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ТИББИЁТДА ЯНГИ КУН НОВЫЙ ДЕНЬ В МЕДИЦИНЕ NEW DAY IN MEDICINE

*Илмий-рефератив, маънавий-маърифий журнал
Научно-реферативный,
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STATODYNAMIC CHANGES IN ACUTE AND CHRONIC DISORDERS OF CEREBRAL CIRCULATION

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✓ Resume

Statodynamic disorders are one of the most common syndromes found in medical practice (about 5% of the world's population suffer from instability of various origins. At the same time, complaints of dizziness and imbalance occur in 5-10% of patients who went to a general practitioner and in 10-20% of patients who came to see a neurologist.

Keywords: *statodynamic disorders, acute disorders of cerebral circulation*

СТАТОДИНАМИЧЕСКИЕ ИЗМЕНЕНИЯ ПРИ ОСТРЫХ И ХРОНИЧЕСКИХ НАРУШЕНИЯХ МОЗГОВОГО КРОВООБРАЩЕНИЯ

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✓ Резюме

Статодинамическими нарушениями являются одним из наиболее частых синдромов, встречающихся в медицинской практике (около 5% населения мира страдают от неустойчивости различного генеза. При этом жалобы на головокружение и нарушение равновесия встречаются у 5-10% пациентов, обратившихся к врачу общей практики и у 10-20% пациентов, пришедших на прием к неврологу.

Ключевые слова: *статодинамические нарушения, острых нарушениях мозгового кровообращения*

БОШ МИЯ ҚОН АЙЛАНИШИНИНГ ЎТКИР ВА СУРИНКАЛИ БУЗИЛИШДЛАРИДА СТАТОДИНАМИК ЎЗГАРИШЛАР

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✓ Резюме

Статодинамик бузилишлар тиббий амалиётда учрайдиган энг кенг тарқалган синдромлардан биридир (дунё аҳолисининг тахминан 5% турли хил келиб чиқадиган беқарорликдан азият чекмоқда. Шу билан бирга, бош айланиши ва номутаносиблик шикоятлари умумий амалиёт шифокорига борган беморларнинг 5-10 фоизиди ва неврологга келган беморларнинг 10-20 фоизиди учрайди

Калит сўзлар: *статодинамик бузилишлар, мия қон айланишининг ўткир бузилишлари*

Relevance

In the group of patients with acute cerebrovascular accidents (ACE and CM), a special category of patients are those who complain of dizziness and unsteadiness in the absence of focal neurological symptoms in their clinical picture (ataxia and nystagmus are allowed) - the so-called isolated dizziness



of central genesis [1.3.5]. It is this category of patients that will be addressed in the present work due to the difficulty of differentiating these life-threatening conditions from benign peripheral vestibulopathies. In the population study by Kerber et al. (2006), ACE and CM was verified in 3.2% of patients admitted to the emergency department with complaints of acute dizziness and unsteadiness. Recently, there have been repeated attempts to develop clinical protocols for the differential diagnosis of acute episodes of dizziness and unsteadiness at the "patient's bedside" [2.4.6.8].

Purpose of the study: To study static-dynamic changes in acute and chronic cerebrovascular accidents.

Materials and methods

The first studies were devoted to finding correlations between complaints, risk factors, disease symptoms and the likelihood of stroke. Thus, a significant relationship was demonstrated between recurrent attacks of dizziness, double vision, age over 50 years and (stroke and CM [7.9]. However, most of these studies were retrospective and therefore characterized by a low degree of evidence. At the same time, the results of some other studies are of certain practical interest. The study by Cnyrim C. et al. (2008) included patients with complaints of rotational vertigo, balance disorders and horizontal-rotatory nystagmus without auditory disorders, brainstem or cerebellar disorders [10.12.14].

The authors have shown that in order to differentiate dizziness of central and peripheral genesis, it is recommended to use a number of clinical tests: the vertical divergence test, the study of nystagmus and subjective visual vertical, the impulse head movement test, and the assessment of smooth tracking movements in the vertical plane. The specificity and sensitivity of the battery of tests for verification of stroke and HM were 92% in the case where all 5 tests indicated the central nature of statodynamic disorders.

