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**PSYCHOSOMATIC FEATURES AND THE LEVEL OF DEPRESSION WITH
CHRONIC HEART FAILURE IN PATIENTS WITH ARTERIAL HYPERTENSION
AND CORONARY HEART DISEASE**

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ABSTRACT

The relevance of the mutual influence of mental and somatic components, the role of psychological factors in the development, clinical course and prognosis of cardiovascular diseases is beyond doubt. According to recent studies, depression is one of the most important factors determining the development and prognosis of cardiovascular diseases. In this regard, special attention is paid to the study of the relationship of depression with arterial hypertension and coronary heart disease. And since they are the main causes of the development of CHF, depression can be considered one of the factors determining the course and prognosis of heart failure. Prevalence of depression in people with CHF, according to various researchers, is 4-5 times higher than in the general population and can reach 10-25% in outpatient patients and 35-70% in hospitalized patients. The frequency of depression is higher in women with CHF compared to men, as well as in patients with higher severity of CHF. The causes of depression in patients with CHF are diverse. A significant place is given to psychosocial factors: this — lack or insufficient social support, impaired adaptation to a chronic disabling disease, the need to adhere to recommended lifestyle changes, difficulties in understanding and memorizing multicomponent drug regimens. An important pathogenetic role in depression is assigned to an increase in the activity of the sympatho-adrenal system, in patients with depression, not only the basal level of circulating catecholamines is increased, but also their production in response to emotional stress is increased, which is also a pathogenetic link of CHF.

Keywords: depression, personal anxiety, reactive anxiety, quality of life, integral indicator of quality of life, chronic heart failure, arterial hypertension, coronary heart disease.

Introduction

Depression is a chronic condition that significantly affects the quality of life of patients with CHF. In most cases, it has a reactive, not very pronounced character, less often endogenous or



psychotic levels of depression are observed. Symptoms of depression aggravate the symptoms of CHF.

A number of large epidemiological and retrospective studies have shown that the presence of depression is an independent factor of an unfavorable prognosis in patients with CHF. Thus, S. P. Clark et al., 2000, when analyzing the data of 2992 patients with CHF, noted that depression turned out to be the most significant prognostic criterion for the deterioration of the clinical condition during 1 year of follow-up, the association of depression with an unfavorable course of CHF remained as pronounced, even if adjustments were made for the age of patients, FC

HSN, FV LH. In people with CHF in the presence of depression, mortality is about 2 times higher, and the probability of hospitalization for CHF is 3 times higher than in patients with similar severity of the disease who do not have depression. Chronic heart failure is the most common cause of significant financial and economic costs both for the state and for the patient himself. With the appearance of symptoms of CHF, the efficiency of patients decreases, there is a high level of disability and the quality of life deteriorates sharply.

According to the WHO definition, the quality of life is considered to be a concept that covers many aspects of a person's life related not only to his state of health, but also living conditions, professional abilities, work, home environment. Medical aspects of quality of life include the influence of the disease itself (its symptoms and signs) and the resulting limitation of functional ability, as well as the impact of treatment on everyday life. vital activity of the patient. Actually, the quality of life is determined primarily by complaints the patient, his functional capabilities, the patient's perception of life changes associated with the disease, the level of general well-being, general life satisfaction. This concept also includes the ability to concentrate, make a decision, memory, vividness of perception, sexual function, mental comfort.

The purpose of the study

To study the level of depression, quality of life, personal and reactive anxiety in patients with chronic heart failure on the background of arterial hypertension and coronary heart disease.

Materials and methods of research

105 patients with coronary heart disease and arterial hypertension (50 men and 55 women) aged from 26 to 72 years (52.9 ± 1.3 years) with manifestations of CHF of functional classes I–IV (FC) according to the classification of the New York Heart Association (NYHA) were examined. Of these, 42 people (40%) suffered from coronary heart disease (stable angina pectoris FC II–III), 36 (34.3%) — arterial hypertension (II–III degree) and 27 (25.7%) — coronary heart disease (stable angina pectoris FC II–III) and hypertension (II–III degree). 33 patients (23 women and 10 men) had chronic heart failure I FC according to NYHA; 33 (23 women and 10 men) had II FC; 20 (13 women and 7 men) — III FC and 19 (9 women and 10 men) — IV FC. The average age of patients with CHF I FC was 35.8 ± 0.9 years, II FC — 47.1 ± 1.1 years, III FC — 55.9 ± 1.4 years, IV FC — 62.5 ± 1.3 years.



