энг кам касалликлар эса кўкрак қафаси соҳасида - 8,4% ташиқил қилган. Аммо, меҳнатга лаёқатсизларнинг ўртача кунли бўйича бўйин соҳаси етакчи ўринни эгаллади (10,6±0,8 кун), бироз камроқ - бел соҳаси (9,8±0,5 кун) ва энг кам - кўкрак қафаси соҳаси (8,4±1,1 кун). Беморларнинг ўртача ёши билан боғлиқ касалликлар, бел оғригининг локализациясига қараб, бел соҳаси кўкрак ва бўйингача ўсишини кўрсатади (мос равишда 41,1±0,6 ёш, 43,3±1,9 ва 46,0±1,0). Ёшнинг ўсиши билан бел оғригига олиб келадиган касалликларнинг оғриги ҳам, меҳнатга лаёқатсизликнинг ўртача кунлари ҳам (20-30 ёшда 8,7±0,8 кун - 50 ёш ва ундан катталарда 12,2±1,0 кунгача) ошади.

Калит сўзлар: бел оғриги, вақтинчалик меҳнатга лаёқатсизлик, поликлиника хизмати.

Relevance

According to a number of authors, during the year back pain is experienced by 76% of the population, while severe pain is noted in 7% of cases, and about 9% of the population loses their ability to work due to pain in this localization. It is this type of pain that occupies a leading position in the structure of seeking medical help. Acute back pain occurs at least once in almost every person, in 15–20% it transforms into long-term (up to 2 months), in 10–20% - into chronic pain, which causes long-term disability [5, 9]. This is one of the most frequent complaints when patients turn to neurologists and doctors of other specialties, a popular topic of publications in specialized publications and speeches at medical forums.

Back pain is a symptom, not a nosological form. Epidemiological studies have shown that in Russia, 35-90% of the adult population had at least one episode of back pain during their lifetime. The highest frequency falls on the 3rd–5th decade of life [2, 6]. According to an epidemiological study conducted in one of the Moscow polyclinics, out of 1300 primary patients who applied for medical care, 24.9% of the main reason for the visit was pain in the lumbosacral region [6].

The epidemiology of pain in this localization has been studied much better than pain in the cervical or thoracic spine. It has been shown that of all patients complaining of "back pain", pain in the "upper part" of the back is isolated in only 15% [6]. The results of an epidemiological study, including a survey of more than 46 thousand residents of Israel and different European countries, showed that 24% suffer from chronic back pain (without specifying localization), 18% from pain in the lumbar region, and 8% from the cervical region. At the same time, 15% of the respondents indicated "damage to the intervertebral discs" as the cause of chronic pain syndrome [16].

Thus, the most common localization of back pain is pain in the lower back (LBP) [2].

LBP syndrome is understood as pain, which is localized between the XII pair of ribs and the gluteal folds. According to experts from the World Health Organization (WHO), the prevalence of LBP in developed countries reaches the size of a pandemic and is a serious medical and socio-economic problem. This is the second most frequent reason for visiting a doctor after respiratory diseases and the third one in terms of the frequency of hospitalizations [6, 10, 15, 20]. In 10–20% of cases in patients of working age, acute LBP transforms into chronic, which causes serious psychological disorders, forms pain behavior, and persists even when the initial triggering cause of pain is eliminated [5, 6, 10]. In developed foreign countries, 60–80% of the population experiences LBP during their lifetime, and approximately 2–5% of the population requires medical care or suspension from work [19]. Thus, in practical neurology, among all pain syndromes, LBP occupy a leading position. The annual presentation for LBP ranges from 15% to 45%, of which 5% represents the onset of LBP. About 52% of patients with acute LBP do not consult a medical professional, and 70% have LBP lasting less than two weeks [10].

A greater risk of pain at the age of 25 to 49 years old is subject to people whose professional activities are related to driving cars, dynamic physical labor (carpenters-builders), as well as office workers [13].

Back pain can be caused by changes in the spine (vertebral bodies, intervertebral discs, joints, ligamentous apparatus), muscle damage and diseases, damage to the spinal cord, roots, peripheral nerves, pathology of the internal organs of the chest and abdominal cavity, small pelvis, mental

disorders [6, 13]. Degenerative diseases of the spine are the most common cause of LBP. The prevalence of vertebrogenic diseases in the population, according to various authors, ranges from 40 to 80%, with a steady upward trend. In most regions, up to 14.7% of the working population annually find themselves temporarily disabled for this reason, which determines the relevance of the problem and the need to find ways to solve it [4, 6].