Another algorithm for differential diagnosis between central and peripheral dizziness is the HINTS (Head Impulse, Nystagmus, Test of Skew) test battery [11.15]. The authors who proposed it stated that the absence of a corrective saccade when performing the Halmagyi test (another name is the head impulse movement test (HIMT)) is the main point in the differential diagnosis of (ACE and HM, and the battery of tests itself is a more specific way to confirm stroke compared to MRI of the head performed early after the onset of an attack of dizziness and instability. Subsequently, Newman-Toker D. et al. added a fourth diagnostic test: hearing assessment - this is how an improved algorithm appeared - HINTS plus. The authors proved that acute hearing loss on the side of a positive HIM in patients with an acute attack of dizziness and instability indicates a vascular genesis of the disease [10.12]. It should be noted that when using CT of the head in patients with an acute attack of dizziness, the probability of a false negative conclusion is very high, since computed tomography has low sensitivity for detecting (ACE and HM in the vertebrobasilar basin [11.15].

Despite the fact that MRI of the head is a more sensitive method for confirming (stroke and chronic myocardial infarction), the technical feasibility of its implementation is extremely low (it is performed in less than 3% of patients [13.14.15] and is not included in the routine examination protocol for patients with suspected stroke. In addition, according to Newman-Toker DE et al. (2016), when performing MRI of the head of a patient with isolated central vertigo in DWI mode, the probability of a false negative result in the first 24 hours is 15-25%, and labyrinthine infarction is not verified at all. Therefore, the analysis of the results of a clinical examination of a patient with an acute attack of dizziness and instability is a complex task and often requires the participation of related specialists, as well as neuroimaging studies to make a decision on the final diagnosis [12.14.15].

Treatment of patients with dizziness and instability due to stroke and chronic myocardial infarction is no different from that carried out for any other type of stroke and is carried out in accordance with current clinical guidelines.

Vestibular migraine (VM) is the most common cause of spontaneous recurrent dizziness. About 80% of patients with VM seek medical attention for dizziness, but the correct diagnosis is made in less than 20% of them. According to the hypothesis proposed by FM Cutler and RW Baloh in 1992, VM accompanied by a headache attack is considered a migraine aura caused by spreading depression across the cerebral cortex in the direction from the primary focus.

Results and discussions

The modern pathogenetic concept of migraine is based on the position of the presence of genetically determined hyperexcitability of the nervous system, characterized by a decrease in the response threshold to various sensory stimuli and the uniqueness of the sensory processing system. The key element of the above-described model of the onset of a migraine attack is the release of calcitonin gene-related peptide into the synaptic cleft. The development of vestibular symptoms in patients with migraine is associated with the presence of a close connection between the vestibular nuclei and neuronal centers responsible for the modulation of nociceptive signals (the dorsal raphe nucleus, cells of the locus coeruleus and lateral tegmentum, the caudal part of the trigeminal nucleus, etc.). Most patients initially present with classic migraine, which is then joined by dizziness after several years, forming the classic picture of certain triggers can provoke paroxysms of suddenly appearing moderate or severe systemic dizziness and migraine headache like an attack of any other form of migraine.

Previously, it was believed that patients with could not have hearing impairments during an attack [13], but this concept has now been revised [12]. Many patients report fluctuating hearing changes, a feeling of fullness in the ear, tinnitus during an attack and periodically in the interictal period, which significantly complicates the differential diagnosis of CM from Meniere's disease. The diagnosis of CM is established based on the typical clinical picture of the disease. In 2018, the International Headache Society (IHS), the International Society of Neuro-otologists (Barany-Society) and other specialists developed a consensus on the diagnostic criteria for CM, which are presented below [13.14.15]: A. At least 5 episodes meeting criteria B and D B. The presence of migraine attacks with or without aura in the anamnesis or ongoing at present C.

Vestibular vertigo is considered moderate if it interferes with, but does not completely prevent, the performance of usual daily work, and severe if it completely interferes. Complex therapy of VM consists of three main components: elimination of migraine-provoking factors, relief of an attack, and preventive treatment.

Conclusion

To stop an attack of VM, it is recommended to use classical antimigraine drugs and vestibular suppressants. Preventive therapy is indicated in case of frequent (two or more per month) and severe attacks of VM. The drugs of choice are β -blockers (propranolol), tricyclic antidepressants (amitriptyline), selective serotonin and norepinephrine reuptake inhibitors (venlafaxine, etc.) and calcium antagonists (verapamil). In addition, valproates (500 mg/day), leviteracetam (500 mg/day) and topiramate (25-100 mg/day) are used.

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