Depending on the cause of CHF, the distribution of patients was as follows: I FC — 17 (51.5%) patients suffered from hypertension, 7 (21.3%) patients — CHD, 9 (27.2%) patients with CHD and hypertension; II FC — 14 patients suffered from hypertension, 8 (24.3%) — CHD and 12 patients (33.3%) — coronary heart disease in combination with hypertension; III FC — 2 (10%) patients suffered from arterial hypertension, 12 (60%) patients — coronary heart disease, 6 (30%) — coronary heart disease and hypertension; IVFC — 12 (63.2%) suffered from coronary heart disease, 7 (36.8 %) — CHD in combination with AH.

The Beck depression scale was used to determine the level of depression. The school questionnaire contained 21 groups of statements with 4 statements in each (0, 1, 2, 3). After reading carefully, it was necessary to note the statement that best reflects the patient's well-being during the last time, including the day of the survey. If several statements in one group were suitable, it was necessary to mark each of them. Each statement was rated at 1 point. The results were evaluated as follows: 0-9 — absence of depressive symptoms; 10-15 — mild depression (subdepression); 16-19 — moderate, 20-29 — severe (moderate severity); 30 or more — severe depression. Items 1-13 — congruent-affective subscale, items 14-21 — subscale of somatic manifestations of depression.

The answer to each question was evaluated on a 7- point scale. To facilitate the perception of the obtained indicators, their conversion into percentages was used. An integral indicator of the quality of life was calculated for 6 sections, which included 6 of the above components.

A person with preserved functions, satisfied with all aspects of his life, has an integral indicator of the quality of life equal to 100% or approaching this level.

A slight decrease in the quality of life was considered to be a decrease in the integral indicator to 75%; moderate — up to 50%; significant — up to 25%, pronounced — less than 25%. The assessment of personal and reactive anxiety was carried out using the Spielberger-Khanin scale of reactive and personal anxiety, which was evaluated in points. Moderate anxiety was 31-45 points, high — 46 and more points, low — up to 30 points.

RESEARCH RESULTS AND THEIR DISCUSSION

According to the results of determining the level of depression, the following data were obtained. The absence of depressive symptoms was noted in 39 patients, which amounted to 37.2 %, depression of varying degrees was detected in 66 patients, or 62.8%. Mild depression was observed in 25 people (41%), moderate — in 26 (34.5%), pronounced — in 11 (18%) and severe — in 4 (6.5%) people.

The average score of depression on the Beck scale in patients with I FC CHF was 8.9 ± 0.6 ; II FC CHF - 12.6 ± 1.1 ; III FC CHF - 17.5 ± 0.8 ; IV FC CHF - 19.0 ± 1.2 . The structure of depressive states in patients with I and II FC CHF was dominated by items 1-13, in patients with III and IV FC - items 14-21. Depending on gender, the distribution was as follows: 23 (33.8%) of 68 women had no depression, 16 (43%) of 37 men had no depression. The average age of patients without depression was 41.4 ± 1.3 years. Mild depression was detected in 6 men and 19 women (28.5 and 42%), the average age of patients was 47.2 ± 0.9 years; moderate



— in 9 men and 17 women (43 and 38%), the average age of patients was 54.3 ± 1.2 years; It was pronounced in 4 men and 7 women (19 and 15.5%), the average age was 58.6 ± 1.1 years, and 2 men and 2 women (9.5 and 4.5%) suffered from severe depression, the average age was 62.5 ± 1.3 years.

For nosological reasons, patients with arterial hypertension of II–III degree and angina pectoris of FC II and III, as well as persons with a combination of coronary heart disease and arterial hypertension, suffered from depression more often.