Diseases of the spine are referred to as dorsopathies (ICD-10). This is a large group of diseases in the ICD-10 (class "Diseases of the musculoskeletal system and connective tissue" - M40-M54), the leading syndrome in which is pain in the trunk and limbs of non-visceral etiology. This group includes dorsalgia and spondylopathies [18].

Dorsalgia is pain in various parts of the back and limbs of non-visceral etiology due to reflex and/or compression complications, degenerative and functional changes in the spine, joints, myofascial pain syndrome, or due to other causes [11, 15]. LBP lasting up to 12 weeks is considered acute, more than 12 weeks - chronic. Patients with acute and chronic LBP differ in the prognosis for recovery and rehabilitation, as well as approaches to diagnosis and treatment [5].

Allocate primary and secondary dorsalgia. Secondary dorsalgia may be associated with congenital anomalies, trauma, neoplastic, infectious, somatic diseases, and osteoporosis [9, 11, 15].

There are symptoms of "danger", indicating the secondary (symptomatic) nature of dorsalgia:

- 1) rapidly increasing pain over time;
- 2) significant intensity of pain;
- 3) non-mechanical nature (independence of pain intensity from changes in body position and movements);
- 4) increased pain at night;
- 5) fever and/or rapid weight loss in a short time;
- 6) a recent history of trauma, the occurrence of pain in connection with the injury;
- 7) focal neurological disorders that go beyond typical radiculopathy;
- 8) signs of a malignant neoplasm, a history of cancer;
- 9) general weakness;
- 10) onset of acute pain syndrome under the age of 15 years, older than 55 years;
- 11) immunodeficiency states, drug addiction, HIV infection, long-term use of corticosteroids, osteoporosis;
- 12) changes in blood, urine, and other laboratory tests [15].

Thus, in understanding the mechanisms underlying LBP, specific, nonspecific and radicular pain are clinically distinguished. Specific pain is defined in cases where BS is a symptom of a nosological form, which often threatens the patient's further health or life [12]. In 5–10% of cases, back pain is caused by a neoplasm (primary and metastatic tumors of the spine, multiple myeloma), syringomyelia, vertebral destruction, osteoporosis, nerve root damage due to infectious processes (epiduritis, osteomyelitis), metabolic disorders (hyperparathyroidism, Paget's disease), congenital anomalies, spinal injuries, etc. BS are possible with various somatic diseases (lungs, heart, kidneys, pancreas, that is, organs of the chest, abdominal cavity, pelvis and retroperitoneal space) - reflected pain [6, 12]. Injury to the spine sometimes leads to fractures of the vertebrae, damage to the discs, but more often to stretching of the capsule of the joints and ligaments of the spinal column. The main potentially dangerous vertebrogenic causes of LBP in 1% of patients who seek medical help are primary and metastatic tumors of the spine (0.7% of cases), inflammatory (spondyloarthritis - 0.3%) and infectious (tuberculosis, discitis - 0.01%) of his defeat. Inflammatory diseases (ankylosing spondylitis - Bechterew's disease, psoriatic and reactive arthritis) are often accompanied by enthesitis - inflammation at the sites of attachment of tendons or ligaments to the bone. Back pain associated with somatic pathology (non-vertebrogenic) occurs in 2% of patients complaining of back pain [6, 12]. In clinical guidelines on back pain, the term "nonspecific back pain" is often used, which means musculoskeletal back pain without signs of damage to the cervical, thoracic, lumbar, sacral nerve roots and without specific injuries of the spine [12]. This is acute pain, in which the exact diagnosis of a serious disease (trauma, tumor, etc.) or damage to the nerve root cannot be identified. LBP most often have a muscular origin and arise as a result of muscle overstrain, associated with stretching, tension, ischemia, microtraumatization, excessive overload of the muscles, ligaments or joints of the spine. When analyzing primary referral to general practitioners for acute pain in the lumbosacral region, its musculoskeletal causes are detected in 85% of patients.

As risk factors for the development of LBP, heavy physical labor, heavy lifting, frequent bending and tilting of the body, a sedentary lifestyle, vibration exposure, prolonged incorrect body position (antiphysiological postures), exposure to high or, more often, low temperature, excessive muscle load, structural inconsistencies - asymmetry in the length of the legs, the height of the ischial tuberosities and / or the pelvic ring with the formation of an oblique or twisted pelvis, dysfunction of the sacroiliac joints, unilateral sacralization, lumbarization and asymmetric orientation of the facet joints, anomalies of the foot that cause excessive stress on certain muscles, hypermobility of the joints, malnutrition, metabolism, concomitant mental disorders that affect the myogenic component of human adaptive motor behavior, creating prerequisites for the development of myofascial pain syndromes (MFPS) [6, 12, 14].

Thus, it is advisable to conduct a diagnostic search for BP between potentially dangerous diseases of vertebral and non-vertebral origin (cauda equina compression, tumor, traumatic, inflammatory, infectious lesions, diseases of internal organs, osteoporosis), compression radiculopathy and musculoskeletal ("non-specific") pain in the back [6].

Back pain (BP) is one of the most common reasons for visiting a neurologist at a polyclinic. Among patients, persons of working age predominate, which emphasizes the socio-economic significance of the problem. Currently, according to WHO experts, in developed countries, BP is comparable in scale to a pandemic and is a serious medical and socioeconomic problem [16]. According to epidemiological studies conducted in the United States and Western Europe, the prevalence of low back pain (LBP) reaches 40-80%, and the annual incidence is 5% [19]. In Russia, temporary disability due to LBP ranges from 32 to 161 days per 100 working people per year [3]. The number of days of disability is annually up to 15% of the total disability. Thus, in the UK in 1999, up to 90 million working days were lost, and 75% were patients of the most able-bodied age - from 30 to 59 years. And this is despite the fact that in most cases BS is not accompanied by disability. In more than 50% of patients, LBP improves after a week, and 40% improve after 8 weeks. The remaining 7-10% continue to experience BS for 6 months or more. It should be noted that in 70-90% of patients pain in the lower back recurs after some time [10, 17].

In accordance with the currently existing classification of LBP, there are [15, 21]:

- specific pain (1-3%) caused by osteoporosis, tumors, compression fracture, infectious diseases, multiple myeloma, pathology of the pelvic organs, etc.;
- radiculopathy (1-5%), which is a compression-ischemic lesion of the spinal root;
- non-specific pain (85-90%) - pain of musculoskeletal origin (dorsalgia).

Nonspecific (musculoskeletal) pain occurs as a result of degenerative-dystrophic changes in the intervertebral disc, facet (facet) joints, and may also be due to the involvement of ligaments, muscles, tendons, fascia and neural structures in the pathological process. Any of the above structures containing nociceptors can be a source of non-specific back pain.

Non-specific back pain (NBP) - musculoskeletal pain that does not exceed 6 weeks is regarded as acute. If the pain lasts from 6 to 12 weeks, then it is considered subacute, and pain lasting more than 12 weeks is considered chronic. Most often, pain is formed due to muscle strain caused by unprepared movements, intense physical activity and prolonged static loads. These processes lead to trauma to the back muscles, their stretching, tears of the musculoskeletal and connective tissue fibers. Muscle-tonic syndrome occurs due to reflex tension of the back muscles due to degenerative-dystrophic changes (osteochondrosis, spondyloarthrosis) of the spine [7, 8].

The diagnosis of NBS is based on a thorough collection of complaints and anamnesis, data from neurological, somatic and neuroorthopedic examinations. A typical clinical picture of NBS: aching pain in various parts of the spine, which can spread to the arms or legs, intensify with movements involving the affected muscles and in certain postures. Examination of a patient with NBS reveals limited mobility of one or another section of the spine due to pain and tense muscles, palpation determines tension and soreness of the back muscles, possibly pain in the area of the facet joints and sacroiliac joints. Focal neurological symptoms are absent. Additional laboratory or instrumental examination methods can be prescribed by a doctor if, according to the anamnesis or examination, "red flags" were identified - signs and symptoms that alert the doctor to other pathologies or specific pains [11, 13].

Clinically, there are four types of back pain: local, projection, radicular (radicular) and pain due to muscle spasm.