In the study of the quality of life, the integral indicator of the quality of life in the group of patients with CHF I FC was $73.8 \pm 3.5\%$, II FC — $62 \pm 3.6\%$, III FC — $44.2 \pm 3.8\%$, IV FC — $23.4 \pm 3.8\%$. From the data presented, it can be seen that the integral indicator of the quality of life of patients with CHF I FC was slightly reduced, II FC was moderately reduced, III FC was significantly reduced and sharply reduced in patients with IV FC.

When analyzing the characteristics of individual components of the integral indicator of quality of life in patients with II, III, IV FC CHF, a significant decrease in physical mobility was noted ($65,4 \pm 3,2 \%$, $28,9 \pm 3,8 \%$, $20,1 \pm 1,2 \%$ respectively), sexual function II FC — $62.5 \pm 2.6\%$, III FC — $37.3 \pm 4.5\%$, IV FC — $23.5 \pm 3.1\%$, the economic situation of II FC — $74.2 \pm 4.6\%$, III FC — $42.6 \pm 4.5\%$, IV FC — $24.7 \pm 1.7\%$ and the emotional state of II FC — $60.8 \pm 3.8\%$, III FC — $39.6 \pm 4.2\%$, IV FC — $27.2 \pm 2.8\%$. A decrease in physical mobility, reflecting the degree of exercise, was noted in patients during the 6-minute walk test. Patients with CHF II FC covered a distance of 390 ± 7.9 m in 6 minutes of walking, III FC — 228 ± 12.8 m, IV FC — 118.7 ± 8.7 m.

For nosological reasons, the integral indicator of quality of life was lower in patients who suffered from arterial hypertension of II–III degree, angina pectoris of FC II–III, as well as persons with a combination of arterial hypertension and coronary heart disease.

The analysis showed that reactive and personal anxiety, depending on the severity of chronic heart failure, had some differences. Thus, there were no significant changes in reactive anxiety depending on FC CHF (I FC — 35.3 ± 0.16 ; II FC — 39.3 ± 0.11 ; III FC — 39.3 ± 0.09). When comparing the level of personal anxiety, a significant increase in this indicator was noted in patients with CHF II FC (50.7 ± 0.14 ; $r = 0.96$; $p = 0.002$) and III FC (49.3 ± 0.18 ; $r = 0.84$; $p = 0.036$).

As follows from the above, the level of reactive anxiety in all groups of patients did not exceed 45 points, that is, it remained moderate, there was no dependence of reactive anxiety on CHF FC, angina pectoris FC and the degree of arterial hypertension. At the same time, a high level of personal anxiety was noted in patients with CHF II and III FC, in patients with stress angina of FC II–III, arterial hypertension of II–III degree and with a combination of stress angina and arterial hypertension.

CONCLUSION

1. Depressive disorders were detected in 62.8% of patients suffering from CHF, cognitive-affective disorders prevailed in patients with I and I IFC CHF, somatic manifestations of depression prevailed in patients with III and IV FC CHF. Depressive disorders were associated with the female sex (68% of women and 32% of men), age over 50 years (55.6 ± 1.3) and



severity of somatic disease (grade II–III hypertension, angina pectoris grade II–III and a combination of these diseases).

2. The level of quality of life in patients with CHF decreases with an increase in CHF FC, the integral QL index is moderately reduced at FC II ($62 \pm 3.6\%$), significantly reduced at FC III ($44.2 \pm 3.8\%$) and sharply reduced at FC IV ($23.4 \pm 3.8\%$). Such components as physical mobility, sexual function, economic status and emotional state contributed to the decrease in the integral indicator of quality of life in patients with CHF II, III, IV FC. There were no significant differences between men and women in the integral indicators of quality of life in patients with CHF and its various components.

3. The level of reactive anxiety in all groups of patients with CHF is moderate, the level of personal anxiety is high and is associated with the II and III FC of CHF, as well as with the severity of somatic disease (stable angina pectoris FC II–III, arterial hypertension II–III degrees and a combination of hypertension and coronary heart disease), which is possible, is associated with the individual characteristics of the personality and the influence of somatic disease on it (FC II–III and a combination of these diseases).

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