According to the mechanism of occurrence, pain is distinguished [1]:

- nociceptive – local, reflected (projective, reflex);
- neuropathic - radicular (radiculopathy), non-radicular (neuropathy of the sciatic nerve, lumbosacral plexopathy);
- psychogenic (psychialgia).

Local pains are usually constant, diffuse with localization in the area of spinal injury. The nature of the pain varies depending on the position of the body.

Projection pains are widespread, from the spine to the lumbar and sacral regions, and from the internal organs. They are more diffuse in nature, there is a tendency to their surface distribution, but in intensity and nature they are close to local ones.

Radicular, or radicular pains usually have a shooting character. They can be dull and aching, but movements that increase irritation of the roots significantly intensify the pain, it becomes sharp, cutting. Almost always, radicular pain radiates from the spine to some part of the lower limb, most often below the knee joint. Bending forward or lifting straight legs, squeezing the jugular veins, as well as other provoking factors (coughing, sneezing, straining), leading to increased intravertebral pressure and displacement of the roots, increase radicular pain as a result of their stretching [11, 13].

Currently, in the genesis of LBP, great importance is attached to myofascial pain syndrome, which is manifested not only by spasm, but also by the presence of painful seals (areas of hypertonicity) and trigger points (myofascial trigger points) in tense muscles. More often it is not associated with osteochondrosis of the spine, it occurs independently of it. Despite the fact that the clinic of myofascial pain syndrome has been described by many authors, there is still no complete histological, biochemical or electrophysiological explanation of the nature of trigger points. The literature suggests that the formation of these points is due to secondary hyperalgesia against the background of central sensitization. In the genesis of trigger points, damage to peripheral nerve trunks is not excluded, since anatomical correspondence between myofascial trigger points and peripheral nerve trunks has been noted [11, 13].

The patient's condition with LBP is assessed by a neurologist, vertebrologist or medical commission. The decision to issue a temporary disability certificate is made on the basis of a generally accepted scale. It takes into account the features and severity of symptoms, history, complications that have arisen in degenerative diseases of the spine, and the duration of the upcoming therapy [4].

The length of stay on sick leave depends on the intensity of the symptoms, their impact on the patient's ability to perform work duties, the need for inpatient or sanatorium therapy. The average duration of treatment for BS of the cervical, thoracic, lumbosacral spine is 3-10 days. During this period, drug therapy, massage and physiotherapy, exercise therapy will be carried out.

If the patient's health does not improve, then the sick leave is extended with the condition of further treatment in a hospital or a surgical operation.

Repeated treatment of the patient with complaints of exacerbation of the pathology becomes the basis for his extradition for such a period:

- intense pain syndrome - 7-10 days;
- carrying out therapy in stationary conditions - 2-3 weeks;
- surgical intervention - 2-6 weeks depending on the method of operation.

If the patient seeks medical help for the first time, then disability is determined for 7 days. This time is sufficient to relieve severe pain and/or aseptic inflammation caused by damage to soft tissues [4].

Thus, LBP is a serious medical and socio-economic problem worldwide. Data on the prevalence, temporary and permanent disability in each region have their own characteristics and differences. The identification of these data gives health authorities the opportunity to plan the number of beds, the staffing of specialists, as well as to find ways to prevent back pain.

The aim of our study was to analyze the temporary disability of patients with back pain according to the data of Andijan polyclinics.

Material and methods. According to the polyclinics of Andijan, within one year, the terms of temporary disability in patients with back pain were selected and analyzed.

Research results

According to the polyclinics of the city of Andijan, for one year (2021), 394 patients of working age with back pain were issued sheets of temporary disability, lasting for various periods (from 5 to 39 days). Among the sick men were 152 (38.6%), women - 242 (61.4%). The patients were of working age - from 20 to 70 years. The mean age of the patients was 42.6 ± 0.5 years, 38.9 ± 0.9 years for men and 44.9 ± 0.6 years for women.

When distributing patients according to the localization of pain in the spine, it was found that the largest number of patients had pain in the lumbar region 253 (124 men, 129 women), in the cervical region there were 108 (22 men, 86 women) patients and the smallest number of patients was in thoracic region 33 (6 men, 27 women) patients (Table 1).

Table 1.

Distribution of patients by localization of back pain, sex, age and days of temporary disability

Localization of pain in the spine	Gender	Number of patients	Average age	Average number of days of incapacity for work
Cervical region	man	22	$41,3 \pm 2,8$	$9,9 \pm 1,0$
	women	86	$47,2 \pm 1,1$	$10,8 \pm 1,0$
	both sexes	108	$46,0 \pm 1,0$	$10,6 \pm 0,8$
Thoracic region	man	6	$36,2 \pm 2,8$	$6,7 \pm 1,1$
	women	27	$55,1 \pm 2,1$	$10,8 \pm 1,3$
	both sexes	33	$43,3 \pm 1,9$	$8,4 \pm 1,1$
Lumbar section	man	124	$38,6 \pm 1,0$	$9,4 \pm 0,6$
	women	129	$43,5 \pm 0,8$	$10,2 \pm 0,8$
	both sexes	253	$41,1 \pm 0,6$	$9,8 \pm 0,5$

Moreover, the distribution of patients by localization of back pain in the gender context revealed that the distribution of patients in the lumbar region between men and women was approximately equal in number, while in the cervical and thoracic regions, the prevalence of women over men was revealed by approximately 4.5 times (Table 1).

When analyzing the average ages of patients, depending on the localization of back pain, it was found that the average ages increased from the lumbar to the thoracic and cervical (Fig.1). This is due to the greater load on the lumbar spine compared to the thoracic and cervical. And in men, compared with women, the average age in the lumbar and cervical regions was 5-6 years younger, while in the thoracic region it was as much as 19 years younger. This is most likely due to the greater physical load on the spinal column in men (Table 1).

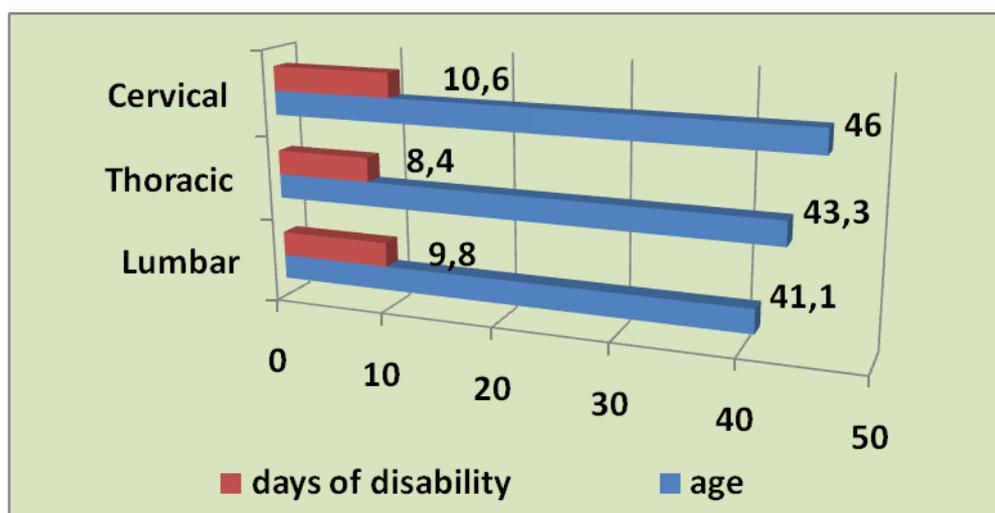


Fig.1. The ratio of back pain by localization, age and days of disability.

When analyzing the dependence of the average number of days of disability on the localization of back pain, it was found that the smallest average days of disability (8.4 ± 1.1 days) were in patients with thoracic localization of pain, by 1.4 days it was more with lumbar localization and at 2.4 days was more with cervical localization of pain (Table 1, Fig. 1).

In a gender analysis of the dependence of the average number of days of incapacity for work on the localization of back pain, it was found that in men, compared with women, the average days of incapacity for work in the cervical and lumbar regions were approximately 1 day less, while in the thoracic region this difference was 4.1 days (Table 1).

Table 2.
Dependence of the days of disability on the localization of back pain and the age of patients, $M \pm m$

age groups	man		women		both sexes
	Cervical region	Lumbar section	Cervical region	Lumbar section	
20-30 years old	$10,8 \pm 4,0$	$9,4 \pm 1,0$	$7,0 \pm 2,0$	$5,5 \pm 0,5$	$8,7 \pm 0,8$
31-40 years old	$9,0 \pm 0,9$	$8,1 \pm 0,8$	$7,9 \pm 1,0$	$10,0 \pm 1,1$	$8,9 \pm 0,6$
41-50 years old	$7,5 \pm 1,4$	$9,8 \pm 1,8$	$12,3 \pm 2,6$	$9,6 \pm 1,2$	$10,3 \pm 1,0$
50 years and older	$12,2 \pm 1,9$	$11,3 \pm 2,1$	$12,3 \pm 1,3$	$12,7 \pm 2,2$	$12,2 \pm 1,0$

When analyzing the dependence of the time of incapacity for work on the age of patients, it was found that, in general, in patients with increasing age, the average days of incapacity for work increase (Table 2, Fig. 2). The gender analysis revealed that this trend of increasing the average days of disability from the age of patients is clearly seen in women. However, in men, such a clear trend is not observed - with some "failure" - a decrease in the average days of disability in the age group of 31-40 years (Table 2). It should be noted that due to the small number of patients with localization in the thoracic spine in both men and women, this group of patients was not taken into account in this analysis. Thus, it can be concluded that during the screening of patients with back pain, on the basis of issued certificates of incapacity for work, it is possible to obtain information about the structure of back pain in the able-bodied population, age and gender characteristics, and the duration of average days of incapacity for work - reflecting the duration of the disease.

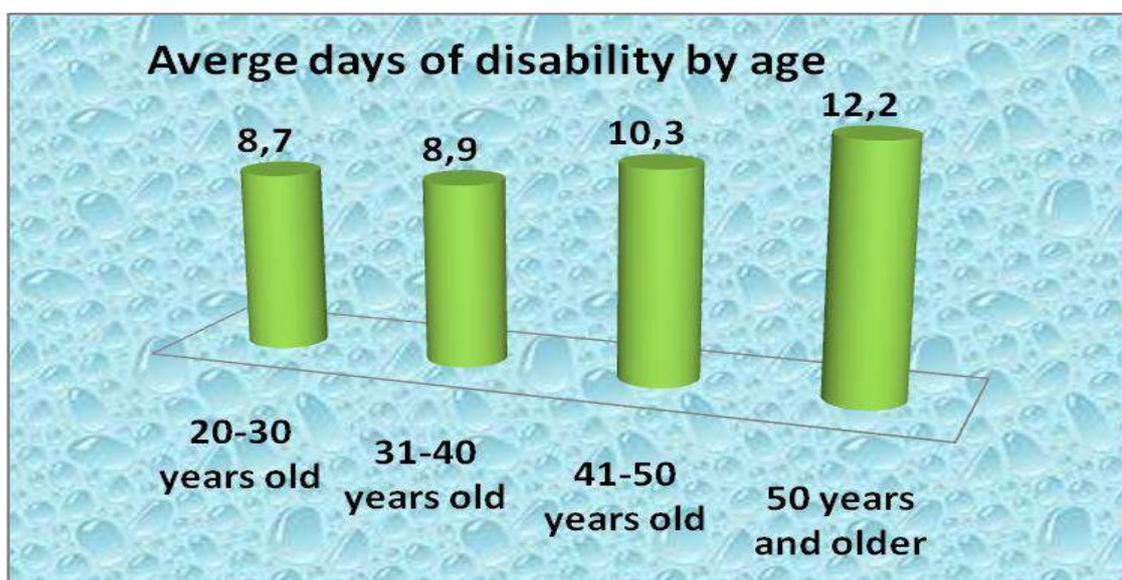


Fig.2. Average days of disability by age.

Conclusions

1. In the city of Andijan, for 1 year, patients with back pain were issued 394 certificates of incapacity for work for periods ranging from 5 to 39 days. Of these, there were 152 men (38.6%), women - 242 (61.4%).

2. According to the localization of pain, the largest number of patients was with pain in the lumbar region - 64.2%, in the cervical region - 27.4%, and the smallest number of patients was in the thoracic region - 8.4%. However, according to the average days of inactivity, cervical localization was the leader (10.6±0.8 days), slightly less - lumbar localization (9.8±0.5 days) and the least - thoracic localization (8.4±1.1 days). In men, compared with women, the average days of disability were less: in the cervical and lumbar regions by 1 day, in the thoracic region - by 4.1 days.

3. The average age of patients depending on the localization of back pain revealed an increase in it from the lumbar to the thoracic and cervical (41.1±0.6 years, 43.3±1.9 and 46.0±1.0, respectively).

4. With increasing age, both the severity of diseases leading to back pain and the average days of disability (8.7 ± 0.8 days in 20-30 years old - up to 12.2 ± 1.0 days in 50 years and older).

LIST OF REFERENCES:

1. Adambaev Z.I., Kilichev I.A. Detailing and severity of pain in degenerative-dystrophic diseases of the spine // Problems of modern science and education, 2016;10(52):174-179.
2. Adambaev Z.I., Kilichev I.A. Structure and nature of back pain among outpatients in a neurological clinic. Bulletin of the Tashkent Medical Academy. 2016;2:55-57.
3. Badalyan O.L. Rational use of combined preparations of diclofenac with vitamins of group B in the treatment of dorsopathies / O.L. Badalyan, A.A. Savenkov // Russian Medical Journal, 2015;12:699–704.
4. Can I take sick leave for osteochondrosis and for how many days. GBUZ of Moscow - medical encyclopedia // <https://stromynka7.ru/blog/bolnichnyj-pri-osteohondroze-mozhno-li-vzjat-i-na/>
5. Danilov A.B., Danilov A.I. Multidomain approach to the treatment of patients with chronic nonspecific back pain. // Journal of Neurology and Psychiatry. S.S. Korsakov. 2020;120(7):113-120
6. Kukushkin M.L. Pain syndrome: pathophysiology, clinic, treatment: clinical recommendations / M.L. Kukushkin, G.R. Tabeeva, E.V. Podchufarov (Edited by Academician of the Russian Academy of Sciences N.N. Yakhno). M., 2014: 64 p.
7. Levin O.S., Shtulman D.R. Neurology: Handbook of Practice. doctor. 9th ed., supplement. and reworked. M.: Medpress-inform, 2013. S. 183–200.
8. Lyashenko E.A., Zhezlov M.A., Levin O.S. Acute back pain: diagnostic and therapy algorithms // Farmateka, 2013;13: 87–94.
9. Non-invasive methods for the treatment of acute, sub-acute and chronic pain in the lower back: new ACP clinical guidelines // Health of Ukraine, 2017;3(42):25.
10. Pizova N.V. Some features of pain in the lower back / N.V. Pizova // Medical Council, 2017; 10:110–117.
11. Popelyansky Ya.Yu. Vertebrogenic diseases of the peripheral nervous system // Diseases of the peripheral nervous system: A guide for doctors. - M.: MEDpress-inform, 2015. 199p.
12. Russian Interregional Society for the Study of Pain. Clinical guidelines “Musculoskeletal (non-specific) pain in the lower back”. 2020
13. Sadokha K.A., Golovko A.M., Krotov V.V. Back pain: causes, diagnosis, treatment, modern view of the problem / Medical News, 2018;1:63-68.
14. Shirokov V.A. Myofascial pain syndrome: problems of diagnosis and treatment // Effective pharmacotherapy. // Neurology and Psychiatry, 2017;21(2):20–29
15. Finucane LM, Downie A, Mercer C, Greenhalgh SM, Boissonnault WG, Pool-Goudzwaard AL, Beneciuk JM, Leech RL, Selfe J. International framework for red flags for potential serious spinal pathologies. // J Orth Sports Phys Ther 2020; 50(7):350-372.
16. Global Health Group Data Exchange <http://ghdx.healthdata.org/gbd-esults-tool> accessed Nov 15, 2020).
17. Hong, J.Y. An Updated Overview of Low Back Pain Management in Primary Care / J.Y. Hong, K.S. Son, J.H. Cho [et al.] // Asian Spine Journal, 2017;11(4):653–660.
18. International Classification of Diseases 10th revision (ICD-10); version 2019 <https://mkb-10.com/index.php?pid=23014>
19. Olafsson G, Emma Jonsson E, Fritzell P, Hägg O, Borgström F. Cost of low back pain: results from a national register study in Sweden. // European Spine Journal 2018; 27:2875-2881.
20. OWH. The Global Burden of Low Back Pain, 2021
21. Petersen T. Clinical classification in low back pain: best-evidence diagnostic rules based on systematic reviews / T. Petersen, M. Laslett, C. Juhl // BMC musculoskeletal disorders, 2017;18 (1):188.

Entered 20.04.2023